A Supportive Supervision Framework for Operational Managers in
the Primary Health Care Facilities of the North-West Province

by

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DECLARATION

I, Maserapelo Gladys Serapelwane, declare that *A Supportive Supervision Framework for Operational Managers in the Primary Health Care Facilities of North-West Province* is my original work and the sources used have been properly acknowledged and that this work has not been submitted at another university for any degree.

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Maserapelo Serapelwane

SERAPELWANE MG

11.02.2019
DEDICATION

I dedicate this thesis to our heavenly Father who blessed me with the strength, perseverance and wisdom for me to complete this project.

*I would have lost heart unless I had believed that I would see the Goodness of the Lord in the land of the living.* [Psalm 27:13]

This project is dedicated to my late and beloved father, Maleho Ben Serapelwane, who used to say ‘*Education is the only legacy that I can provide you with*’. I therefore honour him for this excellent lesson learned.

To my beloved mother, Kelopemang Elizabeth Serapelwane, who instilled in me that there is nothing impossible with God. This work is dedicated to you.

To my late brother, Kgosietsile Jackson Serapelwane, I still cherish your peace, love and support. I therefore know that my achievements are also yours.
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Lack of Supportive Supervision (SS) of Operational Managers is raised as a serious challenge in the Primary Health Care facilities of the North-West Province. These occur despite the burden of disease and a high demand of quality services that should be provided to clients. Regardless of the challenges, Operational Managers (OPMs) are expected to play an effective supervisory role by ensuring that all the health care programmes are implemented according to the set norms and standards. The enhancement of Supportive Supervision of OPMs is necessary as it could impact positively on the provision of services and the burden of disease. In this regard, a qualitative, descriptive, exploratory and contextual research study was conducted aimed at developing a SS framework for Operational Managers in the Primary Health Care facilities of the North West Province. The objectives were: (1) to explore and describe experiences of Operational Managers regarding SS in the Primary Health Care (PHC) facilities of the North West Province, (2) to describe OPMs’ perceptions of how Supportive Supervision of OPM can be facilitated effectively in PHC facilities of the North West Province, (3) to describe a framework for SS of OPMs in the Primary Health Care facilities, (4) to develop a Supportive Supervision framework of OPMs in the PHC facilities, (5) to validate a Supportive Supervision framework of OPMs in the Primary Health Care facilities, and (6) to describe the guidelines for operationalization of a SS framework in the Primary Health Care facilities of the North West Province. The population of this study comprised of OPMs who worked as supervisors for a period of more than a year in the PHC facilities of the North West Province. Purposive sampling was used to select the participants of this study. The researcher followed and applied applicable ethical principles throughout all phases of this study. The study was divided into two phases—the first phase explored and described experiences of OPMs and OPMs’ perception of how Supportive Supervision can be facilitated in the PHC facilities. The data collection methods used was semi-structured in-depth focus group interviews. For this reason, four semi-structured in-depth focus group interviews were conducted in the four sub-
districts of the NWP. The total number of Operational Managers who participated in this study, was twenty three. Their ages ranged from thirty seven to fifty eight years, three of the participants were males whereas twenty were females. The analysis of data followed Tesch’s method of content analysis and open-coding (Creswell, 2009: 184). Four broad themes with their respective categories and sub-categories emerged from the consensus meeting held with the independent co-coder. In the first theme, the participants expressed experiences of factors related to compromised critical aspects of SS. The second theme embodied experiences of factors related to lack of qualities and competencies of a supportive supervisor. The third theme focused on experiences of factors that contribute to poor delegation and supervision in the PHC facilities. In the fourth theme, the participants expressed the factors that can enhance facilitation of effective supportive supervision. Phase two was divided into two stages, and the first stage focused on a description of a framework for Supportive Supervision of OPMs in the Primary Health Care facilities of NWP. The second stage focused on a framework development and description, validation and development of the proposed guidelines for operationalization of the framework. The University of Wisconsin Extension (UWEX) Logic Model guided the whole process of a framework for SS description and development (Powel and Henert, 2008:56). The recommendations included, amongst others, in-service training regarding the critical elements of SS for Local Area Managers and Operational Managers for enhancement of supervision by OPMs in the Primary Health Care facilities, shortage and retention of nursing staff needs an urgent intervention. The health department also needs to advertise vacant posts for managers playing a role in SS of PHCs in order to close the gap caused by acting positions. A developed supportive supervision framework for Operational Managers in the North West Province could improve supervision and management of Primary Health Care facilities.

**Keywords:** Supportive Supervision, Primary Health Care, Operational Managers, Programme, UWEX Logic Model
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LIST OF ACRONYMS

AIDS  Acquired Immune Deficiency Syndrome
CCMDD  Central Chronic Medication and Distributions
CDC  Centers for Disease Control and Prevention
DoH  Department of Health
HR  Human Resources
HRD  Human Resource Development
FGI  Focus Group Interview
FRC  Faculty of Agriculture, Science and Technology Research Committee
ICSM  Integrated Clinical Services Management
ICDM  Integrated Chronic Disease Management
LAMs  Local Area Managers
MCHW  Mother and Child Health Welfare
MEC  Member of the Executive Council
NCS  National Core Standards
NDP  National Development Plan
NIMART  Nurse Initiated Management of Anti-Retroviral Treatment
NHI  National Health Insurance
NWP  North-West Province
OPMs  Operational Managers
PFMA  Public Finance Management Act
PHC  Primary Health Care
PMDS  Performance Management Development System
PMTCT  Prevention of Mother-to-Child Transmission
PSI  Patient Safety Incident
RSA  Republic of South Africa
SANC  South African Nursing Council
SDGs  Sustainable Development Goals
SS  Supportive Supervision/Supervisor(s)
TB  Tuberculosis
USA  United States of America
UWEX  University of Wisconsin Extension
WISIN  Workload Indicators of Staff In Need
WHO  World Health Organization
CHAPTER 1

Overview of the Study

1.1 Introduction

Supportive Supervision (SS) in the Primary Health Care facilities (PHC) remains a major challenge, especially in developing countries. Supportive Supervision is a process of providing support to Operational Managers in supervision and management of PHC facilities (Resource Manual Republic of Phillipines, 2012:5; Adeyemo, 2017:53; Integrated Clinical Services Management, 2014: 1). Supportive Supervision as a challenge is worsened by the burden of disease leading to the increasing demand for support of OPMs in supervision and management of the PHC facilities (Munyewendel, Rispel and Chirwa, 2014:1). These suggest that it is necessary to develop a SS framework for OPMs as it could enhance support of OPMs in order to supervise their subordinates to render effective services. This study was aimed at developing a SS framework for OPM by Local Area Managers in the PHC facilities of North-West Province (NWP) in South Africa. This chapter focuses on the background and rationale, problem statement, research questions, purpose and research objectives. The chapter continues with the significance of the study, paradigmatic perspective, preliminary literature review as well as the research design and brief description of research methods. It also includes measures to ensure trustworthiness, ethical principles and the outline of the chapters.

1.2 Background and Rationale

The World Health Organization (WHO, 2017:10) identified the negative effects of ineffective supervision in the PHC facilities. It is reported that mismanagement of patients during pregnancy and labour is associated with ineffective supervision of nursing staff by the clinic
managers (WHO, 2017:10; Munyewendel et al., 2014:1). The study conducted by Nkomazana, Mash, Wojczewski, Kutalek and Phaladze (2016:9) reported that Operational Managers (OPMs) who did not feel supported during supportive supervisory visits were not productive. On the other hand, Vasan, Mabey, Chaudhri, Epstein and Lawn (2016:443) concluded in their study that poor performance regarding PHC outcomes occurred as a result of supportive supervisory visits that were faults finding and irregular. Vasan et al. (2016:443) also reported that demotivated clinic managers were unable to provide nursing staff with the necessary guidance on how to implement policies and guidelines. The findings suggest that lack of SS of OPMs by LAMs contribute to ineffective supervision of nurses in the provision of PHC services. Lack of SS of OPMs was demonstrated by supportive supervisory visits that were irregular, fault finding and demotivating, leading to inability to guide the nursing staff accordingly. The findings further suggest that supervision of nursing staff by OPMs in the PHC facilities should be strengthened. The study conducted by Mijovic, McKnight and English (2016:7) reported that professional nurses who were not supervised for some period felt uncertain about implementing treatment guidelines and new policies.

The negative effects related to ineffective supervision of nurses by nursing managers are evident whereby patients are mismanaged during pregnancy and labour. The negative effects of ineffective supervision were also demonstrated by lack of confidence of nurses in the implementation of treatment guidelines. A SS framework might help to alleviate the reported negative effects that are associated with ineffective supervision by OPMs in the PHC facilities. These imply that a SS framework of OPMs could have a positive influence on management of patients during pregnancy and labour. A SS framework may also lessen the lack of confidence on the implementation of treatment guidelines. Objective one of Sustainable Development Goals (SDG) number three aims at reducing maternal mortality (WHO, 2016:8).

In this regard, OPMs are expected to play effective supervisory roles to ensure that the set targets for reducing maternal mortality are met. It is imperative to develop a SS framework for
OPMs in the PHC facilities as it could enhance supervision, thus assisting in reaching the set targets stipulated by WHO. Literature reported several SS models and little information about SS frameworks for OPMs working in the PHC facilities. Most SS models found in the literature were those developed for nurses in American and European countries (Resource Manual of Department of Health (DoH), Republic of Phillipines, 2012:13; Health Force Australia, 2011:3; Southern Adelaide Local Health Network, 2013:3; Hodgins, Judd, Kyrios, Murray, Cope and Sasse, 2005:1). A preliminary literature review discovered only four programmes that address clinical supervision for allied health professionals, supervision for registered nurses, nursing peer support programme and supervision programme for social workers (Health Work Force Australia, 2010:2; Russel, 2013:2; ZhiHon and Wang, 2007; Malgas 2011:1). These demonstrate a dearth of literature regarding a SS framework for OPMs working at the PHC facilities in developing countries. The current study focuses on a SS framework for OPMs working in the PHC facilities of the NWP in SA. It is hoped that a SS framework will close the identified knowledge and practice gaps.

The aim of SS is to help OPMs to improve the quality of supervision on the implementation of PHC programmes (Nkomazana et al., 2016:7; Adeyemo, 2017:2). These denote that OPMs should receive SS so that their supervision in the PHC facilities should meet the required standard. Some of the critical aspects that should be adhered to during supportive supervisory visits are joint identification and resolution of problems, reviewing of clinical records, observing clinical practice and giving feedback (Jacobs, Digkale, Maartens and Mkhonto 2014:2).

The findings of Nkomazana et al., (2016:7); Adeyemo, (2017:2) and Jacobs et al., (2014:2) suggest that for supportive supervisory visits to be effective, both the supervisor and a supervisee should work together in identification and resolution of problems. These also indicate that both a supervisor and a supervisee have roles to play in supervision of PHC facilities. This study adopted the University of Wisconsin Extension Logic (UWEX) for
framework development which requires that the resource and activities for each role player to be outlined (Powel and Henert, 2008:56; Wholey, Hatry and Newcomer, 2010:24). These imply that the supervisory roles of persons that should participate in a SS of OPMs are outlined in the description of the framework. Several studies demonstrate the benefits that SS have on the supervisor, supervisee and the PHC services. The study conducted in USA in the rural PHC facilities of Gautamala focused on evaluation of support and supervision given to Auxiliary Nurses (Hernandez, Hurtg, Dahliblom and Sebastian, 2014:4). The nurses reported that regular SS motivated them to complete work responsibilities because they knew that their work is being observed. The nurses further reported that support through guidance in problem resolution improved ability to work in the desired way. The above study reported the benefits of SS focusing on the aspect of direct observation of practice, and joint identification of problem and resolution.

The study conducted in North America and Haiti was to develop case studies of SS projects and how supervision has been used to strengthen HIV programmes (Marshall and Fehringer, 2013:8). The supervisees reported that supervision facilitates professional development and the visits make supervisees feel that they are not alone. The supervision also makes supervisees feel that the supportive supervisors are following closely on what they are doing (Marshall and Fehringer, 2013:8). The findings suggest that direct observation of practice by checking and guiding the supervisee enhances professional development. With direct observation of practice by the supervisor, the supervisees feel that they are not alone during the execution of the tasks. These suggest that supervisees feel supported when the provision of service is closely observed by the supervisor.

The study conducted in Georgia aimed at identifying the effects of SS on the performance of the immunization programme. The participants were nurse supervisors and supervisees working in the PHC facilities of rural communities. (Uduma, Galligan, Mollel, Masanja, Bradley and McAuliffe, 2017:12). The findings revealed improved immunization coverage
rate after implementation of SS guidelines. In addition, improved knowledge about SS was observed on managers (Uduma et al., 2017:12). The findings demonstrate that the supervisees, supervisors and the PHC system gained from continuous and regular supervisory visits. These suggest that supervision could yield good outcomes only when it is regular, continuous and when utilizing SS guidelines. In the European region, the benefits of SS were found to be increased adherence to treatment guidelines and improved quality in management of childhood illnesses (Gera, Shah, Garner, Richardson and Sachdev, 2016:18). The current study takes into consideration the benefits of SS reported by different researchers. A SS framework for OPMs is required, especially in developing countries as it could help to sustain the reported benefits. Although the benefits of SS of nurses in PHC facilities have been reported, challenges regarding SS were also raised, especially in developing countries. Lack of SS of nursing managers in the PHC facilities is one of the challenges reported frequently by several researchers.

In Egypt, it was reported that supervisory visits were irregular, supervisors were acting like inspectors during support visits (Hernandez et al., 2014:9). The problem solving of issues identified in PHC by both the supervisor and the supervisees was rated poor in Egypt. The findings suggest that OPM managers did not get the necessary support and the critical aspects of SS in Egypt were compromised. In Egypt, critical aspects of SS that were found to be compromised were identification and resolution of the problems by both a supervisor and a supervisee. A similar phenomenon was reported in systematic review conducted by Gera et al. (2016:18) as it was found that there was little or no supervision. In Kenya, it was found that the supervision was unsystematic with no technical support of PHC managers (Whittaker, Burns, Doyle and Lynam, 2014:266).

In Nigeria, the nursing staff experienced surprise visits and negative feedback from their supervisors. The study further reported that nurses regarded surprise visits and negative feedback as a punishment received from supervisors (Enwereji and Enwereji, 2013:1). The
lack of SS of OPM in developing countries is manifested by irregular PHC visits, poor identification and resolution of problems as well as lack of positive feedback. A study conducted in South Africa focused on two provinces, and used diaries to explore the work experiences of OPM in the PHC facilities (Munyewendel et al., 2014:7). The diaries reflected the perceived disrespect, punitive behaviour and verbal abuse from supervisors. The OPM of the two provinces indicated that they seldom receive positive feedback or feel appreciated during supervisory visits (Munyewendel et al., 2014:7). Another study conducted in South Africa revealed supervisory visits that were irregular and supervisors who did not use checklists adequately (Whittaker et al., 2014:266). In addition, it was reported that supervisors focused more on errors found during supervisory visits (Whittaker et al., 2014:266). The studies discovered lack of support of OPMs in the PHC facilities in SA (Munyewendel et al., 2014:7; Whittaker et al., 2014:266). Lack of support in supervision of PHC facilities is manifested whereby OPM experienced punitive behaviour, negative feedback, a feeling of being disrespected, irregular supervisory visits and supervisors who focused more on mistakes. A SS framework could address challenges related to lack of support of OPM, thus improving supervision and quality of care in the PHC facilities.

The South African Nursing Council (SANC, 2016:9) reported numbers of nurses charged with misconduct regarding management of patient during pregnancy and labour. This could be due to non-adherence to treatment guidelines and ineffective supervision of nurses by OPMs. In addition, the Minister of Health has publicly registered a serious concern with the number of litigations occurring due to malpractice by clinicians in the public sector (Human Resources for Health South Africa, 2016:61). The Minister further said that improving the operations of the statutory councils is an essential part of improving professional practice and ensuring quality care for the public and private sectors. Despite the nurses being charged with misconduct that could be due to ineffective supervision by clinic managers, and the concerns regarding litigations there is limited published evidence about a SS framework of OPM in the PHC facilities of SA.
This is regarded as a knowledge gap that needs to be closed through development of a SS framework for OPM in the NWP. In the Western Cape Province, the professional nurses reported lack of recognition from supervisors and poor communication (Roomaney, Steenkamp and Kagee 2017:7). The professional nurses in charge of the PHC facility felt that they seldom received positive feedback during SS. The lack of recognition by supervisors and poor communication is a manifestation of lack of support of OPMs during supportive supervisory visits.

In the NWP, the report of Women’s Health revealed numbers of deaths occurring during pregnancy, childbirth and peuperium in the PHC facilities (NDoH RSA Saving Mothers Annual Report, 2014:3). The findings in the NWP are associated with the mismanagement of patients during pregnancy and labour. The findings also indicate the negative effects and the poor health outcomes that could be due to ineffective supervision of nurses by OPMs in PHC facilities (WHO, 2017:10; Munyewendel et al., 2014:1). Despite the challenges related to lack of SS of OPM in supervision of PHC facilities, there is a dearth of literature regarding a SS framework for OPMs in NWP of RSA. It is therefore important for this study to focus on development of a SS framework of OPM working in PHC facilities of NWP.

The vision of the DoH aims for is ‘A long and healthy life for all South Africans’ (Strategic Plan 2015-2020; NDoH RSA, 2015:12). In addition, the mission of the DoH emphasizes improvement of the health status and health care delivery system (Strategic plan 2015-2020 NDoH RSA, 2015:12). The development of a SS framework could enhance SS of OPMs in the PHC facilities and thus contribute to the vision and mission of the DoH.

1.3 Problem Statement

The evidence presented this far revealed lack of SS of Operational Managers in supervision of the PHC facilities. This was also observed by the researcher when she was working as a professional nurse at different PHC facilities in the NWP. The researcher observed that OPMs
were blamed and reprimanded for poor health outcomes in the PHC facilities. The SS of the OPMs by their nursing managers who are Local Area Managers (LAMs) seemed to be punitive and focusing on mistakes. The observation of clinical practice, problem identification and resolution by both the supervisor and a supervisee appeared to be compromised during supervisory visits. These suggested that OPMs were not getting the necessary support to enable them to undertake their supervisory role effectively in the PHC facilities. The literature revealed the knowledge gap about a SS framework for OPMs in developing countries and RSA is not an exception. In addition, the SS models found in the literature are those developed to address supervisory challenges in rural areas of developed countries of the United States of America (USA) and Europe. The literature found only two models developed in Africa and these models still showed the knowledge gap with regard to a SS framework for OPMs in developing countries. In addition, the literature is silent about a SS framework of OPMs in the PHC facilities of NWP which is the focus of this study.

The study conducted by Uduma et al. (2017:2) reported a need for a structured approach for enhancement of SS of PHC facility managers in developing countries. This was supported by the study conducted recently in RSA as a need for a specific approach regarding support of OPMs in supervision and management of PHC facilities was discovered (Gilson, 2016:2). When taking into consideration the reports of poor health outcomes revealed in the NWP in NDoH RSA Saving Mothers Annual Report (2014:3), it is imperative for this study to focus on SS framework. The reported cases of litigations that could be due to lack of adherence to the guidelines also relates to lack of support of OPM in supervision in PHC facilities (SANC, 2016:9). In addition, there is little disseminated research available that developed a SS framework for OPM in the PHC facilities of NWP.

Given the foregoing, this study sought to answer the following research questions:

1. What are experiences of Operational Managers regarding Supportive Supervision by Local Area Managers in PHC facilities of the North West
1.4 Research Purpose

The aim of this study was to develop a Supportive Supervision framework for Operational Managers by Local Area Managers in the PHC facilities of the North West Province.

1.5 Objectives of the Study

The objectives of this study were to:

- Explore and describe experiences of Operational Managers regarding Supportive Supervision by Local Area Managers in the PHC facilities of the North West Province;

- Describe Operational Managers’ perceptions of how Supportive Supervision by Local Area Managers can be facilitated effectively in PHC facilities of the North West Province;

- Describe the conceptual framework of Supportive Supervision of Operational Managers in the PHC facilities;

- Develop and describe a Supportive Supervision framework of Operational Managers in the PHC facilities;

- Validate a Supportive Supervision framework of Operational Managers in the PHC
facilities; and

Describe the guidelines of operationalization of the framework.

1.6 Significance of the Study

The findings of this study will be shared with policymakers to inform them about a SS framework that could improve supportive supervision of OPM in PHC facilities. A SS framework could help to improve the quality of supervision and health outcomes in the PHC facilities of the NWP. The findings might also influence curriculum development to ensure implementation of SS in PHC facilities. The findings of this study could close the knowledge and practice gaps regarding a SS framework for OPMs in the NWP.

1.7 Paradigmatic Perspective

A paradigm is a way of looking at a natural phenomenon and it consists of a set of philosophical assumptions that directs the researchers approach to inquiry (Polit and Beck, 2017:542). The paradigmatic perspective of this study is based on meta-paradigm, theoretical assumptions, central theoretical statements and methodological assumptions as discussed below.

1.7.1 Meta-Paradigm

The meta-paradigm comprises of the overall perspective of a discipline; and meta-paradigm of each discipline specifies its distinctive perspective (Brink, van der Walt and van Rensburg, 2012:25). It is therefore important to reveal that the arguments of this study are based on Roger’s Model for science of unitary persons (Fitzpatrick and Whall, 1996:248). The main focus of Roger’s Model is on nursing, person, health and environment. The meta-paradigm of this study is discussed in the following manner:
1.7.1.1 Nursing

Nursing is defined as “the science of unitary human beings”, and the purpose of nursing is to promote good health to all social beings (Fitzpatrick and Whall, 1996:248). In this study, nursing refers to SS of operational managers in the provision of nursing services in the PHC facilities.

1.7.1.2 Person

Roger defined a person as an open system that is a complex, inseparable human being that needs to be studied in the wholeness (Fitzpatrick and Whall, 1996:248). The person cannot be understood outside the context of the place and time in which she/he is functioning. A person is influenced by the current circumstances and also overburdened by a lifetime experience (George, 2002:230). For the purpose of this study, an OPM is a person who is subject to SS and who plays a fundamental role of supervision in the PHC setting. As a result, the OPMs’ experiences in the PHC settings have an influence in the provision of quality care. It is therefore important for SS of OPMs to be studied and understood within their workplace.

1.7.1.3 Health

The researcher agrees with Rogers’ theory on health Fitzpatrick and Whall (1996:248). Rogers’ theory indicates that health is a process combined with environmental, physical and psychological factors (Fitzpatrick and Whall, 1996:248). For the purpose of this study, Health is viewed as a process combined with the environmental, physical and psychological factors in the PHC facilities. This suggests that it will not be easy to explore the experience of OPMs without focusing on SS in the work environment. Hence, the researcher believes that a SS environment enhance the quality of supervision by OPMs in the PHC facilities. This metaparadigmatic perspective was applied by choosing a qualitative design which influenced understanding of the participants’ view of the SS environment. Rogers’ theory and the qualitative design guided the study during formulation of the title, structuring of research
questions, objectives, purpose, methods for data collection and analysis and the discussions of
the findings.

1.7.1.4 Environment

The environment is described by classifying it into the operational, perceptual and the
conceptual environment. The operational environment consists of those undetected natural
forces that affect an individual (Fitzpatrick, Whall, 1996: 248 and George, 2002:230). The
perceptual environment consists of information that is associated with the psychological well-
being of an individual. The conceptual environment is influenced by the culture, norms and
values of individuals (Fitzpatrick, Whall, 1996:248; George, 2002:230). In this study, the
environment refers to SS of operational managers in the PHC settings of the NWP. The
researcher believes that supervision in PHC environment is having an influence in the quality
of care.

1.7.2 Theoretical Assumptions

According to Burns and Grove (2016:324), theory is an integrated set of defined concepts,
existence statements, and relational statements that present a view of a phenomenon and can
be used to describe, explain, predict and/or control that phenomenon. The theoretical
assumptions of this study focus on the theoretical framework and central theoretical statements.

1.7.3 Theoretical Framework

Figure 1.1 is a schematic representation of the theoretical framework of SS as outlined in the
Resource Manual of DoH Republic of Philippines (2012:5). This framework for SS was
developed for public health nurses and rural midwives in Philippines. The purpose of the
framework is to improve quality in management of health care programmes in the PHC
facilities of the Philippines. This framework demonstrates that when the concepts of SS are
integrated in management of the health service, it will improve the health outcomes and lead
to the ability to enhance the goals of the health system. The Resource Manual of DoH of
Phillipines (2012:13) described the characteristics of the concept SS, goals of SS,
characteristics of a supportive supervisor and nursing supervisee as well as the factors affecting
supervision in the PHC services.
Figure 1.1: Theoretical framework for supportive supervision

Source: Department of Health Republic of the Phillipines, 2012:5
The roles and functions of both a supervisor and a supervisee are also described in the framework of SS. It is assumed that the above framework is appropriate to guide this study because it reflects the aspects that are important for supervision of the PHC facilities. The concepts reflected in this framework helped the study to focus on the main research topic. This enabled the study to focus on SS of Operational managers in the PHC facilities from the problem identification until the final stage. A detailed discussion of the SS framework is accomplished in the literature review (Chapter 3).

1.7.4 Central Theoretical Statements

The theoretical statements of this study include the central theoretical argument and conceptual definitions as detailed below:

1.7.4.1 Central Theoretical Argument

This study focuses on SS of OPM which seems to be a huge challenge in the provision of PHC services. The OPMs are to play an effective supervisory role to ensure that health care programmes in the PHC facilities are implemented according to the guidelines. On the other hand, the health programmes should be monitored by PHC supervisors for quality improvement and to strengthen supervision of the health care programmes. Although both the supervisor and a supervisee have a major role to play in supervision of PHCs, the critical aspects of SS seem to be compromised. The situation is aggravated by the burden of disease leading to high expectations in supervision for the provision of quality care in the PHC settings.

The worst situations seem to be occurring in developing countries whereby OPMs need enough support by LAMs to enable them to improve their supervision of the nursing staff and the management of PHC facilities. The lack of SS of OPM by LAMs seems to be contributing to ineffective supervision in the PHC facilities. When bearing in mind the vision and mission, the strategic goals and the set targets for each health programme of the DoH, there is a need to
strengthen SS of OPM in the PHC facilities (Strategic Plan 2015-2020 NDoH RSA, 2015:12).
The in-depth exploration and description of experiences of OPM regarding SS could lead to a
better understanding of how SS should be facilitated effectively in the PHC facilities. The
framework of SS will state the needs and what should be done in SS of OPM in the provision
of quality care.

1.7.4.2 Conceptual Definitions

Polit and Beck (2010:66) indicated that concepts in which researchers are concerned with are
abstractions of noticeable phenomena, and the researcher’s world views shape how those
concepts are defined. In addition, a conceptual definition presents the abstract or theoretical
meaning of the concepts being studied. It is also indicated that even straightforward terms need
to be conceptually defined by researchers (Polit and Beck, 2010:66). The concepts of this study
are defined as follows:

❖ Supportive Supervision

Supportive supervision is a continuous process that includes joint identification and resolution
of problems, reviewing of records, observing clinical practice and giving feedback (Resource
Manual of the Department of Health Republic of Philippines, 2012:5; National Department of
Health Republic of South Africa, Integrated Clinical Services Management, 2014: 11). In this
study, it means SS provided to OPMs’ as a support to enable them to improve their supervision
and management of PHC facilities.

❖ Operational Manager

In this study, an Operational Manager is a professional nurse who is responsible for general
management and supervision of the PHC facility, and who ensures implementation of all PHC
programmes and provides quality health care service (National Department of Health Republic
Local Area Manager

Is a designated manager and a supervisor who is responsible for performing monthly SS in order to support OPM in supervision and management of PHC facilities of the NWP (National Department of Health Republic of South Africa, Integrated Clinical Services Management, 2014:10).

Primary Health Care Facilities

These are health facilities that render comprehensive integrated Primary Health Care services to individuals, family and the community (Hattingh, Dreyer and Roos, 2013; National Department of Health Republic of South Africa, Integrated Clinical Services Management, 2014:10). In the context of this study Primary Health Care facilities are health care institutions that are supervised and managed by the Operational managers.

A SS Framework

A framework is a broad overview, skeleton or an outline of resources and activities envisaged to achieve the specific outcomes among a particular target group (Powell, Jones and Henert, 2008:2). In this study, a framework is a sequence of resources, activities and events aimed at enhancement of SS of OPM in the PHC facilities of NWP.

1.7.5 Methodological Assumptions

The researcher’s methodological assumptions should state the particular methods of knowing about the reality (Brink, van der Walt and van Rensburg, 2012:24). This study is positioned within the assumptions of constructivism which believes that individuals develop subjective meanings of their experiences (Creswell, 2014:9). The constructivism is characterised by answering the specific ontologic, epistemologic and methodological questions to address the research purpose and objectives (Creswell, 2014:9). The ontological questions of this study are based on exploring the reality about experiences of OPM regarding SS in the PHC facilities. The epistemological assumptions of this study are deeply rooted in understanding the world in
which OPM live and work. According to Polit and Beck (2012:742), the scientific method is a set of orderly, systematic, controlled procedures for acquiring reliable, empirical information. The methodology of this study is structured in a systematic way in order to obtain information that addresses the research questions and purpose. Therefore, the scientific design adopted for this study is qualitative, explorative, descriptive, and contextual. A detailed discussion of the design and method is addressed in Chapter 2.

1.8 Research Methodology

The discussion of the research methodology of this study focuses on the research design and methods, measures to ensure trustworthiness of the study and ethical considerations:

1.8.1 Research Design

A qualitative, descriptive, explorative and contextual design was adopted to enable the study to develop a SS framework (Polit and Beck, 2017:642). This design enabled the current study to describe and explore experiences of OPMs regarding SS in the PHC setting. With this design the researcher was able to find out how SS can be facilitated effectively in the PHC facilities of the NWP.

1.8.2 Research Methods

The population of this study comprised of OPMs in the PHC facilities of the districts in the NWP. Purposive sampling was used to select OPMs and PHC facilities (Burns and Grove, 2015: 543). A detailed description of the sampling criteria is given in Chapter 2. The researcher personally met with the participants to conduct in-depth, unstructured focus group interviews. The interviews were based on experiences of OPMs regarding SS in PHC facilities and how SS can be facilitated effectively in the PHC facilities. The focus group interviews were conducted in English. In this study, the sample size was determined by number of participants and data saturation per sub-district. The field notes were written during data collection and this
included observation notes, personal, methodological and theoretical notes (Polit and Beck, 2012:348). Data was analyzed following the eight steps of Tesch’s method of analysis and open-coding (Creswell 2014:197). The discussion of all data analysis steps followed is outlined in Chapter 2. The current study is divided into two phases:

1.8.2.1 Phase 1

Phase 1 explores and describes experiences of OPM regarding SS, and describes how SS of OPM could be facilitated effectively in PHC facilities of the NWP. Phase 2 is divided into two stages. The study was conducted in the PHC facilities of the NWP, and OPMs working in the four sub-districts of the districts in the NWP were recruited for participation. The sub-districts represent both the rural, semi-rural and urban areas of the NWP.

Description of the Setting

The researcher deemed it fit to collect data where the OPMs experience SS. This study took place at PHC facilities located in both rural and semi-rural areas of the NWP. The setting in research is described as the physical location and conditions in which data collection takes place (Polit and Beck, 2010:568). According to Burns and Grove (2011:549), the setting can be natural, partially controlled or highly controlled. Creswell (2014:185) indicated that qualitative researchers collect data in the field at the site where the participants experience the problem. Figure 2.1 depicts the setting within which the study took place in the NWP of RSA.

The NWP consists of four district municipalities (Municipalities of South Africa, 2012:5). The four district municipalities are named Ngaka Modiri Molema, Dr Ruth Segomotsi Mompati, Bojanala Platinum and Dr K Kaunda districts. Each district is further divided into sub-districts. In this study, data was collected in the PHC facilities of four sub-districts of the districts in NWP. Table 2.1 shows how each district in the NWP is divided into sub-districts.
The study was conducted in the PHC facilities of the four sub-districts in the NWP. These are the sub-districts chosen so that data should address SS aspects of rural, semi-rural and urban areas of the NWP. In addition, due to the differing physical location and setup the information from the facilities which are based in the urban areas may differ from that of rural.
Number of OPMs in the Setting

The total number of OPMs in the four sub-districts where this study took place was 56. The number of males were 12 and females 44 (NWP DoH Updated Sub-District Report, 2016:1).

Gaining Access and Recruitment of Participants in the Research Setting

Gaining access is discussed according to the two phases of this study. During the first phase, the researcher gained access immediately after receiving a written permission to conduct research from the sub-districts. In this regard, the researcher had access to the sub-district during the 08th March 2016 until January 2017. This allowed the researcher to negotiate and arrange for recruitment of prospective participants and for conducting interviews. The gatekeepers were sub-district managers, Local Health Area Managers and communication officers.

Appointments for meeting the Sub-district and Local Health Area Managers were secured telephonically through responsible communication officers.

The main purpose of the meeting was to negotiate suitable dates and central venue for recruitment of the prospective participants. The aim was also to ensure that normal rendering of services were not interrupted. Another purpose of the meeting was to seek help regarding equal representation of the PHC facilities and OPMs from each local health areas within the sub-district. The first meeting with the gatekeepers of Matlosana sub-district occurred during March 2016. The researcher had a meeting with the gatekeepers of Mahikeng during November 2016. In Rustenburg, the meeting took place on the 29th November and in Kagisano and Molopo sub-district it was on 10th January 2017.

In the four sub-districts it was agreed that it will be convenient for the interviews to take place immediately after recruitment. The identified central venues for recruitment and interviews were the board rooms of the bigger clinics and sub-district office. This agreement was influenced by shortage and the OPMs who were coming from the remote clinics. Arrangements for the second phase of this study occurred during March 2018. The communication process applied in the initial phase was followed to reach the OPMs who were expected to continue
with participation in the second phase.

❖ Role of the Researcher in the Setting

The researcher played the following role in the research setting:

❖ Emailing of letters of request of permission to utilize the facilities and OPMs in the four sub-district of the North West Province

❖ Making telephone calls for securing appointments for meeting with the gatekeepers of the four sub-districts

❖ Attending meeting for negotiating ways of recruiting prospective participants

❖ Preparing the venues for interviews by putting stickers of ‘do not disturb’ and sitting arrangement

❖ Facilitation of signing of informed consent

❖ Facilitation of the focus group interview discussions and taking field notes

1.8.2.2 Phase 2

Phase 2 of this study is divided into two stages. Stage 1 addresses description of a framework for supportive supervision. Stage 2 focuses on framework development and description, validation and description of guidelines for operationalization of the framework. The stages of Phase 2 are briefly discussed in the following order:

1.8.2.2.1 Stage 1

A brief discussion of the first stage which focuses on a description of a framework for SS of OPMs in the PHC facilities is as follows:
Description of a Framework for SS

The findings from Phase 1 of the current study is used to describe a framework for SS. This implies that the concepts identified in the results regarding SS were classified to show the relationship with the concepts in the University of Wisconsin Extension (UWEX) Logic Model (Powel and Henert, 2008:56). The most important reason for using UWEX Logic model’ is because it outlines the resources and activities needed to improve specific activities that should be supervised and followed in the specific organization. In this regard the use of UWEX Logic model’s enabled the study to outline the resources and activities required for enhancement of SS of OPMs in the PHC facilities of NWP. The theoretical framework discussed under subheading 1.7.3 of this study doesn’t outline clearly the resources and activities that need to be achieved for improvement of supervision. Therefore, Stage 1 of phase two used UWEX logic model was used to inform the process of development of a SS framework for Operational managers in the PHC facilities of NWP.

1.8.2.2.2 Stage 2

The second stage focuses on framework development and description, validation and guidelines of operationalization. This is discussed in the following manner:

Framework Development and Description

The University of Wisconsin Extension (UWEX) Logic Model was adapted because it is a guideline for recognizing the issues of SS and activities required for enhancement of SS of OPMs (Bernard, 2009:3; Kellog Foundation, 2004:5). The in-depth discussion of the rationale for using this model is provided in Chapter 2. The framework development and description is guided by the six components of the UWEX Logic Model (Powell, Jones and Henert 2002:2; Porteous, Sheldrick and Stewart, 2002:116). These entail that the framework development and description is based on the situation and priorities, inputs, outputs, outcomes, assumptions and external factors (Powell et al., 2002:3, Porteous et al., 2002:6; Bernard, 2009:3; Kellog Foundation, 2004:5). The logic model can be used for framework as well as programme
development, implementation evaluation and communications (Bernard, 2009: 3). For the purpose of this study, the logic model is applied for framework development, description and validation of the programme. The framework implementation and evaluation is not part of the present study. The six components of logic model that guided this study are briefly applied in the following order:

1. **Situation and Priorities**

An in-depth exploration and description of experiences regarding SS of OPMs enabled the study to identify concepts that relates to the current assets in the PHC facilities (Powel and Henert, 2008:56; Kellogg Foundation, 2004; Shackman and Rodriguez, 2015:6). In addition, an in-depth exploration, description of experiences regarding SS, thorough analysis and discussion of the findings, enabled the researchers to deduce the condition of the available assets. These further implies that the description of the situation regarding SS of OPMs and the priorities form the basis and the first step of description of framework for SS (Powel and Henert, 2008:56). It is imperative to indicate that the priorities regarding SS of OPMs in the PHC facilities are dependent on reviewed literature and what the participants said. This is to confirm what has been prescribed by the UWEX Logic Model as it is indicated that the resources, mission and vision, mandates, local dynamics should be considered during the first step of framework development (Powel and Henert, 2008:56). The priorities for framework development for this study are also based on the legislation and mandates regarding SS of OPMs of the South African DoH (Bernard, 2009: 3). A thorough description of this component is provided in Chapter 2.

2. **Inputs**

An in-depth exploration and description of OPMs perceptions of how SS of can be effectively facilitated in the PHC facilities helped the researcher to deduce the needs required. In addition, thorough analysis and open coding of the findings also enabled the researchers to deduce the needs required for enhancement of SS. This confirms what is
exposed in the UWEX logic model as it is indicated that the participants should be given
the opportunity to describe how the existing situation could be improved (Powell and
Henert, 2008:14; Wholey et al., 2010:56; Kellogg Foundation, 2004; Shackman and
Rodriguez, 2015:6). According to Bernard (2009:3), the inputs refer to the resources
invested that allow the framework to achieve the desired outcome.

3. Outputs

The outputs are described in the logic model as the activities and participation in the
framework (Powel and Henert, 2008:56). The activities and participation should clarify the
question of what should be done by whom to address the current situation regarding SS
(Powel and Henert, 2008:56). In this study, the activities necessary for enhancement of SS,
and persons who will participate in the SS process are stated to address the component of
the outputs. The activities and participation are also based on the findings from Phase 1
and reviewed literature.

4. Outcomes

In this study, the outcomes are dependent on the resources and activities to be accomplished
by the persons responsible for SS of OPM in PHC facilities. Therefore, the outcomes focus
on the changes that occur as a result of the inputs and outputs (Powel and Henert, 2008:
56). The component describing the outcomes is thoroughly dealt with in Chapter 2.

5. Assumptions

The assumptions in the logic model are beliefs about the framework and the people
involved in the process (Bernard, 2009:4). In this study, the assumptions about the
programme are stated. These are supported with literature and the findings in Phase 1 of
this study.
6. External Factors

In this study, all the external factors that could have an influence in the success of the framework are described. It is revealed that the external factors are political environment, experiences of the participant, the policies available and priorities that can influence the success of the programme (Bernard, 2009:4). Detailed discussion of the external factors is provided in Chapter 2.

- Framework Validation

The main role players for framework validation were the OPMs who participated in this study, and experienced researchers in framework development. A picture of a framework and the text were the source of information for framework validation. The validation of the framework was guided by four validation questions which are discussed in detail in Chapter 2 (Wholey, Hatry and Newcomer, 2010:54).

- Guidelines of Operationalization of the Framework

The study described the proposed guidelines for operationalization of the framework. The guidelines are based on the findings in Chapter 4 and a literature review with specific reference to SS strategies of PHC in RSA. In this regard, the components of UWEX Logic Model guided the discussion.

1.9 Measures to Ensure Trustworthiness

The first step taken to ensure the trustworthiness of the whole study was bracketing (Burns and Grove, 2011: 96). This helped the researcher not to misinterpret experiences of OPMs regarding SS in the PHC of the NWP. Further discussion about bracketing is dealt with in Chapter 2. The study applied the four principles found in Lincoln and Guba’s Model (1981) of evaluating the trustworthiness of qualitative research (Krefting, 1991:216). The four principles are discussed in Chapter 2.
1.10 Ethical Measures

Ethical clearance was obtained from North West University after the approval of the proposal by North-West University Faculty of Research Committee (FRC), as well as the School of Environmental and Health Sciences—Mafikeng Campus (Annexure A). Permission to conduct the study was obtained from North-West DoH. Participants were allowed to decide voluntarily whether to participate in the study by signing a consent form (Annexure I). The fundamental ethical principles underlying protection of human subjects were adhered to throughout the research process. These included respect for persons, principle of beneficence and the principle of justice (Brink, van der Walt and van Rensburg, 2012:34). A detailed description of the whole process is given in Chapter 2.

1.11 Outline of the Chapters

- **Chapter 1**: Overview of the Study
- **Chapter 2**: Research Methodology
- **Chapter 3**: Narrative Literature Review
- **Chapter 4**: Discussion of the Findings and Literature Control of a Supportive Supervision framework
- **Chapter 5**: A Conceptual Framework for Supportive Supervision
- **Chapter 6**: Supportive Supervision Framework, Development and Description, Validation and Description of Proposed Guidelines for Operationalization
- **Chapter 7**: Evaluation, Limitations, Conclusions and Recommendations

1.12 Conclusion

This chapter provided an overview of this study which encompasses the background and rationale, problem statement, research questions and research objectives. The chapter continued with the discussion of the significance of the study, paradigmatic perspectives, preliminary literature review as well as the research design and methods. The measures to ensure trustworthiness and ethical measures were also introduced. The next chapter will focus
on the research design and methods.
CHAPTER 2

Research Methodology

2.1 Introduction

Chapter 1 focused on the overview of the study and the following aspects were addressed: introduction, background and rationale, problem statement, research questions and research objectives. The significance of the study, paradigmatic perspective and preliminary literature review were also discussed. The discussion also included a brief outline of research design and method, measures to ensure trustworthiness, ethical measures and the outline of chapters. This chapter focuses on an in-depth discussion of the research design and methods of this study. A discussion of the design and methods follows.

2.2 Research Design

In order to address the set purpose, objectives and the research questions, the current study adopted a qualitative, descriptive, explorative and contextual design (Polit and Beck, 2004:729). The design added value to what is affirmed in the methodological assumptions of the constructivism. From the constructivism’s point of view, it is explicit that the design should be structured in the manner that addresses the specific ontological questions (Adom, Yeboah & Ankrah, 2016:3; Creswell, 2014:8).

With a qualitative design of this study an explorative, descriptive questions were asked which addressed the context of this study. A theoretical framework for supportive supervision that guided this study helped the researcher to focus on the main concepts which addressed the objectives (Department of Health Republic of the Phillippines, 2012:5). Integration of the design adopted with the assumptions of constructivism, and the concepts outlined in the theoretical
framework of SS, enabled the study to reach the objectives. This design enabled the researcher to develop a SS framework of OPMs in the PHC facilities in the NWP of RSA. According to Polit and Beck (2010:74) the research design is described as the whole arrangement for getting answers to the questions being studied. The research design directs the planning and implementation of a study in such a way that the researchers achieve the intended goal (Burns and Grove, 2011:547). The following discussion addresses the qualitative, descriptive, and contextual design of this study.

2.2.1 Qualitative Research Design

A qualitative design allows the participants to narrate their experiences regarding SS of OPMs in the PHC facilities (Streubert and Carpenter, 2011:19). The qualitative design was chosen because it confirms what is emphasised by the assumptions of constructivism. According to constructivism, the epistemological questions should be asked in a way that they (questions) generate understanding of the world other people are living in (Adom, Yeboah and Ankrah, 2016:3). This is confirmed by Rogers’ theory as it is indicated that people should be understood and interpreted according to their living environment (Fitzpatrick and Whall, 1996: 248).

In this regard, it was important to adopt a qualitative approach, as it enabled the study to understand OPMs’ experiences in their own perceptual environment (Creswell, 2014:246; Yin, 2011:8). The participants provide an in-depth understanding and they use the given opportunity to interpret their social world regarding SS in the PHC facilities (Yin, 2011:8). Therefore, in this study, multiple realities that exist regarding SS of OPM were obtained through qualitative design (Streubert and Carpenter, 2011:21). In qualitative research it is believed that people do understand and live experiences differently and it is therefore important not to subscribe to one truth, but rather to many truths (Streubert and Carpenter, 2011:21). In qualitative research, social interaction does not use any artificial research procedures and people will be saying what they want to say and are not limited to responding to a researcher’s pre-established questionnaires confined to a laboratory setting (Yin, 2011:8). The in-depth understanding of
experiences of OPMs, and how SS can be effectively facilitated as narrated by the participants enabled this study to develop a SS framework in the PHC facilities of NWP.

2.2.2 Contextual Research Design

Contextual research focuses on discovering what exists in the social environment (Yin, 2011:8; Ritchie and Lewis, 2003:40). The contextual design enabled the current study to explore and describe the social environment in which SS of OPMs takes place. In this study, the participants described their experiences in both the rural and semi-rural environment. The social events and activities were described the way they occurred and reported by the participants. In qualitative research the context includes the environment and the conditions in which the study takes place as well as the culture of the participants and their location (Richie and Lewis 2003:40).

The researchers must be sensitive to the context of the research and immerse themselves in the situation. The personal and social context is important in qualitative research. According to Yin (2011:8), qualitative research includes contextual conditions such as the social, institutional and environmental conditions within which people’s lives take place. It is also revealed that the contextual conditions may strongly influence all human events (Holloway and Wheeler 2010:11). The researcher was sensitive to the OPMs’ social, institutional and political environment, hence every information was handled as confidential. This also helped the researcher to understand the environmental factors that could have an influence on the success of the framework of SS of OPMs.

2.2.3 Descriptive Research Design

A descriptive design enabled the participants to give a thorough description of their experiences regarding SS of OPMs in PHC facilities (Brink and Rensburg, 2012:173). Constructivism allows human beings to construct meanings with the world they are interpreting. In this study open-ended questions enabled the participants to describe own experiences regarding SS (Creswell, 2014:246). Participants were afforded the opportunity to
give thick descriptions of events that occur in the PHC natural setting (Holloway and Wheeler, 2010:7). This enabled the study to describe the real-life situation regarding SS of OPMs in the PHC facilities of NWP (Brink, 2006:201). An intense discussion of situations regarding SS in PHC facilities enabled the researcher to fully examine how SS of OPMs can be effectively facilitated (Burns and Grove, 2011:536). Qualitative research focuses on the basis that individuals are best placed to describe situations and feelings in their own words (Holloway and Wheeler, 2010:7). The framework development is informed by experiences about SS of OPM in the PHC facilities of NWP.

2.2.4 Explorative Research Design

This design explored the way SS of OPMs is taking place in order to get a full understanding of how supervision can be enhanced in the PHC facilities. According to Polit and Beck (2004:20), exploratory qualitative research methods are used to explore the full nature of a phenomenon that is not well understood. The explorative design enabled the study to explore other factors related to SS and this helped to clarify experiences of OPMs. This design increased knowledge regarding the needs required for effective SS of OPM in the PHC facilities of NWP. The purpose of exploratory design is to clarify the various ways in which a phenomenon is manifested and on underlying processes (Polit and Beck, 2004:20). Burns and Grove (2009:700) revealed that exploratory research is designed to study other factors related to the phenomenon understudy in order to increase the knowledge of a field of study.

2.3 Research Methods

This study is divided into two phases. Phase 1 explores and describes experiences of OPM regarding SS of OPM in the PHC facilities of the NWP. Phase 1 continues by describing how SS of OPM can be facilitated effectively in PHC facilities of the NWP. Phase 2 is divided into two stages and stage one addresses description of a framework for supportive supervision. In Stage 2, framework development and description, validation and description of guidelines of
operationalization are discussed. The discussion of the phases of this study follows.

2.3.1 Phase 1

In Phase 1, the focus is on exploration and description of experiences regarding SS of OPMs in the PHC facilities of the NWP. This phase further describes OPMs perceptions of how SS of OPMs can be facilitated effectively in PHC facilities of the NWP. In this study, the research methods focused on the population, sampling, sample, sample size sampling criteria, data collection and analysis. Measures to ensure trustworthiness and ethical consideration apply to both phase one and two. Therefore information addressing issues pertaining to measures to ensure trustworthiness of will only appear only in phase one.

The research methods involved the description of how data collection and analysis and interpretation of the findings are accomplished by the researcher (Polit and Beck, 2010:238; Creswell, 2010:247). This also implies the techniques researchers use to structure a study and to gather and analyze information relevant to the research question (Polit and Beck, 2010:238; Creswell, 2010:247). The research methods of this study are described as follows:

2.3.1.1 Population

The population of this study comprised of the OPMs working in the PHC facilities of four sub-districts of the NWP. Brink and Rensburg (2012:131) defined a population as the entire group of persons or objects that is of interest to the researcher. Operational Managers were the population of interest for this study because they are regarded as the frontiers of supervision in the PHC facilities. This means that, the Operational manager is the one who is responsible for daily supervision and management of the PHC facility. The Operational Managers oversee general supervision of all employees in the PHC facilities, including professional nurses and other junior categories as well as support staff and they are the ones receiving monthly supervisory visits from the Local Area Managers. This is prescribed in the strategies used for supervision of PHC facilities in South Africa, and it is further stated that SS of OPMs by Local
Area Managers should be conducted on monthly basis (PHC Supervision Manual NDoH RSA, 2009:30; Ideal Clinic Manual Version 16 DoH RSA, 2015:16; NDoH RSA Integrated Clinical Services Management, 2014:26; NDoH RSA Integrated Chronic Disease Management, 2014:2). These should be accomplished through visiting specified facilities allocated to each Local Area Manager.

The monthly supervision of PHC facilities in the NWP should be conducted according to the eight steps and principles of supervision with integration of critical elements of SS of PHC (PHC Supervision Manual NDoH RSA, 2009:30). The purpose of the supervisory visits is to support OPMs in ensuring that supervision in the PHC facilities is taking place according to the prescribed supervision strategies and guidelines. (PHC Supervision Manual NDoH RSA, 2009:30; Ideal Clinic Manual Version 16 DoH RSA, 2015:16; NDoH RSA Integrated Clinical Services Management, 2014:26; NDoH RSA Integrated Chronic Disease Management, 2014:2).

Even though the Local Area Managers are playing a fundamental role in SS of OPMs, they were not included in this study because the focus or target population were Operational Managers. The Local Area Managers were the gate keepers for the facilities operating for 8, 12 and 24hrs. Therefore, during participation of OPMs in this study, the Local Area Managers were expected to ensure that the services were not interrupted. Burns and Grove’s (2011:544) perspective of a population is all people, objects, events or substances that meet the criteria for inclusion in the study. At times it is referred to as the target population. Based on the above discussions, it was necessary for OPMs to be given a priority to participate in development process a SS framework for OPMs in the PHC facilities of NWP. In order to support the notion of OPMs as frontiers of supervision in the PHC facilities, Figure 2.2 shows the flow of supervision in the PHC facilities of the North West Province.
The flow of supervision reveals an Operational manager being the one at the frontline where actual supervision of the provision primary health care is taking place. The Local Area Manager is shown as an immediate supervisor to an OPM, an OPM who takes the full responsibility of the onsite supervision. In this regard, Local Area Manager is expected to support OPMs in supervision of the PHC facilities. Hence it is necessary to explore and describe experiences of OPMs regarding SS in the PHC facilities. The summary of the main roles of OPMs in supervision of the PHC facilities are to:

- Oversee the supervision of implementation of the PHC programmes which include TB programme, HIV/AIDS & Nurse Initiated Management of Anti-Retroviral Treatment (NIMART), Mother and Child Health Welfare (MCHW), Mental Health, Non-communicable diseases
- Play a leadership and management role
- Ensure quality care

The Local Area Manager plays a role of support of OPMs in supervision and management of PHC services. These include supporting OPMs by ensuring that responsible programme coordinators are supporting OPMs with implementation of TB, HIV/AIDS, NIMART, MCHW and mental health programmes on quarterly basis. Furthermore the Local Area Manager oversees general management of PHC facilities that fall under his/her area (PHC Supervision Manual NDoH RSA, 2009:30; Ideal Clinic Manual Version 16 DoH RSA, 2015:16; NDoH RSA Integrated Clinical Services Management, 2014:26; NDoH RSA Integrated Chronic Disease Management, 2014:2).

2.3.1.2 Sampling

The sampling method of this study consists of the sample, the sampling criteria and the sample size. The non-probability purposive sampling is followed to select the OPMs and PHC facilities in the NWP. The OPMs were selected because they are the ones exposed and knowledgeable about SS in PHC facilities. Non-probability sampling is the selection of sampling units from a population using non-random procedures (Emmel, 2013:36; Polit and Beck, 2010:561). In purposive sampling, the researcher selects participants based on personal judgement of who will be most informative (Emmel, 2013:36 and Polit and Beck 2017:565).

Polit and Beck (2017:75) stated that researchers typically collect data from a sample which is
a subset of the population. According to Brink and van Rensburg (216:217), the sample is a subset of the population that is selected to represent the population. The sampling is described as the process of selecting a group of people events, behaviours or other elements that are representative of the population being studied (Emmel, 2013:36; Burns and Grove, 2011:548). The following is a description of sampling criteria.

2.3.1.3 Sampling Criteria

Sampling criteria includes a list of the characteristics essential for inclusion or exclusion in the sample (Emmel, 2013:36; Burns and Grove, 2015:548). An inclusion and exclusion criterion was necessary as it ensured that data was collected on OPMs who had in-depth experience of SS. The inclusion criteria of this study were as follows:

- Inclusion Criteria for the PHC Facilities
  
  The facilities were to be:

  - Operating for 8 to 24 hours
  
  - The facilities should be within the four chosen sub-districts of NWP.

  The representation of the PHC facilities of the four sub-districts were ensured by including at least one or more clinics from each local health area that operate on a 24-, 12-, or 8-hour basis.

- Exclusion Criteria for the PHC Facilities
  
  - Mobile clinics
  
  - The facilities should be within the four chosen sub-districts of NWP.

- Inclusion Criteria for OPMs
  
  - Operational manager who played a role of supervision in the PHC facility for one year and more
Operational manager should be working in Kagisano Molopo, Mafikeng, Rustenburg and Matlosana sub-districts.

Exclusion Criteria for OPMs

- Operational managers of less than a year in a supervisory position
- Operational managers who were not working in Kagisano Molopo, Mafikeng, Rustenburg and Matlosana sub-district were excluded in this study

2.3.1.4 Sample Size

In this study, four focus group interviews were conducted. The number of participants ranged from 4-8 per group and the number of OPMs who participated in the interviews totalled twenty three. Data saturation was ensured by prolonged engagement until the participants reported the same information repeatedly.

2.3.1.5 Data Collection

Data collection refers to an orderly manner of obtaining information significant to the purpose and objectives of the study (Burns and Grove, 2015:548). In this study, the researcher collected data by means of face-to-face interviews with participants who volunteered to participate in the study. Informed consent was signed by the participant at the interview venue and it was done after indicating their interest to participate (Annexure A: 289). This was also done before actual facilitation of the interview discussions. During the first meeting with the gate keepers, the Local Area Managers were given the responsibility of ensuring that the services would not be interrupted during the interviews. In this regard, the researcher ensured that at the end of recruitment the Local Area Manager gets information regarding OPMs who did not volunteer for participation. Therefore, the Local Area Managers ensured that OPMs who did not volunteer continued with normal rendering of services for that day.
2.3.1.5.1 Semi-Structured In-Depth Focus Group Interviews

In this study, the semi-structured in-depth focus group interviews were conducted by the researcher in the four sub-district of NWP. The open-ended questions were asked (Annexure L1), this allowed the participants to provide an in-depth description of experiences regarding SS in PHC facilities (Streubert and Carpenter, 2011:36). The in-depth interviews afforded the researcher an opportunity to explore and examine the factors related to SS of OPMs in the PHC facilities. This created intensive discussions and more descriptive and in-depth information about SS of OPMs. The semi-structured in-depth interviews encouraged the participants to describe their experiences regarding SS in the PHC facilities.

According to Streubert and Carpenter (2011:6), a semi-structured interview provides the opportunity for greater clarifications in the answers provided. With the unstructured interview, the researcher should ask open-ended questions. These types of questions allow the participant to move freely in his/her description of a phenomenon. The semi-structured in-depth interviews give the participant a chance to thoroughly describe the reasons, experiences, feelings and beliefs about the topic under study (Yin, 2011:13). Moreover, in-depth interviews enable the researcher to explore fully all the factors that the participant could mention when responding to the questions. In-depth interviews are more intensive and useful when researchers do not having enough knowledge of the content to be studied (Boyce and Neule, 2006:3; Polit and Beck, 2017:314). Semi-structured interviews are more like a conversation, with the focus being limited to the research questions (Brink and van Rensburg, 2014:158).

2.3.1.5.2 Focus Group Interviews

According to Yin (2011:13) and Richie and Lewis (2003:22), a focus group is a particular form of group interview intended to make use of group dynamics. Focus group interviews promote self-disclosure among participants, by openly depending on the group dynamics in discussions. The focus group interviews have been found to be most useful in qualitative research, but most importantly when using broad open-ended questions.
According to Gill, Stewart, Treasure and Chadwick (2008:5), focus group interviews are useful in generating a rich understanding of participants’ experiences and beliefs. In focus group interviews, the interviewer is regarded as the moderator who will guide the discussion focusing on the topic (Polit and Beck, 2010:341; Centers for Disease Control and Prevention (CDC), 2008:2).

In this study, the researcher conducted the focus group interviews and guided the discussions using the interview guide which was also developed by the researcher with the following two broad questions (Annexure P).

*What are your experiences regarding SS in PHC facilities?*

*How SS in PHC facilities can be effectively facilitated?*

The focus group interviews provided this study with dense information from different points of view about SS of OPMs. This method of interview benefited this study by generating an in-depth and rich understanding of OPMs’ experiences. The data about how supervision can be effectively facilitated in PHC facilities of NWP were generated. The participants had ample time to share their individual experiences regarding SS in the PHC facilities.

2.3.1.5.3 Pilot Study Interview

For the focus group interviews to yield quality results, it is necessary for the facilitator to conduct a pilot study before a major study (Streubert and Carpenter, 2011:46; Polit and Beck, 2010: 363; CDC, 2008:3). According to Polit and Beck (2017:363) as well as CDC (2008:3), facilitation of a focus group needs practice. Facilitating a focus group is an acquired skill, and each topic and audience requires a different approach and flexibility on the part of the facilitator. Thus, focus group interviews require good facilitation and communication skills. In this study, one focus group interview was conducted prior to the actual data collection of the major study.
The purpose of conducting the pilot interview was to enhance facilitation and communication skill required for focus group interviews and for evaluation of the interview guide (Annexure P). The participants of the pilot interview were experienced professional nurses exposed to management of health facilities. During the discussions, communication techniques used allowed participants to give more clarity and new information about the topic was generated. The discussions from the pilot interview were evaluated to check whether it is necessary to adjust the questions and for appropriate use of communication and facilitation skills. The findings from the pilot interview conducted did not show a need of adjusting of questions reflected in the interview guide (Annexure P).

The following communication techniques were utilized throughout the interviews:

- **Clarifying**

  The interviewer seeks clarity on a particular aspect of what was said by the interviewee. The example to this may be “I seem not to understand how often you practiced netball with your colleagues” (Madrigal and McClain, 2009:6). In this study, clarity seeking questions were asked for a particular aspect which was not understood by the researcher. The clarity seeking questions asked were “What do you mean by they are not visiting us?”.

- **Paraphrasing**

  According to Burns and Grove (2015:243) and Madrigal and McClain (2009:5), paraphrasing is to clearly restate the ideas of the interviewee in the interviewer’s own words. Paraphrasing demonstrates that the interviewer is listening and understands what the interviewee has said. In this study, the researcher did paraphrasing by repeating what the participant had just said, but using different words. Paraphrasing ensured that the researcher obtained the correct information about experiences of SS of OPMs and how SS of OPMs can be facilitated in the PHC facilities.
Minimal Verbal Response

According to Madrigal and McClain (2009:6), minimal verbal response are words or sounds that are used to express interest during communication. Minimal verbal responses are important because they encourage the person to continue speaking and shows that you are interested and paying attention. It is indicated that when minimal verbal responses are used properly, the person will not feel interrupted while s/he is speaking (Madrigal and McClain, 2009:6). In this study, the researcher used minimal verbal responses such as “mm...mm., okay” and nodding during the natural pauses of the participants speech or at the end of a sentence. The minimal verbal response was needed to reveal interest in what the participants were saying and this encouraged them to speak more.

Probing

Probing is described as queries made by the researcher to get more information from the participant about a particular question (Burns and Grove, 2015:244). It is a process of obtaining more useful information from the interviewee in the first reply to the question asked (Polit and Beck, 2015:564). In this study, probing was done through making a follow-up questions on what the participant said to get more information.

Reflecting

Is whereby the researcher communicates to the interviewee about verbal or non-verbal statements observed. This involves responding to the emotions heard in the participants’ voice rather than the content (Madrigal and McClain, 2009:5). Reflecting on what the researcher heard or observed on the participant is important because it shows attentive listening, observing and understanding of the feelings of the participant. In this study, statements like: “You seem a little frustrated when talking about this” was said as a sign of reflection.

Summarizing

In qualitative interviews, summaries are brief statements extracted from longer discussions of
the interview session. In summarising, the interviewer should mention verbal and non-verbal communication observed by restating them for the client as accurately as possible (Australian Institute of Professional Counsellors, 2012:8). In this study, a summary was made by the researcher before moving to the second broad question. This was done by pointing the major statements of what was said and observed during the discussions. Thereafter, the participants were encouraged to add any experience that they thought were left out. The summary of the discussion that addressed the second question was also done before final closure. The closure of the whole session included restating the measures of confidentiality on handling of raw data, publication of results and appreciation of the participants. A sample of a focus group interview transcript is attached (Annexure R).

The Interview Setting

According to Brink and van Rensburg (2012:159), the interviews should be at convenient place and time for both the participants and the researcher. The environment needs to be conducive for discussion and concentration. This indicates that the place should be private, quiet and physically comfortable. In professional interviews, it is helpful if telephones can be directed to another extension or to voicemail to avoid interruption (Ritchie and Lewis, 2003:166). In this study, the sub-district and local health area managers helped by deciding about comfortable time and place for interviews to take place. This was to alleviate the interruptions that could occur during official working hours. The interviews took place at sub-district board room and community health centres. The researcher ensured that privacy was maintained by placing a notice of “Do Not Disturb, Interview in Progress and Strictly Private” at the venue. During the discussions, privacy was maintained as participants were addressed by alphabetical codes that were placed in front of them.

Data Saturation

Data saturation is the point in data collection and analysis when new information produces little or no change to the codebook (Saunders, Kingstone, Baker, Waterfield, Bartlam,
During data collection and after prolonged engagement with the participants, the researcher started to hear the same information coming again and again from the participants. The researcher would then confirm with participants that they do not have any more information to share. These indicated to the researcher that data saturation has been reached and this was allowed to happen in the four focus group interviews.

- **Tape Recording**

The recording of interviews is one of the techniques that must be considered to ensure that data is recorded and stored appropriately. The tapes contain the exact words of the interview and questions. The tape recorder allows the researcher to have eye contact and pay attention to what the participants say (Holloway and Wheeler, 2010:94). In this study, the consent to use a tape recorder was requested from the participants and the interviews were conducted in English.

- **Field Notes**

Field notes uncover what cannot be captured with a tape recorder. In this regard, there were valuable aspects of data collection in this study. In addition, the field notes were part of data collection and analysis. Therefore, field notes that were taken in this study are descriptive or observational, personal, methodological and theoretical notes (Polit and Beck, 2017:348). The documents for field notes taken in the four sub-district are attached (Annexures L, M, N and O).

- **Descriptive or Observation Notes**

The descriptive notes should record what has happened, time, place and the description of the events, conversations and the context within which they occurred. These also include objective information about actions and dialogue. In this study, both the researcher wrote the time and place where interviews took place. The way in which each participant expressed their experiences were also written. Therefore, during discussions verbal and non-verbal cues were
noted.

 Personal Notes

In qualitative research, personal notes are remarks about the researcher’s own feelings in the field. It is indicated that field experiences give rise to personal emotions; therefore, it is necessary to reflect on such feelings. In addition, personal notes can also include reflections relating to ethical dilemmas that occurred in the field (Polit and Beck, 2017:549). In this study, the researcher wrote down her emotions and ethical dilemmas and expectations that occurred immediately after completion of the interview session. The personal notes assisted the researcher to recognize her own influence and bias on the findings. The researcher experienced an ethical dilemma in one sub-district. This was immediately after the interview and during the refreshments. Two OPMs were frustrated about a short notice of district performance review meeting received in their WhatsApp messages. The dilemma was the meeting was scheduled for 12:30 meaning that they were already running late as the interview ended at 12:00. Another issue was they had to travel 80 kilometres to the venue and they had to start to make transport arrangement for attending the meeting. Finally, the researcher advised OPMs to send an apology that they will arrive late for a meeting.

 Methodological Notes

According to Polit and Beck (2017:548), methodological notes is whereby the researcher is reflecting on the way observations were made. This is important because observers tend to do things that do not work at the end of interviews (Polit and Beck, 2017:548). In this regard, the methodological notes should reveal thoughts about new approaches or about why the strategy was effective (Polit and Beck, 2017:548). The methodological notes can also describe how subsequent observations will be made. In this study, methodological notes were completed by reflecting and writing down on the way facilitation of interviews and observations were carried out. This helped the researcher to maintain consistency and improving observations with subsequent interview sessions.
Theoretical Notes

Theoretical notes should reveal the researcher’s thoughts about the information gathered from interview session (Polit and Beck, 2017:548). This is regarded as the beginning of subsequent analysis. In this study, the researcher wrote a summary of her thoughts and ideas about the whole process of interviews as part of the analysis. The writing of thoughts was done immediately before moving to the next interview session.

2.3.1.6 Data Analysis

The study applied Tesch’s method of data analysis and open-coding process as outlined in Creswell (2014:197). Burns and Grove (2015:535) indicated that data analysis is the technique used to reduce, organize and give meaning to data. Coding is the way of indexing or identifying categories in qualitative data (Burns and Grove, 2015:535). Coding includes organizing the material into sections in order to develop a general sense of it (Creswell, 2014:241). According to Brink and van Rensburg (2012:58), qualitative analysis entails the integration and synthesis of narrative non-numeric data. Tesch’s method of analysis and open-coding was applied thus:

- Step 1: Arrangement and Preparation of Data
  The arrangement and preparation of data was completed through verbatim transcription of all the interviews. This implies that the researcher listened to voices of participants in the tape recorder and has written word-for-word what was said. This step included typing up of all the field notes.

- Step 2: Get a Sense of the Whole
  In this step, the researcher has repeatedly read through all the transcribed interviews and field notes. Re-reading enabled the researcher to reflect on general information provided by the participants. The researcher focused on making sense from the information by writing down general thoughts about the data.

- Step 3: Pick One Document of An Interview
  The researcher picked the most interesting interview; the shortest one and browsed through it
to get the meaning and thus thoughts were written on the margin of the transcript. This task was continued with the other three transcripts.

- **Step 4: Make a List of All Topics**

In this stage, the researcher developed a list of all topics derived from reading the transcripts and similar topics were grouped together. Thereafter, the topics were formed into columns and arranged into major, unique topics and leftovers.

- **Step 5: Narrow Topics Into Codes**

In this step, the researcher narrowed the topics into codes and codes were written next to the appropriate part of the text.

- **Step 6: Make Final Decision About the Codes**

The researcher made a final decision on the codes for each category and put the codes in alphabetical order. In this step the descriptive wording of topics was made and turned into categories. The researcher further reduced the total list of categories by grouping topics that relate to each another.

- **Step 7: Description of Themes**

The researcher started describing the setting as well as the narrative of categories or themes. The description was about people, places and events in the PHC facilities of NWP. Thereafter, a co-coder conducted an independent analysis of data. In this regard, the interview transcripts of four sub-districts was given to an independent co-coder to perform own analysis. This was followed by a consensus meeting that was held regarding analysed results of both the researcher and a co-coder. Finally the final themes, categories and sub-categories were confirmed by an independent co-coder (Annexure K). Subsequently, an illustration of themes in a table format and discussion was done by the researcher.

- **Step 8: Interpretation of the Findings**
In this step, interpretation of the research findings and comparison of the findings with the existing literature was done. The findings were peer reviewed by the promoter of this study and the scientific team in the school of nursing science of North West University.

2.3.2 Measures to Ensure Trustworthiness

The trustworthiness of this study was ensured by bracketing and applying the four principles of Lincoln and Guba’s Model (1981) as described in Krefting (1991:216). The four principles applied are: Credibility, Confirmability, Dependability and Transferability. The strategies followed to achieve the principles of Lincoln and Guba’s Model (1981) are truth value, applicability, consistency and neutrality. The trustworthiness of this study was ensured in the following order:

2.3.2.1 Bracketing

In order to ensure trustworthiness regarding SS of OPMs in the PHC facilities of NWP, the researcher’s bracketing is specified in the following manner: “I hold in suspension my own experience about SS of OPMs in the PHC facilities of NWP. I am putting aside my own values and knowledge regarding the meaning of SS of OPMs. I therefore approach the whole study including the focus group interviews, analysis of data, the discussion of the results and framework development and validation openly. The analysis of data will depend entirely on the field notes, and on what the participants expressed as their experiences regarding SS of OPMs in the PHC facilities and how SS of OPMs can be effectively facilitated in the NWP”.

According to Tufford and Newman (2010:5), bracketing is the task of sorting out the qualities that belong to the researcher’s experience of the phenomenon. In this study bracketing was achieved by putting aside own values, knowledge regarding SS. Tufford and Newman (2010:5) and Gearing (2004) explained bracketing as a scientific process in a researcher suspends or holds in abeyance his/her presuppositions, biases, assumptions, theories, or previous experiences in order to see and describe the phenomenon. This was also achieved by putting
aside own experience regarding SS in the PHC facilities of the NWP.

2.3.2.2 Credibility

Johnson and Rasulova (2016:15) asserted that a study is viewed credible when the researcher has confidence in the truth of the findings. In order to enhance credibility of this study, the strategies of truth value were applied by:

- Prolonged engagement with the participants and the interviews lasted from 1:30 to 2:45. For the purpose of prolonged engagement the researcher ensured that all the communication techniques were applied during the interview sessions. These imply that the principles of clarifying, reflection, paraphrasing, follow up question, probing was applied to each and every participant. In addition, member checking was done by returning back to the participants during the second phase of the study whereby with the table of themes was presented to the participants. This was to verify if the findings were representing what the participant expressed during the first phase of this study and a consensus was reached in this regard.

- Probing questions enabled the researcher to get an in-depth understanding of experiences of OPM regarding SS in PHC facilities.

- Allowing data saturation to take place in each focus group interviews.

Data saturation is the point in data collection and analysis when new information produces little or no change to the codebook (Sauders, Kingstone, Baker, Waterfield, Bartlam, Burroughs & Links, 2017:6; Tran, Porcher, Falissard & Ravaud, 2016:7). During data collection and after prolonged engagement with the participants, the researcher started to hear the same information coming again and again from the participants. These indicated to the researcher that data saturation has been reached and this was allowed to happen in the four focus group interviews. Data saturation also
occurred during analysis whereby during coding similar information emerged over and over again until no new codes were observed.

- Credibility was also ensured by recording observations made and writing down thoughts regarding each interview session.

- During the interviews, the researcher talked less and the participants had more time to voice their experiences without any interruptions.

- Verbatim re-checking of information on the transcripts.

- The findings of this study were peer reviewed by other qualitative expects.

2.3.2.3 Confirmability

Confirmability refers to ensuring that the research process and the findings are not biased (Johnson and Rasulova, 2016:15). This was also emphasized by Brink and van Rensburg (2012:173) and Krefting (1991: 216) in that confirmability denotes to the potential for compatibility of data in terms of correctness, relevance or meaning. Confirmability is concerned with establishing whether the data represent the information presented by the participants. In this study, the principle of confirmability was achieved by using the strategy of neutrality. The analyzed data was validated by an independent co-coder (Annexures J and K). The promoter of this study cross-checked all the interview materials and results. Confirmability was further ensured through external moderation of the whole study.

2.3.2.4 Dependability

Dependability is to ensure consistent data collection and repeatability of the research process without variations. This is the ability to trace the sources of information, methods and decisions taken in the field (Johnson and Rasulova, 2016:15). According to Brink and van Rensburg (2012:173), dependability is explained as the provision of evidence such that if the study could
be done again on the same participants its findings would be similar. The promoter of this study verified the transcripts for consistency regarding the whole research process.

2.3.2.5 Transferability

Transferability is whereby the research as well as the findings are fully described to draw similarities with another context. This principle should be achieved by applying the strategies of applicability (Johnson and Rasulova, 2016:24; Krefting 1991:215). The researcher has the ethical responsibility to describe the findings in the way that enables the reader to decide whether to use the findings to suit the context. In addition the goal of qualitative research is not to generalize the findings. For the purpose of transferability the researcher ensured sufficient description of the following:

- The place where the study took place to enable the reader to establish how transferable the results could be to other settings.
- The researcher clearly explained the research questions, purpose of the study as well as the aims and objectives to ensure that the results were shared with other providers of health care services.
- The discussion of the research design and methods, sampling as well as data collection and analysis are described.
- The findings of this study are tabulated to reveal the richness of the experiences of OPMs regarding of SS in PHC facilities.
- A SS programme for OPMs is adequately described.

2.3.3 Ethical Measures

Polit and Beck (2010:553) accentuated ethics as a system of moral values that is concerned
with the degree to which research procedures adhere to professional, legal, and social obligations to the study participants. In this study, the following ethical procedures were adhered:

2.3.3.1 Approval and Permission to Conduct Research

The researcher presented the proposal to the School of Environmental and Health Science as well as the Faculty of Agriculture Science and Technology Research Committee (FRC), and the certificate of approval was granted. The ethical clearance certificate from North West University Institutional Research Ethics Regulatory Committee was received after the approval of proposal by FRC (Annexure A). A letter was written to the North-West DoH to request permission for the researcher to conduct the study (Annexure B), and the permission was granted in writing (Annexure C). Permission to conduct the research was requested in writing to the managers of four sub-districts where this study took place (Annexure D). The permission to conduct research in the PHC facilities was also granted in writing by sub-district managers (Annexures E, F, G and H). The following principles were observed throughout the study: respect for persons, principle of beneficence and the principle of justice (Polit and Beck, 2010:121).

2.3.3.2 Principle of Respect for Persons

It is revealed that in research individuals have the right to self-determination and this right should be respected (Brink, van der Walt and van Rensburg, 2012:34). The principle for respect for person was maintained in this manner:

2.3.3.3 Obtaining Informed Consent

Burns and Grove (2011:540) explained that informed consent is an agreement by a prospective participant to voluntarily participate in a study after s/he understood the important information about the study. In this study, informed consent was ensured in the following manner: The
researcher explained to the participants that:

- The purpose of this study was to develop a programme of SS for OPMs in PHC facilities of the NWP.
- The information that will be gathered could improve SS of OPMs and nursing practice in NWP.
- They will be expected to describe their experiences regarding SS in PHC facilities.
- The duration of interviews is estimated to be 1-2 hours. Therefore, prospective participants are also expected to talk more about their experiences and the researcher will guide the discussions.
- The questions that will guide the discussions are: ‘What are your experiences regarding SS of nurses OPM in PHC facilities’ and, ‘How can SS be effectively facilitated in PHC facilities of NWP’.
- The discussions will be audiotaped and field notes will be taken.
- There will be no payments for participating in this study.

According to Burns and Grove (2011:125), voluntary consent means that the prospective participants have agreed to take part in the study without any intimidation or undue influence. In this study, participants who were interested to take part in this study, were given consent forms to sign before interviews were conducted (Annexure I). In order to limit coercion, two separate meetings were held. The first meeting was for recruiting prospective participants and the second one was for those who showed interest of participation.

2.3.3.4 Principle of Beneficence

Through this principle, the well-being of an individual should be secured in terms of the right
to protection from discomfort and harm (Brink and van Rensburg, 2012:35). The participants should be protected from physical and emotional harm (Brink and van Rensburg, 2012:35). To avoid emotional harm, the subjects were told that they were free to withdraw from the research at any stage when they (participants) feel uncomfortable. During the discussions, the participants were closely observed for verbal and non-verbal cues that might be a sign of emotional harm. The principle of beneficence was also adhered to by explaining to the participants that the information will not be disclosed in public against them.

2.3.3.5 The Principle of Justice

The principle of justice refers to the participants’ right to fair selection, treatment and right to privacy (Brink, van der Walt and van Rensburg, 2012:36). The study applied the principle of justice in the following order:

- Right to Fair Selection and Treatment
  According to this principle, the participants must be selected fairly and receive equal treatment. Researchers should clearly show that the participants were not selected because they were readily available or for specific benefits from the study (Burns and Grove, 2011:118). During recruitment, voluntary participation was also reinforced to ensure fairness in selection and treatment.

- Right to Privacy
  The participants are at liberty to decide on the time, extent, and general conditions under which their private information will be shared with or withheld from others (Burns and Grove, 2011:114). In this study, the right to privacy of participants was exercised in the following manner:

  - Confidential Procedures
    Participants have the right to believe that the information gathered will be kept confidential
Confidentiality is the researcher’s management of private information gathered from the participants (Burns and Grove, 2011:117). In this study, confidentiality was achieved in this way:

- The researcher explained to the participants that signed consent forms will be kept privately and the researcher is going to make use of codes instead of names on the interview documents.
- The researcher explained to participants that raw information will remain nameless and kept under lock and key.
- The participants were told that all the interview materials e.g., audiotapes and transcripts will be kept under lock and key.
- The participants were assured that the people who will have access to audiotape, interview documents are the researcher and the promoter of this study.
- It was explained to participants that the researcher intends to publish the findings and all principles of confidentiality will be adhered to.

2.3.4 Phase 2

Phase 2 of this study is divided into two stages and the first stage focuses on a framework for supportive supervision. The second stage discusses framework development and description, validation and guidelines for operationalization of the framework. It is therefore fundamental to state that framework implementation and evaluation is not part of the current study. The stages of Phase 2 are discussed next.

2.3.4.1 Stage 1: Description of a Framework for Supportive Supervision of OPMs in PHC Facilities

This stage focuses on description of a framework for a SS of OPMs in the PHC facilities. A
framework for supportive supervision is informed by the findings of the first phase of the current study and the literature review (Powel and Henert, 2008:56). Therefore, what came out as experiences of OPMs regarding SS influenced the description of a framework for supportive supervision. In addition, the information that emerged when addressing the question of how SS can be facilitated in the PHC facilities was also used for description of a framework.

In this phase, the concepts of SS were identified from the findings and thereafter classified according to the six components of the University of Wisconsin Extension (UWEX) Logic Model of programme development (Powel and Henert, 2008:56; Wholey, Hatry and Newcomer, 2010:54). A diagram showing SS concepts identification and classification following University of Wisconsin Extension (UWEX) Logic Model is drawn and discussed in Chapter 5. This stage is regarded as a baseline for the whole process of development of a supportive supervision framework. The second stage of Phase 2 of this study is discussed below:

2.3.4.2 Stage 2: Development and Validation of Guidelines for the SS Framework

In this stage, a SS framework is developed, validated and the proposed guidelines for operationalization is described. The discussion of this stage is as follows:

2.3.4.2.1 Framework Development and Description

The study adopted University of Wisconsin Extension (UWEX) Logic Model to guide the development and description (Powel and Henert, 2008:56; Wholey, Hantry, Newcomer, 2010:54). The rationale for using UWEX Logic Model is because it is able to give an overview of the problems that could impact negatively on quality of fundamental aspects of the organization (Powel and Henert, 2008:56; Wholey, Hantry, Newcomer, 2010:54). Unlike other models, the UWEX Logic Model provides the sequence of events and activities hoped to bring about improvement in SS. Furthermore the UWEX Logic Model should describe how the activities and events are linked to the results the framework is expected to achieve. In this
regard, the researcher viewed it necessary to adopt this model for framework development and description.

A logic model is described as a visual or a snapshot of a framework that communicates the anticipated relationship between framework goals, activities, outputs, and intended outcomes. Logic models are an interactive tool useful for planning and evaluation purposes. Briefly, logic models graphically describe the theory or logic of how a framework is supposed to work (Silverman, Mai, Boulet and Leary, 2006:8). The University of Wisconsin Extension (UWEX) Logic Model comprises of six components that is used as a guideline for a framework development (Powel and Henert, 2008:56; Wholey et al., 2010:54).

These are the situation and priorities, inputs, outputs, outcomes, assumptions and the external factors (Powel and Henert, 2008:56; Wholey et al., 2010:54). The six components of UWEX Logic Model were applied during framework development of a SS of OPMs in the selected PHC facilities of the NWP.

Figure 2.3 represents the adopted UWEX Logic Model used for framework development.
Figure 2.3: Adopted UWEX Logic Model used for framework development (Powel and Henert, 2008:56)
Situation and Priorities

In this study, the description of the situation regarding SS of OPMs is the starting point of framework development (Innovation Network, 2010:24). This implies that the first step in developing a framework using the UWEX Logic Model is to clearly articulate the situation or a problem the research is intending to solve. In other words, the researcher should frame a particular situation and a challenge of a specific population the framework will try to solve (Innovation Network, 2010:24). For the purpose of describing the situation regarding SS of OPMs, this study applied data from the first phase. This basically means that the concepts derived from experiences regarding SS in the PHC facilities of NWP were used to address the component known as the situation.

Therefore, the summary of the findings addressing the question of “What are your experiences regarding SS of nurses in the PHC facilities in the NWP” were used to describe the situation regarding SS of nurses in PHC facilities. The first step included thorough assessment of the needs and assets necessary for SS of OPMs in the PHC facilities of the NWP. The lessons learned from the narrative literature review of this study were used to describe the priorities regarding SS of OPMs in the PHC facilities of the NWP. As a result, the priorities of framework development of this study included the SS strategies and legislations used in the PHC facilities of Department of Health, South Africa.

This is to confirm what has been prescribed by the UWEX Logic Model as it is indicated that the mandates of the organization should guide the process of framework development (Whooley et al., 2010:54). According to Whooley, Hatry and Newcomer (2010:54), holding interviews and conducting a literature review is an essential aspect of framework development. Whooley et al. (2010:54) emphasized that the key stakeholders to the framework should be interviewed. Conducting the literature review is to gain insights on what others have done to solve similar problems, and on key contextual factors can reveal important evidence as to whether or not the framework approach is correct. During the analysis and synthesis of information collected, the
programme developer should stay alert to the factors that could influence the performance of
the framework (Wholey, Hatry and Newcomer, 2010:54). The originating problem or issue
should be put within socio-political, environmental and economic circumstances. The factors
having an influence on the situation or problem should be set as priorities (Bernard, 2009:3).
These indicate that the component of the situation and priorities should depend on the
information gathered from the interviews and relevant literature review.

❖ Inputs
The component of the inputs was addressed by applying OPMs’ responses to the question of
‘How SS can be facilitated effectively in the PHC facilities’. Therefore, the participants’
responses assisted the study to specify the resources needed for SS of OPMs in the PHC
facilities. The literature review about resources required for effective facilitation of SS also
informed the components of the inputs. According to Powel and Henert (2008:64), what goes
into the programme is commonly known as the inputs which actually mean resources. Inputs
include staff, money, time, equipment, partnerships, and the research base (Powel and Henert,
2008:64).

The inputs are also regarded as resources invested that allow the programme to achieve the
outputs or activities. The input should answer the question of what raw materials will be used
to conduct the effort or initiative. Silverman, Mai, Boulet and Leary (2006:8) asserted that the
categories of major resources for the programme should be outlined and specified in the stage
of the inputs. This could help the framework to achieve the intended goals and outcomes
(Silverman et al., 2006:8). The components of the inputs are also depended on the findings of
Phase 1 and literature review.

❖ Outputs
The literature reveals that the output as a component of the logic model is divided into the
activities and participation (Bernard, 2009:7). In this study, the component of the output
described the activities necessary to satisfy the needs of OPMs regarding SS in the PHC
services. The output answers the question of what we do and whom we reach and it indicates the activities, services, events, products, and the people to be involved (Bernard, 2009:7). The activities integrated into the framework of this study included training, debriefing and regular supportive supervisory visits. The participation, as part of the output in this study, includes health department, PHC supervisors, nursing staff and community members (Powel and Henert, 2008: 58).

❖ Outcomes

When using the logic model for framework development, the component of the outcomes should specify the short-, medium- and long-term benefits (Powel and Henert, 2008:60). The short-term benefits include changes in awareness, knowledge, skills, attitudes, opinions and intent. The medium-term benefits include changes in behaviours, decision making and actions. The long-term outcomes are often called impact in the social, economic, civic, and environmental conditions (Silverman et al., 2006:8). The outcomes for this framework are described in the Chapter 6, i.e., Supportive Supervision framework Development and Description, Validation and Description of Proposed Guidelines for Operationalization. This includes specification of the short-, medium- or long-term benefits of each activity and participation.

❖ Assumptions

In this study, the assumptions about the framework developed are based on experiences of nurses regarding SS and the literature review. In addition, the description of assumptions about a framework of SS for OPMs is integrated in all the components discussed in Chapter 6. Furthermore, the summary of assumptions is shown in the diagram of a SS framework of nurses in the PHC facilities of the NWP. According to Powel and Henert (2008:60), the component of the assumptions describes the beliefs the framework developers has about the framework, the people who will use the programme, the belief regarding how the framework will operate, what the framework aims to achieve.
External Factors

The component of external factors describes the aspects external to the framework that influence the way the framework operates (Powel and Henert, 2008:60). The environment in which the framework operates includes the variety of external factors that can influence the success of the framework. The external factors described in the programme development focused on changing policies and priorities, staff and community members.

Format for Describing and Communicating a Framework

The format used to describe and communicate a SS framework of OPMs in the PHC facilities in NWP is adapted from programme action-logic model as revealed by Powel and Henert (2008:56). The two methodologies that can be used to communicate the framework when using a logic model are reverse- and forward-logic approaches (Powel and Henert, 2008:56; Silverman, Mai, Boulet and Leary, 2009:12). The forward approach is when you start reading the framework from the left side starting with the component of situation or problem and moving forward (Silverman, Mai, Boulet and Leary, 2009:12; Powel and Henert, 2008:56). The forward-logic approach uses the ‘if’ or ‘then’ statements to communicate the intended changes resulting from activities. The reverse-logic approach is used when you start reading the framework from the right starting with the outcome and moving backwards. The reverse-logic approach uses the question ‘how’ to communicate how to reach the intended goal. In this study, the approach used to communicate the framework is the forward-logic approach to communicate the intended changes resulting from activities. Therefore, the framework will be read from the left side starting with the component of situation and priorities moving forward.

2.3.4.2.2 Validation of the Framework

In this study, the researcher convened a meeting with OPMs who participated in the first phase to validate a developed SS programme. The diagram representing a SS framework of OPMs and the text for description was the main source of validation.
The validation was guided by the following questions (Wholey et al., 2010: 72).

- Is the framework clear enough to create understanding of the components and their interrelationship?
- Is the framework logic simple and complete? That is, are all the key components accounted for?

The above two questions were simplified by asking one central question, “Tell me how you understand this framework.” Through these questions, the participants were able to refine some of the concepts, and the questions enabled the participants to have inputs regarding the framework logic. The validation process was further completed by the researcher through responding to the following validation questions (Wholey et al., 2010:72).

- Is the framework logic theoretically sound?
- Do all the components fit together logically?
- Have all the key external contextual factors been identified and their potential influences described?

A SS framework derived from this study was also sent for external evaluation by research experts in framework development. The full process and the results of framework validation of this study are discussed in Chapter 6.

2.3.4.2.3 Guidelines for Operationalization of the Framework

According to Wilder Research (2009:10), the end stage of framework development is the description of how the framework should be put into practice. In this regard, the components of the UWEX Logic Model are the basis of description for operationalization of the framework. This implies that the situation and priorities regarding SS, the resources and activities required
for enhancement of SS of OPMs guided the process. In addition, the SS strategies were applied in order to ensure that the goals and objectives of the South African DoH are addressed. A thorough description of guidelines for operationalization of the framework is discussed in Chapter 6.

2.4 Conclusion

Chapter 2 discussed the research design and methods which is divided into two phases. In Phase 1, the methods used for exploring and describing the experiences of OPMs regarding SS, and how SS can be effectively facilitated in the PHC facilities in the NWP were addressed. Measures to ensure trustworthiness of the study and ethical considerations were discussed. Phase 2 was discussed in two stages, and the stages are a conceptual framework of SS as well as framework development and validation. The guidelines for operationalization of the framework as a topic in Phase 2 were also discussed. The next chapter focuses on the narrative literature review of this study.
CHAPTER 3

Narrative Literature Review

3.1 Introduction

In Chapter 2, the research design and methods were discussed. The first phase in Chapter 2 focused on the methods used to explore and describe experiences of SS and described how SS can be facilitated effectively in PHC facilities of the NWP. Measures to ensure trustworthiness of the study and ethical considerations were also discussed in the first phase. The second phase of Chapter 2 provided a description of a framework for supportive supervision, framework development, validation and guidelines for operationalization. This chapter focuses on literature review.

A literature review is an objective, thorough summary and critical analysis of the relevant available research on the topic being studied. The main purpose of conducting a literature review is to update the researcher on the current information and practice regarding the topic being studied (Cronin et al., 2015:2). There are no acknowledged guidelines for narrative literature reviews (Jahan, Naveed, Zeshan and Tahir, 2016:1; Ferrari, 2015: 230). The narrative literature reviews are best suitable for broad qualitative topics to compare different studies and to interpret the results in value added content. The results of narrative literature reviews are of a qualitative rather than a quantitative meaning (Ferrari, 2015: 230). In this study, the narrative literature review was conducted to survey current information and practices regarding SS of OPM in PHC facilities. The narrative literature review in this study is based on the following sub-headings:

- What is Meant with Supervision and Supportive Supervision;
Discussion of the critical aspects of SS in the PHC Services;

Review of existing supervision programmes;

Supervision models: A global view;

The hindrances of SS in PHC facilities; and

Strategies used for SS in the PHC facilities of RSA and a framework for SS.

Why a Framework development is important for the current study

3.2 What Meant with Supervision?

Before dwelling into further discussions, it is imperative for this study to review the definition of the concept “supervision” as outlined by several authors. Adeyemo (2017:3) stated that the word supervision literally means “to oversee”. It implies that someone more senior is watching over to see that someone junior is performing their job properly. According to Jacobs et al. (2014:2), supervision is the process of guiding, helping and encouraging staff to improve their performance so that they meet the defined standards of their organization.

In addition, supervision is defined as a range of measures to ensure that personnel carry out their activities effectively through direct, personal supervisory contact on a regular basis, to guide, support and assist designated staff to become more competent in their work (Kirk, Sweeney, Gupta, Drobac and Manzi, 2015:6). Furthermore, supervision is a process during which managers in higher levels of a health system (e.g., district) interact with peripheral health care workers to monitor work processes, understand the causes of problems and provide possible solutions (Whittaker, Burns, Doyle and Lynam, 2014:251).

With regard to the definition of supervision, the authors described some processes of supervision such as monitoring of work performance, the process of guiding and helping
supervisees, understanding problems encountered and supervisors to come with possible solutions. These clearly suggest that in order to enhance supportive supervision (SS), the processes mentioned in the definitions of supervision should be put into practice. In the context of this study, the processes mentioned in the definition of supervision are considered important for SS framework development. In realizing various descriptions of processes that enhance supervision, this study deemed it necessary to review the meaning of the concept SS.

3.3 What is meant By Supportive Supervision?

The literature exposed several definitions of SS. For the purpose of this study it important to provide the general definition of the concept SS before description of an in-depth discussion of the characteristics of the concept. It is indicated that SS is both a process and a relationship that promotes sustainable and efficient programme management by encouraging a two-way communication as well as performance planning and monitoring (Resource Manual Republic of Phillipines, 2012:5). Another definition by Nkomazana et al. (2016:1), demonstrates that SS is a process of helping staff to improve their own work performance continuously.

It is further said that SS is carried out in a respectful manner and it takes place in a non-imposing way. In this study, OPMs are those receiving SS from LAMs which could help OPMs in improving their own supervision of staff members in the PHC facilities. The supervisory visits are regarded as an opportunity to improve knowledge and skills of health staff (Adeyemo, 2017:53). Again, SS entails leading the staff to a continuous quality improvement and the supportive supervisor does that by focusing on the needs of his/her staff and looking at them as customers or clients (Department of Health Republic of Philippines, 2012:5; Adeyemo, 2017:53).

The SS definitions suggest that SS is deeply rooted in process of two-way communication, planning and monitoring, helping staff on a continuous basis (Department of Health Republic of Philippines, 2012:5.) It came out clear from the definition that SS should not impose, but
rather it must portray a relationship that promotes growth and development. Given the aforesaid definitions, this study emphasizes that the SS processes highlighted in the discussions are fundamental for OPMs who are supervising staff members in the PHC facilities of NWP. It is learned from the literature that there are critical aspects that should be considered when helping OPMs to improve their work performance. In this regard, it is thus significant to explore the critical aspects of SS.

3.4 Critical Aspects of Supportive Supervision of PHC Settings

Literature revealed the most critical aspects that should be adhered to when performing SS. These aspects are direct observations of service delivery, reviewing of clinical records, joint identification and resolution of problems, direct feedback, provision of technical updates and guidance, following on previously identified problems and setting up supportive supervisory visits (Resource Manual Republic of Phillipines, 2012:5; Adeyemo, 2017:53; Jacobs et al., 2014:3). The above mentioned critical aspects of SS are discussed in the subsections that follow:

3.4.1 Direct Observation of Service Delivery

This aspect consists of observation of actual services provided in the PHC facilities by both the supervisor and a supervisee during supervisory visits. This includes communication, observation of nurses during client diagnosis, treatment and counselling to confirm that the activities are being done according to the set standards. Where the staff member is seen to have missed an important element or seen to be giving incorrect information or treatment to the patient, the supervisor should intervene and demonstrate the correct procedure so that the patient receives a quality service.

The whole process should be supportive, facilitative and not a fault finding process (PHC Supervision Manual DoH RSA, 2009:30; Adeyemo, 2017:53; Jacobs et al., 2014:3). For the purpose of SS, direct observation of service delivery should be done by both supervisor and
supervisee. In this study, the OPM is a supervisee who should receive SS from the PHC supervisor, the LAM through direct observation of service delivery. This implies that both the PHC supervisor (LAM) and OPMs should together observe staff members rendering services. Both parties should reach consensus regarding the quality of service delivered to clients, and that should be in-line with the set standards.

The above discussions suggest that observation of service delivery is critical as it is where the supervisor should display support in a facilitative way. The literature emphasize that immediate demonstration of the correct way of providing the service enhance the quality of care and professional development. Therefore, the aspect of direct observation of service delivery should be implemented during SS of OPMs. In addition, direct observations of service suggest that the supervisor is compelled to display good communication skills.

3.4.2 Reviewing of Clinical Records

This aspect focuses on checking of the general administration of the PHC facility, the information system and individual health programmes. The review of the general administration will include, among others, checking of the number of staff members on duty and facility coverage, duty list and checking of essential equipment. The patients’ files and registers should be checked to confirm that nursing care is carried out appropriately and according to the guidelines.

Consequently, the checklist should be used in order to assess whether the services rendered meet the set standards. The information obtained from records or from the assessment of records can be used to help identify opportunities for improvement (PHC Supervision Manual DoH RSA, 2009:30; Resource Manual Republic of Philippines, 2012:8; Adeyemo, 2017:53; Jacobs et al., 2014:3). These imply that both the PHC supervisor and OPM should together check the records to confirm if the activities rendered are within the set guidelines. Reviewing of clinical records include checking of whether there is sufficient staff to render the service.
The checking of essential equipment demonstrates that potential problems that can occur during emergencies should be explored during SS.

Literature suggests that the nursing practice should be checked against the set norms and standards through review of the appropriate documents. As a result, the reviewing of clinical records is more relevant in SS because it comprehensively reflect on how PHC services are rendered. This further suggests that, through documents review, the supportive supervisor can easily identify the kind of support required by OPMs in supervision of PHC services.

3.4.3 Joint Identification and Resolution of Problems

The PHC supervisor should involve the supervisee in problem identification and resolution, and thereafter engage with general health care personnel regarding any problems which are being experienced (PHC Supervision Manual DoH RSA, 2009:30; Resource Manual Republic of Phillipines, 2012:5; Jacobs et al., 2014:3). They should prioritize problems by using the criteria of the extent of the problem, the impact of the problem on health services, the feasibility of solving the problem, and the resources needed to solve the problem.

Both parties should jointly analyze problems that are a priority to determine the underlying cause. The plan of action should follow thorough analysis of problems identified. Many problems can be attended to immediately at the PHC facility whilst others will have to be taken by the supervisor to the District or other level of management (PHC Supervision Manual DoH RSA, 2009:30; Resource Manual Republic of Phillipines, 2012:5; Jacobs et al., 2014:3).

This study emphasizes that joint identification and resolution of problems is an integral part of SS of OPMs. It is necessary to help and guide OPMs in problem identification and resolution in supervision of PHC facilities. In this study, both PHC supervisor and OPMs should involve general staff members in analysis of problems experienced and resolutions thereof.
3.4.4 Provision of Technical Updates and Guidance

The nursing supervisor should provide his/her supervisee with technical updates and guidance on new developments regarding provision of PHC services. On the basis of researchers’ clinical experience, technical updates include new ways of performing certain procedures, changes with regard to treatment guidelines as well as new policies. This can be done through in-service training and by convening a formal staff meeting (PHC Supervision Manual DoH RSA, 2009:30; Resource Manual Republic of Phillipines, 2012:5; Jacobs et al., 2014:3). The literature reveals that a supervisor should be a reliable source of support and guidance regarding new policies and procedures. These suggest that the supervisor should possess the necessary knowledge and skills about the current issues in PHC practice.

3.4.5 Direct Feedback

Immediately after assessment of practice, the supervisor should provide direct feedback to address problems and this could be part of a teachable moment for personnel (PHC Supervision Manual DoH RSA, 2009:30; Resource Manual Republic of Phillipines, 2012:5; Adeyemo, 2017:53; Jacobs et al., 2014:3). It is further cited that direct feedback should be done in two ways in order to be supportive and corrective. The feedback should be supportive in a way that it appraises the good behaviour observed during the supervision process. The corrective feedback should be given in a way that encourages change of behaviour, including alternative ways of behaving or doing things. Direct feedback is most effective when used with direct observation because most feedback involves a combination of supportive and corrective feedback. Giving feedback is probably the most important quality improvement skill for a supervisor (Adeyemo, 2017:56).

The above discussions demonstrate that a feedback session should not send a message of failure to a supervisee. This is to emphasize that staff members should be praised on good performance and at the same time allowed to be given alternative ways of improving on the gaps identified. This aspect is viewed as critical for support of OPMs who are expected to
oversee supervision and quality care in PHC facilities. Therefore, this study supports two processes of displaying a supportive and corrective behaviour during the immediate feedback session.

3.4.6 Following on Previously Identified Problems

The follow-up of an action plan agreed on during supervision should reflect actions the supervisee and supervisor have agreed to implement (PHC Supervision Manual DoH RSA, 2009:30; Resource Manual Republic of Phillipines, 2012:5; Adeyemo, 2017:53; Jacobs et al., 2014:3). After each supervisory session, both the supervisor and supervisee should review the action plan to ensure that all their obligations are fulfilled. Some actions need to be taken at the supervisory level and the supervisor should also decide upon the frequency of follow-up. On the other hand, the supervisee in charge of the facility should share supportive supervisory findings with staff members. The supervisees should be determined to do a self-assessment using the recommended checklist so as to monitor and improve their own performance (PHC Supervision Manual DoH RSA, 2009:30; Resource Manual Republic of Phillipines, 2012:5; Adeyemo, 2017:53; Jacobs et al., 2014:3). The literature suggests that SS should include planning with regard to how to improve on the identified gap as well as follow-up. This is also to show that if follow-up is ensured continuous quality improvement could be met.

3.4.7 Setting up Supportive Supervisory Visits

The supportive supervisory visits should be done on a regular basis following a set schedule, and supervisees should always be notified of a visit. Therefore, a regular schedule for SS visits should be set or called at least 24 hours ahead to notify the supervisee of a SS visit (Marshall and Fehringer, 2013:14; Jacobs et al., 2014:3). In addition, the OPM should have a plan and record the dates on which the PHC supervisor expects to visit each of the PHC facilities for which s/he is responsible. These dates should be set well in advance to ensure that monthly visits take place, maybe even a fixed day each month. Should a change in schedule become
necessary, the PHC facility should be notified in advance regarding the changes made (Marshall and Fehringer, 2013:8; Jacobs et al., 2014:3).

Literature suggests that supervisory visits should not be a surprise to OPMs, meaning that the external supervisor should communicate the envisaged visits regularly. This is to ensure that the services for that particular day are not interrupted and is to have a meaningful plan for that day. Again this is to demonstrate that for a set supervisory schedule to be a success, both an external supervisor should confirm appointments. The overall discussions demonstrated that SS of OPMs rest on direct observation of service delivery, reviewing of clinical records, joint identification and resolution of problems, direct feedback, provision of technical updates and guidance, following on previously identified problems and setting up supportive supervisory visits. The critical aspects that are identified in the literature are significant for the development of a programme of SS for OPMs. Therefore, all the aspects mentioned in the above discussion informed this study during analysis of data a supportive supervision framework development and validation as well as guidelines for operationalization. Given the critical aspects of SS, it is significant to explore what is known about the existing programmes related to the topic under study. This is to update the study on the current information regarding enhancement supervision in the working environment. The literature review regarding supervision programmes is discussed next.

3.5 Review of Existing Supervision and Support Programmes

This study reviewed programmes related to SS in order to get ideas regarding different methods available for enhancement of supervision. The literature search selected studies that addressed the following concepts: (1) Supportive supervision programme for nursing managers (2) Supervision programme for nursing managers (3) Support programmes for nurses and allied health. The reason for selection of concepts was to ensure logic and relevance in terms of the processes to be followed in enhancement supervision and support in the work environment. In order to get current information, the study searched for the articles that were published during
The following supervision programmes were discovered.

3.5.1 Clinical Supervisor Support Programme

The programme was developed in Australia and it aims at expanding clinical supervision capacity and competence across each professional area, including allied health, dental, medical, nursing and midwifery (Health Workforce Australia, 2010:6). The development of a clinical support programme consists of four phases. Phases 1 and 2 included consultations with the DoH, public sector and private sector and not for profit health and other stakeholders, including accreditation bodies, specialist medical colleges, professional associations and regulatory bodies (Health Workforce Australia, 2010:6).

Phase 3 combines the information from Phases 1 and 2 to provide a basis for gap analysis and identification of policy options to increase student supervision capacity. Phase 4 focuses on the development of a national clinical supervisor strategy (Health Workforce Australia, 2010:6). The clinical supervisor support programme informs the study about the steps followed as well as relevant stakeholders for programme development. The programme focused on support of supervisors on supervision of students. The current study focuses on SS of OPMs working in the PHC facilities in the NWP.

3.5.2 A Clinical Supervision Programme for Registered Nurses

This is another study conducted in Australia aimed to develop, implement and evaluate a clinical supervision programme for registered nurses (Russel, 2013:14). The process of programme development was guided by the current literature in relation to the role of the clinical supervisor, the theories and principles of adult learning, as well as the theories of attitude and attitude change. The process of programme development was also guided by quantitative and qualitative findings. The study explored knowledge and attitudes towards clinical supervision, both before and after attending the clinical supervision programme.
The aim of the programme was stated as to provide an environment conducive to learning for nursing clinical supervisors that would assist them to understand the bigger picture of student placements in Australia. The discussions of the programme reflected on the roles of the supportive clinical supervisor, core competencies barriers to clinical supervision and negative influences of clinical supervisors (Russel, 2013:116). The processes mentioned in the programme developed for nurses in Australia relate to the steps followed for the current study. In this study, the framework is developed for OPMs responsible for supervision of the PHC facilities in the NWP.

3.5.3 A Nursing Peer Support Programme

The study conducted in China by ZhiHon and Wang (2007:1) developed a support programme to provide mutual support between colleagues. This is to enable the colleagues to deal with work-related or non-work-related stress. The role players for this programme are peer support staff, peer support coordinators and professional personnel. The role players for peer support staff look out for opportunity to deal with emotional needs in a timely manner. The peer support staff help in dealing with patient deaths, poor patient outcomes, personal issues or other work-related stressors such as conflict with colleagues and difficulty in communicating with patients’ families (ZhiHon and Wang, 2007:1).

The peer support staff should take the assessment and work with the affected individuals in helping them to reach their own solutions to the issues faced. The peer support coordinators in the programme are responsible for coordination of peer support staff through identification of training and education. Professional personnel include psychiatrists and psychologists. The roles of psychiatrists and psychologists are brief daily interactions between staff, individual support, group debriefing and training. The selected topics for training are communication skills, family events, anger management, anxiety and depression, attitude adjustment, dealing with grief, the problem of addiction and critical stress debriefing.
Training continues on a regular basis in the form of quarterly peer support staff communication meetings, related continuing education classes, annual peer support training seminars and personal research of related journals and articles. The above programme informs this study on the role players important for supporting staff on dealing with non-work-related and work-related stress. The information discovered in a nursing peer support programme is more relevant for enhancing SS of OPMs in the PHC facilities of NWP.

3.5.4 A Supervision Programme for Foster Care Social Workers

The study conducted in the Free State Province of South Africa developed a supervision programme for social workers who manage and oversee foster care placement (Malgas, 2011:2). The study used a mixed method approach and the findings provided an overview of supervision of foster care social workers. The supervision programme development is guided by the general purposes and aims of social work supervision. The needs of the social workers are included as well as the roles and responsibilities (Malgas, 2011:2). It is mentioned that social workers who manage foster care placement need training, guidance to improve supervision of foster care placement. The developed supervision programme reveals main goals to be reached by the programme, and activities to meet the set objectives as well as the time frame. Even though the above supervision programme was not designed for nursing managers, it informs this study on the relevant processes to be followed for SS framework development.

The information provided relates to the processes outlined in the logic model that guides the current study (Hatry and Newcomer, 2010:54). The supervision programme for social workers remodels the current study regarding the needs and roles and responsibilities of the beneficiaries of the programme. The programme further informs this study about the goals and objectives that need to be stated, and the activities to be met for improving supervision. Refer to chapter 6 sub-heading 6.2.4 which represents the integration of steps as part of lessons learned from.
A literature search yielded few supervision and support programmes which suggest that there is a need for a framework that could address challenges relating to lack of SS of OPMs. The programmes revealed information regarding the methods and processes to be followed in programme development. The information provided in the programmes demonstrates that it is important to reveal the goals and objectives of a framework of SS. It is learned that the activities that should be completed for enhancement of supervision should be clearly stated.

The current study is further informed by existing supervision support programmes that there should be regular training on helping nurses to deal with work-related stress. The information from existing supervision and support programmes is necessary for a SS framework for OPMs. The current study explored the supervision models in the following manner:

3.6 Supervision Models: A Global View

This study deemed it fit to examine the supervision models so as to reveal what is known and to denote the knowledge gaps. The section addressing supervision models is separated from the discussion of supervision program in order to learn the different approach of enhancement of supervision. These also helped the researcher to clearly identify the knowledge gap. As a result, the models are discussed as follows:

3.6.1 Self-Model of Training and Supervision

This model was developed in the United States of America for therapists and trainees of the University of Georgia. The model focuses on developing the "person of the therapist" and "the use of self" as an instrument of change (Wells and Pringle, 2004:12; Snow, 2006:25). Use of self in this model is defined as a process through which therapists and trainees learn how to use their personal reactions and knowledge of self as this could inform interpretation of their clients’ struggles, create a therapeutic relationship that is collaborative and conducive, and may help them to overcome difficulties and facilitate personal growth in their work environment. In this model, the role of supervisors is to encourage therapists to do self-reflection on
supervision experiences.

The findings demonstrate that knowledge of self and reflecting on supervision provided is a fundamental tool of improving support to the clients. The findings further indicate that reflecting on personal reaction to supervision enhances professional growth. Although the model reveals the important aspects that could improve support and supervision in the working environment, it was not developed for nursing managers working in the PHC facilities. For the purpose of this study, the use of self and self-reflection during and after supervision is important for improving support of OPM in the PHC facilities.

3.6.2 A Model of Supervision in Mental Health for General Practitioners

This model was developed for general practitioners caring for patients with mental illness in rural Australia (Hodgins, Judd, Kyrios Murray, Cope and Sasse, 2005:2). The model was developed because it was identified that general practitioners did not have access to support and supervision and there was no specific framework in this regard (Hodgins et al., 2005:2). The model indicates a two-way interaction as the basis for a supervision process and explains that the supervisor learns from the supervisee’s work environment. The model further reflects supervision focusing on four options, namely, patient-specific, diagnosis-specific, treatment or general supervision (Hodgins et al., 2005:187).

For the purpose of this study, it is emphasized that the two-way interaction is the starting point of supervision. The findings by Hodgins et al. (2005:187) demonstrate that patient-diagnosis and treatment-specific options are priorities whereby nurses need the SS. The two-way interactions, patient, diagnosis and treatment specific and supervisor learning from the supervisee’s work environment are regarded as the basis of a SS framework for OPMs.

3.6.3 A Model for Clinical Supervision in Allied Health

Another model was developed in rural Australia based on supervision of allied health interns
The main reason for developing this model was lack of support and supervision that was occurring among speech therapists, physical therapists, occupational therapists as well as psychologists. The model revealed facilitation of supervision through interactive television for education with onsite face-to-face sessions, supervising session and contact through secure email and other advanced technology (Miller et al., 2003:1).

The model reveals supervisors’ use of television, emails and other advanced technologies to close the gap of lack of support of supervisees. In this study, the use of technology in supervision of OPMs is regarded as fundamental in improving the quality of care. This suggests that OPMs need to be supported with necessary knowledge and skills for appropriate use of technology in managing the burden of disease. This study regards the use of technology necessary for work administration as well as for personal development.

3.6.4 Video-Aided Supervision Model

This model was developed for support of in-service training of caregivers working with infants and toddlers. The model aimed at creating new standards of caregiver-child interactions in Jerusalem’s early childhood day care setting (Gatt and Rosenthal, 2010:26). In this model, the approach to supervision is humanistic, client-centred and reflective. In addition, supervision focuses on supervisee choice, interests as well as motivations and needs during the supervision sessions. In this model, the supervision sessions are intensive and occur after every two weeks and are individualized. Again in this model, the video medium is introduced to the child-care settings for the purpose of child observation and caregivers’ self-observation. The model demonstrates that humanistic, client-centred and reflective approaches are important aspects of supervision. The model also revealed supervision through a video and the interaction of both a supervisor and supervisee observed in a real setting. Therefore, the approaches of supervision mentioned in the video-aided supervision model are viewed as important in improving the support of OPMs in the PHC facilities.
3.6.5 Seven-Eyed Model of Supervision

Hawkins and Shohet (2000) cited in Gray (2007:4) revealed a model for supervisors working with individuals, groups as well as with organizations in the human service professions. The seven-eyed model focused on the human service professions which include social workers, physiotherapists, medical doctors and educators. The model specifies seven areas that supervision can focus on. The first area is the supervisee system which focuses on the supervisee situation or the problem the supervisee needs help with, how they present the issues and the choices they are making. The supervisor’s intervention is the second area which focuses on the interventions done by the supervisor and how and why it was done and what they might have done.

The third area focuses on the relationship between the supervisor and the supervisee. Important in this one is for the supervisor to develop a better understanding of the dynamics of the supervising relationship. In the fourth area, the supervisor focuses on his/her own experience as an instrument for registering what is happening beneath the surface of the supervisee system. The parallel process is the fifth area where the focus is on what the supervisor has identified or learned from the supervisee and how it may improve the relationship between supervisor and supervisee. The supervisor’s self-reflection is the sixth area whereby the supervisor reflects on his/her experience to see how this can be used in the supervisor/supervisee relationship. The seventh area is called the wider context in which the focus is on the wider organizational, social, cultural, ethical, and contractual contexts within which the supervision is taking place (Gray, 2007:4). The findings in the seven-eyed model suggest that during supervision, it is important for a supervisor to have an understanding of the supervisee’s situation or the problem. The supervisor’s intervention is regarded as an important aspect of supervision. The findings also suggest that the supervisors experience in the field of work ease the supervision process. The supervisor’s self-reflection is also highlighted as imperative in supervision.
3.6.6 Participatory Supervision Model

In Thailand, the supervision model was developed and thereafter the implementation was done at two rural PHC facilities. The research design used for implementation was a mixed-method study. The study compared and identified the strengths and challenges of two supervision models in order to determine their effects on enhancing the health promotion capacity of health officers. The participants of the study were nursing supervisors and supervisees, technical officers and community members (Sennun, Suwannapong, Howteerakul and Pacheun, 2006:3). It was found that both supervisory models appeared effective in terms of the clients’ perceived service quality and satisfaction with care.

The findings further indicated that for successful implementation of participatory supervision several issues need to be improved. Those issues were: supervisors’ knowledge and ability, supervisees’ workload and communication skills (Sennun et al., 2006:3). The findings of this model suggest that knowledge and ability, workload and communication skills affect the quality of supervision and nursing care. For the purpose of programme development of SS for OPMs, the knowledge and abilities of both supervisors and supervisees are important.

3.6.7 Comprehensive Supportive Supervision Model

The study conducted in Pakistan about assessment of the District Health Supervisory System recommended a Comprehensive Supportive Supervision Model. This model was derived from the participatory supervision model of Thailand and video-aided model of supervision from Jerusalem. The Comprehensive Supportive Supervision Model contains three prongs, namely: Direct supervision, indirect supervision and community involvement (Pakistan Initiative for Mothers and Newborn, 2006:26). The model was developed for general PHC workers, thus not specifically addressing nursing. The findings of this model suggest that direct and indirect supervision should be practiced in supervision of PHC services.
3.6.8 Concise Exposition of the Supervision Models

The models discussed informed this study about several practices of improving support and supervision of professional service providers. It is discovered that the use of self and self-reflection improves supervision and the quality of service. The two-way interaction emerged as the starting point of supervision. The approaches such as the use of video, television and email are frequently cited as having positive effects on improving support and supervision of service providers. The understanding of the supervisee’s problems or situation and intervention of a supervisor is found to be a fundamental aspect of improving supervision and support. Therefore, the information found in the supervision models is viewed as constructive for programme development of SS of this study. Despite the information provided in the supervision models, little is specified about the SS activities required for OPM during supervision in the PHC facilities. The literature is also silent about the resources relevant to support OPMs on improving the quality of supervision in PHC facilities. This is therefore regarded as a knowledge gap regarding SS of OPM in the PHC facilities in the North-West Province of South Africa. In this study, the SS framework closes the gap identified by specifying the relevant resources and activities required for OPMs to enhance supervision in PHC facilities. Taking into consideration the abovementioned knowledge gap, it is imperative for this study to be informed about the hindrances regarding SS in the PHC facilities.

3.7 Hindrances Regarding Supportive Supervision in the PHC Facilities

It is important for this study to understand what is already known with regard to the hindrances regarding SS of OPMs in different PHC settings. This is to update the current study about the factors that can affect or influence supervision, and what has been done to address situations pertaining to SS in PHC facilities. Therefore, the global literature review regarding the hindrances regarding SS is reported as follows:

The study conducted in Georgia, Southern America, discovered some hindrances to SS in PHC facilities. The hindrances reported in this study are poor communication with remote health
facilities, lack of official regulations and clear format for providing SS; low technical capacity of local health providers; and lack of recognition among health providers on the importance of SS (Hernandez et al., 2014:11). The same study recommended research that could clarify the roles of supervisors on implementation of SS of OPMs in the PHC facilities.

The findings indicate a knowledge gap regarding role clarification on implementation of SS in Georgia. The current SS framework of OPMs show the activities to be accomplished by the main role players which could close the identified knowledge gaps regarding the role of supervisors. The study conducted in North America in Haiti found a breakdown in communication that was evident before and after the supervisory visit (Marshall and Fehringer, 2013:14). Prior to a visit, supervisees were not notified that a supervisor was coming which increased stress on supervisees. The feedback was not given immediately, which could have improved the two-way communication between supervisors and supervisees, and allow supervisees to monitor their own progress and professional development. In addition, the supervisors reported that some of the hindrances emanated from lack of resources (Marshall and Fehringer, 2013:14).

The results of the above study demonstrate that lack of immediate feedback to supervision had a negative influence on staff development. Likewise, lack of resources appeared to be a major contributory factor to failure in practicing SS. The findings of the study conducted in Haiti showed that surprise visits were affecting supervision in a negative way since it increased stress on supervisees. This further suggests that OPMs did not feel supported because of failure to notify them prior the actual visit.

The study conducted in Central America in Costa Rica reported that supervisors of community health workers spent only 41% of the expected amount of time on supervision. The same study revealed that supervisors only interviewed supervisees instead of observing clinical practice (Hill, Dumbaugh, Benton, Karin Källander, Strachan, Asbroek, Tibenderana, Kirkwood and Sylvia Meek, 2014:4). The study further discovered that the causes of these problems were an
insufficient number of vehicles for supervisors, inadequate fuel supply, and heavy workload of non-supervision activities that reduced time for supervision. Therefore, lack of resources was affecting supervision in such a way that clinical observation of practice was not implemented by supervisors.

In Bangladesh, a systematic review of studies reported that hindrances to regular and quality of supervision were limited professional development for supervisors, poor job motivation caused by low salaries, supervisors doing other jobs, inadequate skills and job descriptions that did not explain how to plan visits and perform supervision tasks, no job manual, training on technical knowledge, but not supervision skills, and no tools or standards to measure supervisory functions and progress, poor supervisory support and guidance, and other logistical and official factors, such as population size and area, lack of transportation, and too much administrative work (Hill et al., 2014:4). A study conducted in Nigeria which was aimed at assessing PHC facilities’ service readiness revealed lack of essential equipment and drugs led to poor supervision (Oyekale, 2017:10). The same study discovered that basic drugs, suction machines, batteries and generators were poorly available at the selected health facilities. The findings suggest that lack of essential equipment hindered supervision in the PHC facilities of Nigeria.

In Egypt, lack of formal induction programme to newly qualified health professionals to particular aspects of management, leadership and communication skills as well as technical aspects of their job were enormous challenges to supervision. On the other hand, lack of training sessions for supervisors on problem solving, problem identification, and team building were reported as sources of impediment to SS (Hernandez et al., 2014:9). The study revealed that lack of induction programme to newly qualified nurses and lack of skilled supervisors was an impediment to SS. The findings further revealed lack of orientation to leadership activities, lack of leadership skills, problem identification and resolution affect SS. The same study recommended research that could identify effective strategies for improving supervision
frequency and quality (Hernandez et al., 2014:9). A SS programme of this study specifies the relevant activities to improve the skills of supervisors and supervisees. These observations indicate that the current study contributes to the knowledge gap regarding strategies for improving the quality of supervision in the PHC facilities.

The study conducted by Panda, Pati, Nallala, Chauhan, Anasuya, Som and Zodpey (2014:11) in India reported some impediments to SS. It was reported that the DoH was not allocating sufficient funds to conduct SS or did not transfer funds to peripheral facilities. This made the job of PHC supervisors difficult to finance and to coordinate the visit. The lack of communication and problem-solving skills was reported as another impediment to SS process of OPMs in India (Panda et al., 2014:11). The findings of the above study demonstrate that resource allocation play a role on SS of OPM in the PHC facilities. In Tanzania and Malawi, shortages of staff at both district and facility levels, were described as major impediment to carrying out regular supervisory visits. Other challenges included conflicting and multiple responsibilities of district health teams and financial constraints (Bradly, Kamwendo, Masanja, de Pinho, Waxman, Boostrom and McAuliffe, 2013:1).

A mixed-method study conducted in the three districts of Mpumalanga in South Africa focused on evaluation of PHC supervision services. The study revealed OPMs raising a concern that they never received any PHC supervision visits at their facilities (Jacobs et al., 2014:17). The same study revealed the majority OPMs saying that PHC supervisors were spending less than 4 hours per supervision visit (Jacobs et al., 2014:17). The findings further indicated that PHC supervisors were not adhering to the prescribed time of SS, the minimum hours prescribed for supervision is 4 hours or more (PHC Supervision Manual NDoH Republic of RSA, 2009:22). A qualitative study conducted in Cape Town, Western Cape Province of South Africa, focused on experiences of PHC OPMs regarding leadership and management practice. The study reported lack of guidance on implementation of policies such as establishment of a clinic committee, lack of induction and training on leadership and management skills. The OPMs
further complained of too many initiatives which increased job demands which hindered supervision in the PHC facility (Gilson, 2016:2).

The literature reported numerous hindrances that are affecting SS in the PHC facilities. Despite the hindrances reported there is dearth of literature regarding a SS framework of OPMs in PHC facilities. What emerged clearly in the literature were recommendations suggesting a need related to strategies that could improve support and supervision of OPMs. The dominant aspects of the hindrances reported in developing countries are lack of training sessions for both supervisors and supervisees on problem identification and resolution and lack of team building, conflicting guidance from supervisors, and lack of observation of patient care by PHC supervisors.

In addition, the literature is repeatedly showing evidence that supervisors focus mainly on administrative matters, interviewing supervisees instead of observing service delivery as well as lack of leadership skills. The staff shortage, lack of transport and allocation of funds were reported as some of the main factors affecting SS of OPMs in the PHC facilities. The above findings are significant for this study as a SS programme reveals the activities, resources and other factors that could enhance SS of OPM in the PHC facilities. In view of the hindrances of SS found in the literature, it is necessary to review literature regarding the strategies that are used for supervision of PHC facilities in South Africa.

3.8 Strategies Used for Supervision of PHC Facilities in South Africa

The literature revealed several supervision strategies which have a common goal of strengthening the quality of supervision and health care in the PHC facilities. These include: (1) PHC Facility Supervision Manual, (2) The National Core Standards, (3) PHC Re-Engineering, (4) The Ideal Clinic Manual, (5) The Central Chronic Medication Dispensing and Distributions (CCMDD) System, (6) Integrated Clinical Services Management, (7) Integrated Chronic Disease Management. The strategies are discussed below.
3.8.1 PHC Facility Supervision Manual

The purpose of the manual is to support Assistant Directors of PHC Services (Local Area managers, programme managers and PHC facility managers in their roles of supervision. The manual also aims to improve the quality of primary health care in PHC facilities (PHC Supervision Manual DoH RSA, 2009:22). The manual was also designed to support critical elements of SS of PHC facilities. These manual comprises of the tools that guide PHC supervisors on how to accomplish the supervisory process (PHC Supervision Manual DoH RSA, 2009:22). The manual outlines the eight steps and activities to be followed by the supervisor when conducting supervision, and the five guiding principles of quality supervision which are discussed as follows:

- The Eight Steps and Activities to be Followed by PHC Supervisor

There are two major integrated activities within the steps and these are assessment and facilitation. The assessment activity involves observation and assessment of patient and management, and assessment of PHC facility resources. The activity of facilitation involves feedback to service providers. The manual outlines the steps and the objective of each step and the checklist to be used for each step. The eight steps are discussed below.

The first step is to introduce quality supervision and to describe objectives and steps to the clinic staff. This indicates that the supervisee should be fully aware of what is going to happen with each step. The second step addresses observation of case management and the objective is to assess compliance and reinforce skills through feedback. The third step addresses the reviewing of records in order to assess compliance and reinforce skills through feedback. The fourth step focuses on reviewing of clinic resources and to complete facility supports checklist. This is followed by facilitation of problem solving with clinic staff—the fifth step. The sixth step is to write down the plan and summary of the report and results of the visit and actions to be taken to solve problems. This is followed by a complete monitoring whereby the graphs showing the monitoring are monitored—the seventh step. This is followed by making follow-
up at sub-district and district to address some of the problem and feedback—the *eighth step*.

The eight steps revealed flow of activities that need to be accomplished for improving the quality of PHC supervision. This demonstrates that the supervisors need to be conversant with the steps of supervision prescribed by the manual. The eight steps and activities that need to be followed by PHC supervisors are integrated in programme development. The observation of case management, reviewing of records, giving of feedback and facilitation appears as the outputs in programme development.

❖ Guiding Principles of Quality PHC Supervision

The PHC supervision manual outlines the five guiding principles of quality supervision and these are systems perspective, integration of assessment and facilitation, monitor quality improvement, address problems, change and on-going needs at multiple levels. The principles are explained as follows:

The *systems perspective* explains that supervisors should understand the relationship between the resources and activities as the outcomes. This will enable them to apply a systems approach during assessment and facilitation. It is indicated that supervision visits consist of assessment and facilitation plus planning and monitoring, hence the principle of *integration of assessment and facilitation* should be adhered to. In the step of *monitoring of quality improvement*, the supervisors should review plans from the last visit and identify activities to be completed by the next supervisory visit. In the step of *addressing problems at multiple levels*, the supervisor must do follow up regarding plans for specific and resolution of problem and support.

This might be either at PHC level, district or Provincial level. The step of change and on-going needs should explain that for quality supervision to result in improved outcomes, the following are essential: organisational and health care, personal behaviour change, supervisor and health care personnel learning and support, and on-going support from sub-districts, districts and provinces. The guiding principles of quality PHC supervision are viewed as important in the
current study, hence were integrated during programme development. The study applied the eight steps to be followed by a supervisor and the guiding principles of quality supervision during description of guideless for operationalization of a SS framework.

The current manual used for supervision in the PHC facilities of RSA, revealed the steps of supervision and the principles to be used when conducting monthly supervision. The manual shows an integration of critical elements of SS of PHC with the steps and principles of supervision. Although this integration is shown, it seems as if the critical elements of SS shown in the supervision manual are not adhered to during support and supervision of OPMs. Despite an integration of critical elements of SS with the steps as shown in the supervision manual, there is a dearth of literature regarding a specific framework for SS of OPMs in the NWP. This is regarded as a knowledge gap which could be closed by development of SS framework through exploration of OPMs experiences regarding SS, and perceptions of how SS could be facilitated.

3.8.2 The National Core Standards for Health Establishments in South Africa

The National Core Standards (NCS) is one of the strategies that have been put in place to improve the quality of health care service. The NCS are formulated to serve as a guide to all managers and supervisors in service planning and delivery (A National Complaints Management Protocol DoH RSA, 2014:7; Lourens, 2013:12). The NCS was launched and piloted in 2008 and the full implementation occurred in 2010. The NCS are structured in seven cross-cutting domains, namely, patients’ rights; safety, clinical governance and care; and clinical support services, public health; leadership and corporate governance; operational management; and facilities and infrastructure (A National Complaints Management Protocol DoH RSA, 2014:7; Lourens, 2013:2). The six ministerial priorities or ministerial marching orders which fast track the implementation of NCS are values and attitudes, waiting times, cleanliness, patient safety, infection prevention and control and availability of medicines. The nurses in the PHC facilities are the main role players of ensuring quality on implementation of
NCS and the ministerial marching orders. The methods that are used to assess compliance to the implementation NCS include observation of clinical practice, patient and facility records analysis, patients’ interview and the methods emphasize availability of evidence (Lourens, 2013:2). The methods used to assess the implementation of NCS are similar to the SS approach.

This information on the NCS suggests that OPM require supervision that is more supportive for monitoring the implementation of this strategy. The NCS are important in development of the programme as it focuses on the most aspects that need to be considered when performing SS (A National Complaints Management Protocol DoH RSA, 2014:7; Lourens, 2013:12). The NCS could have an influence on the success of a SS programme of OPMs working in the PHC facilities of the NWP.

3.8.3 Primary Health Care Re-Engineering

PHC re-engineering was launched by the Minister of Health in 2010 as part of the health sector’s contribution to the overall government strategy of “A Long and Healthy Life for All South Africans” (Pillay and Barron, 2011: 2). PHC re-engineering is structured or divided into three streams, namely, ward-based PHC outreach team for each electoral ward; strengthening school health services; and district-based clinical specialist teams with an initial focus on improving maternal and child health. The three streams of PHC re-engineering are discussed by Pillay and Barron (2011: 2) as follows. Each ward should have one or more PHC outreach teams. This team consists of a professional nurse, environmental health and health promotion practitioners as well as six community health care workers. The main function of these teams is to promote good health and prevent ill health through a variety of primary interventions. Each team should also be linked to a PHC facility through the professional nurse who is the team leader. The findings regarding the PHC outreach teams demonstrate that the OPMs’ support of the team leader is necessary. This is to ensure that the health promotion interventions and referrals to the PHC facility are carried out effectively. Therefore, OPMs requires SS regarding issues pertaining to PHC outreach teams.
The stream of strengthening school health services focuses on prevention and control of ill health and the main thrust is on quintile one and two schools for providing health education and assessment of health in poorest schools. This stream should make referrals from schools to the nearby PHC facility and is run by the professional nurse. These indicate OPMs are expected to support the school health professional nurse with regard to school health nursing.

The district-based clinical specialist team consist of a gynaecologist, paediatrician, anaesthetist, family physician, advanced midwife, advanced paediatric nurse and a PHC nurse. A task team has been appointed to develop details around how these teams will function by building on what exists in each province. The basic functions of the specialist teams are to strengthen clinical governance at PHC level as well as in district hospitals, to ensure that treatment guidelines and protocols are available and are used, to ensure that essential equipment is available and are correctly used, to ensure that mortality review meetings are held and that recommendations from these meetings are implemented to support and supervise PHC nurses.

The information regarding the district-based specialist teams demonstrate that maternal and neonatal deaths in the PHC facilities should be prevented at earlier stages. The strategy of PHC re-engineering is found to be significant for this study as it is integrated in the general management and supervision of PHC services. The district specialist team should play an active role in supporting the PHC facilities against maternal deaths. The OPMs are expected to support the outreach teams and school health activities which indicate active involvement on the implementation of the strategy. Therefore, all these indicate that a SS programme is necessary as it could have an influence on implementation of the PHC re-engineering strategy.

3.8.4 The Ideal Clinic Manual

An Ideal Clinic is defined as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use
applicable clinical policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community. An ideal clinic cooperates with other government departments as well as with the private sector and non-governmental organizations to address the social determinants of health (Ideal Clinic Manual Version 16 DoH RSA, 2015:16).

The definition suggests that an ideal clinic is the health facility that conforms to almost all the standards set by the DoH. The ideal was started by South Africa in 2013 as a way of systematically improving and correcting deficiencies in PHC clinics. The strategy was fully implemented in 2016 (Ideal Clinic Manual Version 16 DoH RSA, 2015:16). The Ideal Clinic Manual has been developed to assist managers at various levels of health to correctly facilitate the assessment of quality and to correct the deficiencies. The ideal clinic is regarded as a reference document which guides the managers to determine the status of ideal clinic elements in a facility. It is revealed in the manual that integrated clinical services management is a key focus within an ideal Clinic.

The Ideal Clinic Manual systematically outlined the nine components that need to be assessed for quality. The components outlined in the manual are Administration, Integrated Clinical Services Management, Pharmaceutical And Laboratory Services, Human Resource Health, Support Services, Infrastructure And Support Services, Health Information Management, Communication and District Health System Support (Ideal Clinic Manual Version 16 DoH RSA, 2015:16). The information revealed in the Ideal Clinic Manual is found to be essential for the programme development and the guidelines for operationalization of the study. In addition OPMs are playing an important role in the implementation of the strategy of ideal clinic.

3.8.5 Central Chronic Medication Dispensing and Distributions (CCMDD) System

This system focuses on dispensing prescribed medications based on the geographic locations
of the patients with all chronic conditions, based on patients’ choice and convenience, without going to PHC facility every month. These demonstrate that the key role players in the implementation of CCMDD at the PHC level are the professional nurses and the pharmacist. This strategy was launched in 2016 with the main aim of improving the quality of PHC services by reducing long waiting time in the PHC facilities (Operation Phakisa, 2014:8). The private sectors are involved in the implementation of the CCMDD system. The CCMDD is viewed relevant in this study, as OPMs need to receive SS in ensuring the implementation of the strategy.

The literature regarding strategies of supervision in the PHC facilities revealed PHC supervision manual, NCS for health establishment for SA, PHC re-engineering, ideal clinic and the CCMDD system. As revealed in literature the main aim of the use of all these strategies is to improve the quality of PHC services, and to support or enable managers to provide quality supervision. It is imperative to consider all these strategies in developing the programme of SS of OPM in the PHC facilities of NWP. It is found in the literature that all these strategies are developed to guide and support supervisors. Hence, it is vital to develop a support programme for OPMs who are expected to implement the prescriptions set by all these strategies.

3.8.6 Integrated Clinical Services Management (ICSM)

Integrated Clinical Services Management (ICSM) is a supervision strategy that guides facility managers on how to implement integrated clinical services. This strategy is important for improving the process of the flow of clients within the facility and quality of clinical care (NDoH RSA Integrated Clinical Services Management, 2014:26). Integrated Clinical Services is described as arranging health services in such a way that people get the care they need, when they need it, in ways that are user-friendly in order to achieve the desired results, and provide value for money (NDoH RSA Integrated Clinical Services Management, 2014:27). Integrated clinical services adopt a supermarket approach in the organization of the delivery of services.
The supermarket approach refers all services offered daily and services are organized in different streams. The main aim of ICSM is to assist facilities to achieve compliance with the domain 2 of the National Core Standards (NCS). These also include assisting in compliance to the prescriptions of the Ideal Clinic Model (NDoH RSA Integrated Clinical Services Management, 2014:26). These imply that the OPMs have to implement this strategy by supervising the health staff in organizing the services according to ICSM.

3.8.7 Integrated Chronic Disease Management (ICDM)

This is a model of managed care that provides for integrated prevention, treatment and care of chronic patients by ensuring continuity of care and self-management within the community (NDoH RSA ICDM, 2014:2). The purpose of the ICDM strategy is to act against the increasing burden of chronic diseases in South Africa in an efficient and cost-effective manner (NDoH RSA ICDM, 2014:2). The DoH listed the aspects that are required for the success of the implementation of ICDM which include health service reorganization and clinical management, and support at facility level (NDoH RSA ICDM, 2014:2). These indicate that the OPMs at the PHC facility should drive the processes of the ICDM at by supervision of nursing staff. These also demonstrate that it is important to enhance SS of OPMs so that the implementation of ICDM should be a success.

The literature regarding strategies of SS revealed PHC supervision manual, NCS for health establishment for SA, PHC re-engineering, ideal clinic model and the CCMDD system. These also include the strategies known as integrated clinical services management and integrated chronic disease management. Given the aforementioned strategies, it is imperative to develop a SS programme for OPMs who are expected to implement and supervise the norms and standards set by all these strategies. The main purpose of the use of all these strategies is to improve the quality of provision of PHC services. Therefore the SS strategies that are discussed in this chapter guide programme development, this is to ensure that the norms and standards set by the department of health are adhered to.
3.9 Supportive Supervision Framework

It is imperative to provide a detailed discussion regarding SS framework as it guides the whole study. As stated in Chapter 1, the discussion of a SS framework will be based on (1) The characteristics of the concept SS, (2) Goals of SS, (3) Characteristics of a supportive supervisor, (4) Characteristics of a nursing supervisee, (5) Roles and function of a supervisor, (6) Roles of a supervisee, and (7) Factors affecting supervision in PHC services.

3.9.1 Characteristics of the Concept Supportive Supervision

The previous sub-heading in 3.3 provided a general definition of the concept hence an in-depth discussion of the characteristics of SS is addressed in this section. Supportive supervision is characterised by a relationship that ensures performance planning and monitoring, and is also shown by a relationship between the supervisor and the supervisee that promotes the development of responsibility, skill, knowledge, attitudes, and ethical standards in the health care practice (Kirk et al., 2015:6; Resource Manual of DoH of Philipines, 2012:14). Supportive supervision focuses on mentoring, provision of constructive feedback, joint identification and resolution of problems, and helping to optimize the allocation of resources, promoting high standards, teamwork and two-way communication. According to the Resource Manual of DoH of Philipines (2012:14), SS is characterised by continuous quality improvement, the guiding principles of which are client-oriented mindset; staff involvement and ownership; focus on processes and systems; cost consciousness and efficiency; continuous learning, development, and capacity building and on-going quality improvement.

In this study, performance planning and monitoring by both a supervisor and supervisee are the pillars of a SS of OPMs. During supervision, the relationship between the supervisor and supervisee should promote the development of responsibility, skill knowledge and good attitudes and ethical standards in order to serve and improve the health of the communities. In this study, a SS of OPMs focuses on mentoring, provision of constructive feedback, team work, joint identification and resolution of problems. This study emphasizes that the OPM and his/her
immediate supervisor should work together in performance planning and monitoring.

3.9.2 Goals of Supportive Supervision

According to the Resource Manual of DoH of Philippines (2012:14), SS aims at achieving the goals of improved performance and quality of service. It is also revealed that SS is directed at different levels of clients which are individuals, families and communities as well as the health service providers. Supportive supervision aims at striking a balance between those who are supposed to provide health services and those who are to receive the services.

Supportive supervision protects the rights of the individual, families, communities and to safeguard the integrity of the health service providers. In the context of this study, the clients as the recipients of health care as well as the health care providers are equally important during SS of OPMs. This implies that the rights of clients and the integrity of health care providers are one of the priorities when supervising the PHC facilities. In this regard, the OPMs require SS so as to maintain the rights of the clients and the integrity of health care providers.

3.9.3 Characteristics of a Supportive Supervisor

It is revealed in the framework of SS that the supportive supervisor is the one who possesses certain qualities and competencies that will equip him/her to deliver responsibilities that are responsive to the needs of the staff being supervised. The following is a discussion of qualities of a supportive supervisor:

3.9.3.1 Qualities of a Supportive Supervisor

According to a Resource Manual of DoH of Philippines (2012:18), a SS is a leader, good communicator, good decision maker, human relations facilitator, and a team player. Supportive supervisors are technically knowledgeable and are expected to teach and train the subordinates. A SS is knowledgeable about PHC programs, the job, and all the tasks required by it. A SS
leads teams, and must therefore be able to inspire others towards a shared direction. While establishing trust and promoting teamwork among the staff, s/he also shares the vision of high quality services.

A SS is a team player, meaning that the focus is not only to delegate tasks, s/he shares or do the tasks. A SS is a good motivator, s/he can motivate staff to work efficiently despite the circumstances. With regard to adaptability, a supportive supervisor is open to new ideas. S/he displays positivity and flexibility in adapting to new ideas. S/he is ready to manage change efficiently when it occurs. According to Kirk et al. (2015:6), a SS has excellent communication skills which not only entail relaying information, but also receiving information.

Supportive supervisors listen carefully to what clients, both internal and external say. With regard to fairness and objectivity, SS are fair and promote gender equity among the staff. They take care in delegating and allocating tasks to subordinates to increase efficiency and productivity. With regard to accountability, any mistake done by any of the staff will be the supervisor’s responsibility. A SS always remains accountable, responsible and s/he is always prepared to have the next task ready for implementation. S/he is time- and cost-conscious, thus no time is wasted on the job.

A SS has social skills that encourage staff to do good work all the time. S/he is courteous, and is respectful of other people’s rights and dignity. S/he does not ridicule or humiliate staff when they commit mistakes. S/he is also generous with praise when work is done well. A SS is also one who can diplomatically mediate between his/her team’s external and internal clients. S/he knows how to balance and how to tactfully mediate between the two. A SS has self-discipline. S/he possess the self-motivation skills and knows how to follow the rules, regulations and deadlines (Resource Manual of DoH of Philippines, 2012:18). In this study, the OPM is a supervisee who requires a supervisor with qualities of the SS. These imply that the qualities of a SS are important resources of a SS programme for OPMs in supervision of PHC facilities.
3.9.3.2 Competencies of a Supportive Supervisor

A SS should have certain competencies to enable her/him to work effectively. Therefore, a SS knows how to work and help individuals and team in achieving the goals. This entails that a supportive supervisor is good in assisting individuals or teams in achieving work goals. A supportive supervisor is good in maintaining productive interpersonal relationships.

This indicates that the supervisor is good in interacting effectively in ensuring achievement of work-related goals. A SS focuses on the results by ensuring that planning and organizing are closely related to the set time and the objectives. This entails that a SS establishes courses of action for self and others to ensure that work is completed efficiently.


The SS framework suggests that a supervisor who is knowledgeable is able to help and motivate the supervisees to perform delegated tasks. In this study, the OPM requires leadership skills that could help him/her to improve in the general supervision of nurses in the PHC facilities.

3.9.4 Roles and Functions of a Nursing Supervisor

A supportive nursing manager’s immediate role is to teach others how to undertake the quality improvement process, with the aim of enabling them to provide high-quality services that meet their community needs (Manual of DoH of Philippines, 2012:23). The assessment of training needs is a priority that should be carried out on a daily basis. For the purpose of this study, the assessment of training needs should be done by the LAM during monthly supervisory visits.
through joint problem identification and resolution with OPM (PHC Supervision Manual DoH RSA, 2009:22). The SS should play an active role in training because that is where sharpening of existing skills as well as learning new skills occur. The nursing supervisor should by all means create and maintain a non-threatening environment. This should happen during the whole supervision process, especially in facility meetings and in-service training.

The non-threatening environment can be maintained by treating all nursing supervisees with respect, as equals, and use facilitation skills to make sure that all staff treat each other with respect and equality, regardless of the position (Manual of DoH of Philipines, 2012:23). The SS is expected to document all daily activities, including guidance and training provided. The nursing supervisor as a good decision maker involves staff in the decision. Evaluation role entails the systematic appraisal of the nursing supervisees to determine if s/he is able to perform functions as expected. These include identification of the supervisees’ strengths and weaknesses, and these become the bases for the kind of development s/he needs. The roles and functions of a supervisor suggest that teaching and creation of a positive learning environment is core in SS of OPM. In this study, teaching, assessment of learning needs and documentation of teaching and trainings provided is regarded as core element of supporting OPMs.

3.9.5 Characteristics and Roles of a Nursing Supervisee

As outlined in the Resource Manual of DoH of Philipines (2012:22), a supervisee in nursing is someone who works under the general supervision of the designated nursing manager. To be an effective SS of a nurse who is working in the rural places, the nursing manager should know the roles and responsibilities of the supervisee, including his/her strengths and weaknesses. The roles and responsibilities of a nursing supervisee are to work with the nursing manager in planning and evaluating health services at the facility level. The roles include provision of midwifery services and to carry out medical and nursing functions as authorized by the DoH.
The nursing supervisee should mobilize the community for health action, carry out health education and communication activities. Furthermore, the nursing supervisee should monitor and supervise health and health-related activities within the catchment area and to participate in development and training programmes. A detailed discussion of the roles and functions of a supervisee as stated in the SS framework are as follows:

3.9.5.1 Works With the Nursing Manager in Planning and Evaluating Health Services At Facility Level

The supervisee is expected to assist and be part of planning and organizing the PHC facility and this includes preparation of monthly schedule of activities in coordination with the facility doctor, environmental health officers and other health professionals. The supervisee should plan for activities in the PHC facility and participates in determining health needs of individuals, families, and the community at large. The nurse should participate actively in the periodic evaluation of the quality of care of the PHC services (Royal College of Nursing, 2013:5; Resource Manual of DoH of Philippines, 2012:25).

These indicate that a supervisor who is knowledgeable about the role of a supervisee can play an effective supervisory role by involving them (supervisees) in planning and evaluation of health services. This also demonstrates that the OPM is expected to be knowledgeable about the roles of his/her supervisees. This will enable the OPM to guide the supervisees effectively in planning and evaluation.

3.9.5.2 Carries Out Medical and Nursing Functions As Authorized by the Department of Health

The nursing supervisee should carry out activities such as obtaining clinical history, performing simple routine physical and laboratory examinations, administration of emergency and therapeutic procedures based on the standing orders. S/he refers cases that need further diagnostic and management by the doctor and other health professionals and keeping of
accurate records of medical and nursing care rendered in the facility, homes and community
framework demonstrates that for comprehensive provision of care the nursing supervisee is
expected to work with other professional team members. It is revealed that accurate record
keeping whilst providing care is essential in PHC facilities. In this study, the OPM should be
supported, supervised in ensuring that all the nursing activities mentioned in the SS framework
are carried out.

3.9.5.3 Provides Midwifery Services

The midwife should give direct care to normal, childbearing women during pregnancy until
puerperium, as well as to newborns (Royal College of Nursing, 2013:5, Resource Manual of
DoH of Philippines, 2012:25). The referrals, in case of suspected abnormalities, should be
directed to the doctor or an advanced midwife. A SS framework indicates that the patient
should be referred to other professionals who are experts in nursing and midwifery. This
demonstrates that nurses require supervision and guidance when referring patients to other
health care professionals. This study emphasize that SS of OPM is necessary to enhance
supervision of nurses during referral of midwifery cases.

3.9.5.4 Mobilizes Community for Health Action

The aspect of community mobilization should be addressed by identification of individuals
and groups in the community that can participate in the delivery of health care. The nursing
supervisee is responsible for organizing individuals and groups to support activities in relation
to the delivery of health services within the catchment area. The community mobilization
includes facilitation of community health development projects. This demonstrates that
community involvement and participation is part of the roles and function of a supervisee.
These also suggest that SS of OPMs regarding community involvement and participation is an
essential aspect in supervision of PHC facilities.
3.9.5.5 Carries out Health Education, Information and Education Communication Activities

The nursing supervisee is expected to conduct individual and group teaching using information and education communication materials. In this study, the OPMs require support to strengthen supervision of nursing staff in health education of the communities.

3.9.5.6 Monitors and Supervises Health and Health-Related Activities Within the Catchment Area

The nursing supervisee guides other staff members such as administration staff, student nurses, cleaners and health promoters assigned to her facility (Royal College of Nursing, 2013:5; Resource Manual of DoH of Philippines, 2012:25). The required nursing records and forms for activities undertaken should be completed regularly. The nursing supervisee prepares and submits reports of activities and needs for supplies and other logistic requirements of the PHC facility. The supervisee in nursing should be a facilitator, a resource person in the training of health promoters, volunteer and community leader. These demonstrate that one of the roles of a nursing supervisee is to supervise community members. The OPM is expected to oversee supervision of nurses and all staff members. A SS programme should state the support necessary to strengthen supervision by OPMs in PHC facilities.

3.9.5.7 Participates in Training Programmes

This entails that with the knowledge and skills attained in nursing and midwifery practice, the supervisee has an active role to play in training co-workers and the community at large. A SS framework suggests that supervision by OPMs in nursing and midwifery activities of PHC is necessary. This could help nursing staff to train co-workers and community members in participating in health care programmes. In this study, the OPMs account for all training activities that takes place in the PHC facilities. A SS programme of OPMs should specify support related to training that should take place in the PHC facilities.
3.9.6 Factors Affecting Supervision

The framework that guides this study revealed three factors that affect supervision of nurses in the PHC facilities. These are factors related to the supervisor, the supervisee, and the work situation or organizational environment (Royal College of Nursing, 2013:5; Resource Manual of DoH of Philippines, 2012:25). The factors affecting supervision are discussed as follows:

3.9.6.1 Factors Related to the Supervisor

It is revealed that the factors affecting supervision is rooted in the supervisor’s supervisory skills, commitment and interpersonal qualities of the supervisor (Resource Manual of DoH of Philippines, 2012:22). The factors related to the supervisor are:

- Supervisory Skill

It is demonstrated that during the supervisory process, there are certain supervisory skills that should be displayed by a nursing supervisor. The supervisory skills entail managerial proficiency, technical competence, coaching and training, guidance and counselling skills, interpersonal relations, leadership, communication, problem-solving and the skill regarding decision making (Resource Manual of DoH of Philippines, 2012:27; WHO, 2012:29). It is accepted that these skills will enable the nursing manager to carry out her supervisory duties and responsibilities. It is revealed that with sharpened managerial skills, the nursing manager will be able to forecast, plan, organize, lead, coordinate and control her work as well as her supervisee’s efforts. The nursing supervisor who possesses technical knowledge establishes his/her authority. The manager who provides guidance and counselling skills will be able to help the supervisees to become mature well-adjusted, productive, motivated, and emotionally stable health service providers. These will again help supervisees to relate well with others, improve their performance and experience job satisfaction. The leadership skill portrayed by the nursing manager will ease the completion of the set work targets, and the maintenance of the team’s morale and cooperation. The effective nursing supervisor keeps the supervisee
informed and updated on departmental policies, objectives and programmes, administrative new developments, and changes in plans and policy directions.

The nursing supervisor who has good communication skills gives clear instructions for members to know exactly what s/he wants, but is also willing to consult or seek the opinions of other team members. The problem solving and decision making skill enables the nursing supervisor to analyze and prioritize the problem, identify causes and make a sound decision. The nursing managers’ ability to make a sound decision will facilitate the process of helping the supervisee.

A skilled supervisor will be able to decide who among her supervisees need frequent supervisory visits, which problems need immediate attention, and what type of action to take. The findings in the SS framework suggest that SS of OPMs is necessary to enhance coaching and training, guidance, problem solving skills as well as counselling of staff members in PHC facilities. In this study, the OPMs should receive coaching training, helped in resolution of problems and counselling. This could assist OPMs in strengthening supervision in the PHC facilities, thus improving health outcomes.

✧ Commitment

Commitment is fundamental aspect in supervision and entails commitment to the mission, vision, philosophy, goals and objectives of the DoH. A committed nursing supervisor who displays commitment in performing his/her duties and responsibilities can be a good role model to supervisees (Resource Manual of DoH of Philippines, 2012:27). The findings suggest that a SS inspires the supervisees through commitment to his/her work. The SS should display commitment during supervisory visits as this could inspire OPMS, thus enhancing good role modelling in the PHC facilities.

✧ Interpersonal Qualities of the Supervisor

The following interpersonal qualities will enable nursing manager to be more effective in the
performance of the job. These are willingness to supervise and take responsibility, ability to explain thoroughly and listen actively, open-mindedness, ability to accept and withstand criticism, reliability, well-organized, calmness during emergency, persuasiveness, warmth and optimism, fairness, patience, tact and discretion, awareness of limitations and willingness to spend time and effort to improve good health (Resource Manual of DoH of Philippines, 2012:29). The finding implies that lack of the abovementioned interpersonal qualities will result in compromised critical aspects of SS, consequently leading to inability to listen and resolve problems encountered by supervisees in the working environment.

3.9.6.2 Factors Related to the Supervisee

The factors related to the supervisee that are affecting supervision are competence of the supervisee, organizational vs. individual goals, personal situation, motivation and value attached to work (Royal College of Nursing, 2013:5; Resource Manual of DoH of Philippines, 2012:28). These are discussed in the following order:

❖ Competence of the Supervisee

It has been shown that supervision becomes undemanding when the nursing supervisees are equipped with the necessary technical knowledge and skills required for the job. The supervisee’s positive attitude facilitates the nursing manager’s work. The positive attitude entails aspects such as optimism, enthusiasm to learn and completion of the task on time (Royal College of Nursing, 2013:5). These suggest that a supervisee who is supported with necessary knowledge and skills to perform the job could portray a positive attitude towards work. In this study, it is necessary to support the OPM to enable him/her to display a positive attitude towards his/her supervisees. On the other hand, the findings suggest that the supervisee who is not equipped with necessary knowledge could have a negative attitude towards work. It is therefore important to supervise and support the OPM to improve competency and technical knowledge necessary for supervision.
Motivation and Value Attached to Work

The framework of SS revealed that it is unproblematic to supervise the supervisee who is motivated, who values his/her work and who is always concerned with producing the work outputs on time. On the other hand, it is problematic to supervise nursing personnel who lack motivation, who has low morale, dissatisfied, and who exhibits negative attitudes (Royal College of Nursing, 2013:5). These suggest that continuous motivation of OPM during SS can have an influence on boosting the morale of demotivated supervisees.

Organizational vs Individual Goals

The nursing manager will have a hard time working with supervisees whose personal goals do not match with the organizational goals, objectives and values. This happens when the supervisee attends to her personal needs first while patients are waiting for her/him during official hours (Royal College of Nursing, 2013:5). These suggest that a supportive supervisor should be able to identify supervisees who do not respect the goals and objectives of the organization. This further suggests that the use of official hours is an aspect to be highly considered in provision of patient care. In this study, the OPM need support to ensure that the supervisees value the use of official hours to meet the set organizational objectives.

Personal Situation

The factors that affect supervision include emotional difficulties of a supervisee, inability to work well with co-workers because of different expectations, and unwillingness to spend time and effort to attend continuing education programmes. This could occur especially to supervisees who are married and living far from their families. This suggests that a supportive supervisor should be able to identify personal problems that could make supervision difficult. The supportive supervisory visits should therefore be able to help OPMs in the identification and resolution of such supervision problems.
3.9.6.3 Factors Related to the Work Situation

The factors related to the work situation that affect supervision are classified into two, and address the supervisors work situation and supervisees work supervision (Royal College of Nursing, 2013:10; Resource Manual of DoH of Philippines, 2012:30). These are discussed in the following order:

- **Supervisor’s Work Situation**

  It is stated that if the condition or organization’s environment is conducive to the performance of the activities then the supervisors’ job will be easier. The factors related to supervisor’s work situation that affect supervision in nursing environment are administrative and technical support from upper management, good human relationships, recognition and acceptance, relationship with peers and co-workers, difficult terrain, peace and order situation, non-observation of line function (Royal College of Nursing, 2013:5; Resource Manual of DoH of Philippines, 2012:30). The above situations are discussed as follows:

  - **Administrative and Technical Support from Upper Management**

    The nursing manager who is recommended for professional advancement returns to his/her job better equipped with knowledge and skills and a wholesome attitude to carry out her functions. Such recommendations from the senior management are regarded as the fundamental support that can be offered to the supervisors. This study emphasizes that in-service training of OPMs contributes to improvement of supervision in the PHC facilities.

  - **Good Human Relationships**

    If the rural health doctors provide and maintain a climate that fosters good human relationships, then the nursing supervisor’s work becomes easier. This could be maintained by sending all communications and directions for the supervisees through the nursing supervisors. This indicates that good communication between nursing managers and other professional team members affect supervision in a positive way.
 Recognition and Acceptance

It is revealed that recognizing and appreciating a job well done of a supervisee can help to increase the morale, which is important in achieving job satisfaction and improving work performance. Recognition and appreciation can be done by recognizing a nursing manager as the immediate supervisor of the nursing supervisee (Royal College of Nursing, 2013:12). This demonstrates that appreciation of a job well done has an important role in supervision and improvement of work performance. In this study, the compromises and jobs well done by OPMs should be appreciated for improvement of work performance.

 Relationship with Peers and Co-Workers

It is revealed in the SS framework that the nursing manager is a member of a peer group and his/her success or failure will depend on how s/he can influence, or is influenced by peers. These suggest that a good relationship with peers and co-workers contributes to a positive outcomes. On the other hand, a poor relationship with a supervisee could affect supervision and the performance outcome in a negative way.

 Difficult Environment

A difficult environment is whereby the nursing manager can visit only a limited number of supervisees in the PHC facilities. This could be due to lack of transport and travelling long distances from the supervisor’s main workplace to the PHC facilities. In addition, bad roads and travelling can take more time of his/her official hours, thus leading to limited time for supervision. The SS framework indicates that lack of transport, travelling long distances can have a negative impact on supervisory visits of the PHC facilities.

 Peace and Order Situation

Planning and implementing work will be difficult if there is no peace and order in the work environment. It is further indicated that the nurse who is executing tasks is concerned with his/her own safety and that of the client. This demonstrates that a peaceful environment is
fundamental to both the nurse and a client. In this study, the OPM should ensure that the safety of nursing and support staff as well as the clients is not compromised. This could be achieved through supporting OPM in ensuring safety of staff and community members. It is therefore important that planning and implementation of PHC activities are executed in a stable environment.

- **Non-Observation of Line Function**

The non-observation of line function entails being supervised by many managers. This practice will result in a dual or multiple subordination problems where nursing personnel become accountable to more than one supervisor. Multiple supervisors might end up creating confusion thus leading to insubordination.

- **Supervisee’s Work Situation**

The factors related to the work situation that affect supervision includes attitudes of the community towards the nursing supervisees. The geographical condition in the catchment area which limits mobility leading to low coverage is another situation that affects supervision. The political influence, peace and order situation can inhibit performance of work in health facilities. The support system entails administrative and technical support of nursing personnel working in the PHC facilities. These include supplies and other logistics, technical support from the nursing managers, provision for orientation and training and recognition of performance support.

This shows that the attitude of community members towards nurses, and the conditions of the roads and distance influence SS. The findings in the SS framework suggest that the political environment, the technical support of OPM has an influence in supervision and the quality of care. A SS framework revealed the characteristics of the concept SS, the goals of SS as well as the characteristics of supervisor and supervisees. The roles and responsibilities of both supervisor and supervisee have been discussed. The factors affecting supervision which showed factors related to both supervisor and supervisee and the work situation of both are
also reported. For the purpose of this study, it is important to indicate that all the concepts discussed guided the whole study. Furthermore, the concepts found in the SS framework were the basis of data analysis and the discussion of the results.

3.10 Why a Framework Development is Important for the Current Study

A framework in this context is significant because it indicates a set of principles, ideas or beliefs which could be useful in dealing with problems related to poor SS of OPMs in the PHC facilities of the NWP (Brown, 2010:4). A framework that has been developed therefore outlines a specific way of how effective SS of OPMs by LAMs can be facilitated in the PHC facilities of the NWP. This confirms what is mentioned by Brink et al. (2012:26), that a framework creates a specific way of looking at a particular phenomenon.

In the current study, a framework could serve as a guide that may address a gap that can be found between the aim and specific activities that should be achieved for enhancement of SS of OPMs (Rycroft-Malone & Tracy, 2010: 228). For the purpose of the current study a framework could enable stakeholders to focus on the critical elements of SS during planning for and monitoring of supervision by OPMs. These confirm what is discovered in the literature that a framework assists different stakeholders to focus on the fundamentals regarding management of a specific venture (Wholey et al, 2010: 54 ; Brink et al, 2012:26 and Rycroft-Malone & Tracy, 2010: 228). A framework developed in this study is therefore important to guide SS of OPMs in the primary health care facilities of North West Province.

3.11 Conclusion

Chapter 3 focused on a critical discussion of literature relevant to this study and numerous electronic data bases were used to search for information relevant to the development of a supportive supervision framework. The electronic database used for the search of information were Google Scholar, Scopus, Medline, Elsevier, Chochrane, ScienceDirect, Ebscohost and Google. The related terms used for the search were supportive supervision in the PHC
facilities, supervision for nursing managers, and framework for supportive supervision in the PHC facilities. The search was further narrowed to supervision models, supervision programmes and supervision for nurses. The information that came out from the search was critically examined for relevance, appropriateness to be used for a development of a SS framework. The lessons learned from each article were summarised at the end of the discussion of each sub-heading. Through literature search this chapter defined and explored the concepts supervision and SS. The critical aspects of SS in PHC facilities were discussed as well as the hindrances to SS. This chapter further reviewed the strategies of SS in South Africa. A SS framework guiding the whole study was also covered. The chapter ends with a discussion of why a Framework development is important for the current study. The next chapter focuses on the findings regarding experiences of OPMs pertaining to SS in PHC facilities of NWP and how SS can be facilitated in the PHC facilities of NWP.
CHAPTER 4

Discussion of the Findings and Literature Control of a Supportive Supervision Framework

4.1 Introduction

The previous chapter focused on the narrative literature review of this study. This chapter explains the findings and provides a discussion of the results of focus groups interviews on the experiences of OPM regarding SS in the PHC facilities, and their perceptions of how SS of OPM can be facilitated effectively in PHC facilities of the NWP as well as the literature control. Four semi-structured in-depth focus group interviews were conducted in four sub-districts of the NWP.

The objectives of the study were to:

- Explore and describe experiences of Operational Managers regarding Supportive Supervision by Local Area Managers in the PHC facilities of the North West Province;

- Describe Operational Managers’ perceptions of how Supportive Supervision by Local Area Managers can be facilitated effectively in PHC facilities of the North West Province;

- Describe the conceptual framework of Supportive Supervision of Operational Managers in the PHC facilities;

- Develop and describe a Supportive Supervision framework of Operational
Managers in the PHC facilities;

- Validate a Supportive Supervision framework of Operational Managers in the PHC facilities; and

- Describe the guidelines of operationalization of the framework.

4.2 Realization of the Sampling

Table 4.1 summarizes the realization of the sampling of this study

**Table 4.1: Realization of the study sample**

<table>
<thead>
<tr>
<th></th>
<th>Total number</th>
<th>Age range (years)</th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>23</td>
<td>37-58</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Permanent positions</td>
<td>18</td>
<td>5</td>
<td>18 months-12 years</td>
<td>8-28 years</td>
</tr>
<tr>
<td>Acting positions</td>
<td>24-hour clinic</td>
<td>12-hour clinic</td>
<td>8-hour clinic</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The total number of OPMs who participated in this study were twenty three. Their ages ranged from thirty seven to fifty eight years. Three of the participants were males whereas twenty were females. Eighteen OPMs were on permanent positions and five were placed on acting positions. Their PHC SS experience in the current positions ranged from 18 months to twelve years. Their professional nursing experience ranged between 8 and 28 years.

The number of OPMs working in the PHC facilities that operate for 24 hours were 9 and those working in the PHCs operating for 12 hours were 2. It was found that OPMs who were working in the facilities operating for 8 hours were 12. Three of the OPMs reported that there were times whereby they were delegated to act in Local Area Managers’ (LAMs) positions. The
demographic information provided in the discussion of the realization of the sample gives evidence to show that the inclusion and exclusion criteria appeared as planned (field notes, Annexure: M, L, N & O).

4.3 Discussion of the Findings and Literature Control

The analysis of the data followed Tesch’s method of content analysis and open-coding (Creswell, 2009:184). Four broad themes with their categories and sub-categories emerged from the consensus meeting held with the independent co-coder. In the first theme, the participants expressed experiences of factors related to compromised critical aspects of SS.

Two categories that emerged from the first theme are (1) OPMs experience of supportive supervisory visits as negative (2) OPMs experience LAMs as supportive regarding human resource issues. These categories are supported by sub-categories as they appear in Table 4.2. In the second theme, the participants reported experiences of factors related to lack of qualities and competencies of a supportive supervisor.

The first category for the second theme is OPMs expressed experiences of frustrations related to a need for emotional support. The second category is experiences of Lack of necessary skills to support OPMs and the third category is Experiences of lack of professional behaviour and lack of respect. These categories are also supported by sub-categories as they appear in Table 4.2. In the third theme, the participants reported experiences of factors that contribute to poor delegation and supervision in the facility.

The first category for the third theme is shortage of nursing staff and the second category is lack of essential equipment. The sub-categories for shortage of staff appear in table 4.2. The fourth theme report perceptions of how effective supportive supervision of OPMs can be facilitated. The first category that emerged in the fourth theme is LAMs to adhere to the principles of SS.
Table 4.2: Themes with their categories and sub-categories that emerged from Tesch’s method of content analysis and open-coding

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Sub-Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Participants expressed experiences of factors related to compromised critical aspects of supportive supervision</td>
<td>1.1 OPMs experienced supportive supervisory visits as negative</td>
<td>1.1.1 OPMs’ experience of lack of joint problem identification and resolution with LAMs as evident in focus on fault finding and lack of constructive feedback</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.2 OPMs experienced LAMs as blaming for poor facility performance and supervision</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.3 Outstanding problems due to LAMs failing to analyze and resolve problems and lack of and unfair staff discipline</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1.1.4 Lack of guidance on implementation of policies and new guidelines</td>
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<tr>
<td></td>
<td></td>
<td>1.1.5 Lack of support by programme coordinators</td>
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<tr>
<td></td>
<td></td>
<td>1.1.6 Lack of support by direct observation of service delivery by LAMs</td>
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<td></td>
<td></td>
<td>1.1.7 Lack of support regarding handling of problems related to staff shortage</td>
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<tr>
<td>1.2 OPMs experience LAMs as unsupportive regarding human resources</td>
<td>Frustrations regarding human resource issues:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1.2.1 Delay in payments of night duty allowance</td>
<td></td>
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<tr>
<td></td>
<td>1.2.2 Lack of capturing leave days increases staff absenteeism</td>
<td></td>
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<tr>
<td></td>
<td>1.2.3 Delay in rank translations</td>
<td></td>
</tr>
</tbody>
</table>
Table 4.2: Themes with their categories and sub-categories that emerged from Tesch’s method of content analysis and open-coding (continued)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Sub-Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Participants reported experiences of factors related to poor qualities and competencies of a supportive supervisor</td>
<td>2.1 OPMs expressed experiences of frustrations related to a need for emotional support</td>
<td>OPMs experiences of:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.1.1 Demotivation due to lack of emotional support</td>
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<tr>
<td></td>
<td></td>
<td>2.1.2 Unequal staff treatment evident in close friendship with some OPMs, PMDS rewards and Allocation of resources</td>
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<tr>
<td></td>
<td></td>
<td>2.1.3 Frustrations due to lack of appreciation of compromises made by OPMs</td>
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<td></td>
<td></td>
<td>2.1.4 Lack of support in cases of litigations</td>
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<tr>
<td></td>
<td></td>
<td>2.1.5 OPMs frustrated by absence of LAMs evident in using non-contact communication</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.1.6 Failure to follow channels of communication</td>
</tr>
<tr>
<td></td>
<td>2.2 Experience of lack of necessary skills to support OPMs</td>
<td>2.2.1 Programme coordinators lacking knowledge regarding guidelines</td>
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<td></td>
<td></td>
<td>2.2.2 Lack of advocacy due to LAMs non-assertiveness</td>
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<tr>
<td></td>
<td>2.3 Experiences of lack of professional behaviour and lack of respect</td>
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</tbody>
</table>

Continued/...
Table 4.2: Themes with their categories and sub-categories that emerged from Tesch’s method of content analysis and open-coding (continued)

<table>
<thead>
<tr>
<th>Theme</th>
<th>Category</th>
<th>Sub-Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Participants reported experiences of factors that contribute to poor delegation and supervision in the facility</td>
<td>3.1 Shortage of nursing staff</td>
<td>Experience of overworked due to:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1.1 Limited time for supervision and administrative work due to high workload</td>
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<td></td>
<td></td>
<td>3.1.2 Small number of nursing staff</td>
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<tr>
<td></td>
<td></td>
<td>3.1.3 Increased supervision strategies</td>
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<tr>
<td></td>
<td></td>
<td>3.1.4 Nurses experience insults and blame by community members regarding long queues</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3.1.5 Lack of essential equipment and inadequate infrastructure</td>
</tr>
<tr>
<td>4. Participants expressed the factors that can enhance facilitation of effective supportive supervision of OPMs</td>
<td>4.1 LAMs to adhere to the principles of SS</td>
<td>OPMs expressed a need for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.1.1 Regular SS visits</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4.1.2 LAMs to observe the practice and create opportunities to give feedback</td>
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<tr>
<td></td>
<td></td>
<td>Training of staff members regarding:</td>
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<tr>
<td></td>
<td></td>
<td>4.2.1 Human resources and labour relations issues</td>
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<tr>
<td></td>
<td></td>
<td>4.2.2 Policies and guidelines</td>
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<td></td>
<td></td>
<td>4.3.1 Leadership and management skills, including how to deal with difficult staff</td>
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<tr>
<td></td>
<td></td>
<td>4.3.2 Assertiveness</td>
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<tr>
<td></td>
<td></td>
<td>4.3.3 Professional conduct</td>
</tr>
<tr>
<td>Theme</td>
<td>Category</td>
<td>Sub-Category</td>
</tr>
<tr>
<td>-------</td>
<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>4. Participants expressed perceptions on how effective supportive supervision of OPMs can be facilitated</td>
<td>4.4</td>
<td>Involvement of OPMs on issues of budget</td>
</tr>
<tr>
<td></td>
<td>4.5</td>
<td>Improvement in communication and working relationship</td>
</tr>
<tr>
<td></td>
<td>4.6</td>
<td>A need for evaluation of the effectiveness of SS strategies</td>
</tr>
<tr>
<td></td>
<td>4.7</td>
<td>OPM expressed a need for debriefing sessions</td>
</tr>
<tr>
<td></td>
<td>4.8</td>
<td>A need for a clear communicated plan of OPMs supervision in the facility</td>
</tr>
<tr>
<td></td>
<td>4.9</td>
<td>Address issues of staff shortages</td>
</tr>
<tr>
<td></td>
<td>4.10</td>
<td>Transparency and openness to facilitate community understanding</td>
</tr>
</tbody>
</table>
The second category is OPMs expressed a need for in-service training. The third category report a need for Training on supervisory skills and the fourth category report a need for involvement of OPMs on issues of budget. The fifth category report and need for improvement in communication and working relationship. The sixth category is a need for evaluation of the effectiveness of SS strategies, the seventh category is OPMs expressed a need for debriefing sessions, the eighth category report a need for a clear communicated plan of OPMs supervision, the ninth category is address issues of staff shortage and tenth category is transparency and openness to facilitate community understanding.

4.3.1 Theme 1: Factors Related to Compromised Critical Aspects of Supportive Supervision

The participants expressed experiences of factors related to a compromise in critical aspects of SS in the PHC facilities. From this broad theme it emerged that OPMs experienced supportive supervisory visits by LAMs as negative and OPMs experienced LAM as unsupportive regarding human resource issues. These two categories are discussed in the following order:

4.3.1.1 Category 1.1: OPMs Experience Supportive Supervisory Visits as Negative

The participants reported experience of negative supportive supervisory visits. This experience is summarized in sub-categories as follows:

- OPMs’ experience of lack of joint problem identification and resolution with LAMs as evident in focus on fault finding and lack of constructive feedback
- OPMs experienced LAMs as blaming them for poor facility performance and supervision

OPMs’ experience of:

- Outstanding problems due to LAMs failing to analyse and resolve problems
and lack of unfair staff discipline

- Lack of guidance on implementation of policies and new guidelines
- Lack of support by programme coordinators
- Lack of support by direct observation of service delivery by LAMs
- Lack of support regarding handling of problems related to staff shortage

The following is the discussion of each sub-category that came out of OPMs’ experience of supportive supervisory visits as negative in the PHC facilities of the NWP.

4.3.1.1 Sub-Category 1.1.1: Experience of Lack of Joint Problem Identification and Resolution with LAMs as Evident in Focus on Fault Finding and Lack of Constructive Feedback

During the discussion with the participants experience of lack of joint problem identification with the supervisor was lacking. This emerged in the discussions with OPMs in the four sub-districts as fault finding and lack of constructive feedback. Experience of lack of joint problem identification and resolution as evidenced by focus on fault finding emerged and one of the participants in FGI (b) said:

*When she realises that there are problems like for instance last week she came and the clinic was full. She just shouted you know...just in front of the clients..., the clinic is full what, what, It is like she will be pin pointing mistakes only that no...no the clinic is full and it is like your fault or what.*

The similar experience was reported by another participant in FGI (d) who said:

*What I am experiencing is like eeeeh. my supervisor will be coming to my clinic for the wrongs. Like for example neh my supervisor will be.. It’s like a routine neh she will be coming every time in the facility with a checklist neh...to, to tick the wrongs, and show you this is wrong instead of discussing whatever she found with me here., you will be coming in a collective like in a sub-district flagging ... the*
wrongs that you got in my facility.

Another participant in the FGI (e) had this to say:

> Like neh her last, last visit I felt..., I felt... should I say embarrassed because I felt like maybe I am a stupid you will feel like you don’t know what to do, and how to do eeh... your own supervision in the clinic because every time people find mistakes. You know what happened is I didn’t check whether people are on delegated duties then she came and realised that there was no delegation schedule for that day, only to find that the same thing happened previously.” The same participant continued and said: *(holding and showing a blank paper written an alphabet H)* “Is like this paper neh you will be saying that you see the black H but you don’t see the white part of it. So what I mean is that they will be coming for the black spot.

Another participant in the FGI (a) reported similar experience and said:

> What I experience, eh..eh is not supportive supervision *per se* what is, is happening to me is a fault finding, but she will be telling you that she..she, they are coming for supportive supervision. I don’t feel supported by whoever is coming for the supervision in the facility...so... our supervisors are not helping us in a way they are concentrating on finding faults they are not doing what they are supposed to do.

Generally, the participants showed excessive anger, this was manifested by high tone of voices, frowning, and looking sad during description of experiences of fault finding.

The LAMs’ role regarding PHC SS is to ensure that OPMs are fully and actively involved in the process of identification and resolution of problems that hinder the provision of service (A National Complaints Management Protocol DoH RSA 2014:7; PHC Supervision Manual DoH RSA, 2009:14; Lourens, 2013:2; Jacobs et al., 2014:9). The current study discovered that OPMs experienced LAMs as blaming and fault finding as evident by being shouted at during visits. According to the PHC supervision manual the identification and resolution of problems should be followed by completion of a red flag, regular review checklists and quality improvement plan (A National Complaints Management Protocol DoH RSA, 2014:7; PHC Supervision Manual DoH RSA, 2009:14; Lourens, 2013:2; Jacobs et al., 2014:9).
In this study it came out clearly that during supervisory visits OPMs experienced blame for mistakes found by their immediate supervisor, that they were not necessarily responsible for their existence. Supervision is the process of guiding, helping and encouraging staff to improve their performance so that they meet the defined standards of the organization (Kettle, 2015:6).

Contrary to the meaning of supervision, the present study reported that OPMs were not feeling supported and assisted by the supervisor, indicating lack of supportive supervisory visits. The findings further suggest that during supervisory visits LAMs were focusing on the faults which OPMs would have expected LAMs to create an atmosphere where they could jointly identify and resolve them.

The participants also reported experience of lack of joint problem identification and resolution as having contributed to lack of constructive feedback. These emerged from the four FGIs and it was put differently by the participants.

The participant in the FGI (b) said:

My immediate supervisor yes, she does come to the facility for clinic supervision, but for me I am saying what is the use for somebody to come in the facility and not give you feedback on what she has observed, because she will just look at the cupboards whether they are well arranged, she just look at the fridge, to see whether it is well packed. She will never ever on her own sit down with me and say now the situation is like this what are your challenges and where can I help you.

A similar experience emerged from FGI (d) which was expressed in this way.

I don’t see the benefit from her visits because she rarely discusses what she has observed... or discusses the way forward immediately after completing a checklist.

Another participant in the FGI (c) put it in this way:

I understand that immediately after a support visit i should be made aware of maybe the problems found in a friendly manner, maybe the supervisor to say look that is what has happened and this is the way it was supposed to be done and thereafter help me (showing by shaking the head) but now it is not happening.
The same phenomenon was reported differently in FGI (a) as follows:

*It is just a standard thing that or a routine for one to say let me go to this facility so that at the end of the month i can show a completed checklist to show that, or I can claim that I was at the facility D, you as an OPM you don’t get any comments from them.*

As prescribed in the PHC Supervision Manual and the National Core Standards, constructive feedback should be given after every SS and these should be documented (A National Complaints Management Protocol DoH RSA, 2014:7; DoH RSA, 2009:14; Lourens, 2013:2; Jacobs et al., 2014:9). Contrary to what is prescribed, OPMs reported that LAMs rarely discussed what they observed, indicating lack of constructive feedback. The OPMs said that they did not see the benefits of their supportive supervisory visits. The OPMs further said a discussion of a way forward after completion of supervisory checklist was not happening, which also indicated lack of constructive feedback. The findings of this study suggest that the LAMs were coming for SS, but joint problem identification and resolution with the supervisee was not taking place.

Consistent with the findings of the current study, the study conducted in Botswana reported that supportive supervisory visits were mostly limited to demanding information, passing on directives from the National Ministry of Health and crisis management (Nkomazana et al., 2016:3). In contrast with the findings of the current study, and what was found in Botswana, the study conducted in Nigeria reported that the supervisees learned from the interaction with their supervisors which helped with problem identification and resolution (Erchick, George, Umeh and Wonodi, 2017:409).

Erchick et al. (2017:409) discovered that supervisees were able to interact with their supervisor by reviewing routine immunization session plans, vaccine storage and stock balances. It has been revealed in the literature that SS is a process that focuses on mentoring, provision of constructive feedback, joint identification and resolution of problems and promotion of high

Contrary to the meaning of SS process, the current study reports that supervisory visits in the NWP were limited to fault finding and lack of constructive feedback. This study therefore demonstrates that the LAMs were coming to the PHC facilities for SS, but their visits were lacking in problem identification and resolution.

Similar to the findings of the current study, Vasan et al. (2016:438) reported that supervisors were expected to help supervisees in identification and resolution of problems, but often lacked the necessary skills and capabilities. The findings of this study suggest that LAMs were lacking necessary skills regarding problem identification and resolution, hence supervision focused on finding faults and lack of feedback. The findings indicate that the critical aspects of SS were compromised in the PHC facilities of the NWP.

4.3.1.1.2 Sub-Category 1.1.2: OPMs Experienced LAMs as Blaming for Poor Facility Performance and Supervision

During data collection experience of being blamed for poor facility performance and supervision emerged and this was reported in all four sub-districts. A participant reported blaming of OPMs in the FGI (c):

*When coming to the targets because the...my facility is not reaching the HIV Counselling and Testing (HCT) targets, then the cluster manager (LAM) came to my facility and said (pointing finger to participants one by one) keitumetse (not a real name) you are not performing, sister Martha you are not performing, so we are carrying a burden on our shoulders that every time you have to ensure that the patient is happy, the facility is reaching the set targets, and when you look what led this person not to be able to perform it is because there is no sufficient supportive supervision in all spheres.*

A similar experience emerged from the FGI (a) as follows:

*There is a campaign you don’t perform, everything is put on the shoulders of the operational manager and we will be blamed for all poor performance.*
In the FGI (b), the same phenomenon was reported differently and it was put in this way:

*So at the end of the month the statistics will be showing poor performance, now the cluster manager (referring to the LAM) will be saying you are not supervising the indicators are going down. You see something going wrong now you get punished with words like these.*

The same experience was reported differently in the FGI (d) as the participant said:

*But if you are not performing like now neh my HIV re-test rate is below the target...neh, neh and my manager said in the local area meeting that I am not supervising, people are not following the guidelines what and what. Forgetting that the guidelines were not brought to me, is not there written down for people to refer yes mam.*

The vision of the South African DoH strives for a long and healthy life for all South Africans (NDoH RSA Strategic Plan, 2015:1). As stipulated in the National Health Act Number 61 of 2003, nurses should be supported to ensure adequate and efficient rendering of health services (Government Gazzette, 2014:2). It was found in this study, that the OPMs experienced a blame regarding the performance indicators that were below the set targets, the guidelines that were not followed by nursing staff, poor performance regarding the health promotion campaigns held. These demonstrate that OPMs were not receiving SS by LAMs in order to contribute to the vision of the DoH.

Blaming OPMs for the targets that were below set values indicate a lack of support and failure to adhere to the mandate revealed in the National Health Act. This is supported by the study conducted in Gauteng and Free State provinces of South Africa in which the participants pointed out that the senior supervisors are fault finders and very quick to blame and judge when things are not done (Munyewendel et al., 2014:4). The participants in the study of Munyewendel et al. (2014:4) further said that the managers should consider the nurses’ point of view during supervision. The OPMs in the current study indicated that the burden of poor performance and supervision were put on their shoulders which indicate blame from their
supervisors. Similar findings were reported by Adeyemo (2017:3) as it was found that nurses were blamed by their supervisors for poor performance regarding health education of the communities about prevention of malaria. It has been discovered in literature that one of the bad habits of the supervisor is putting the blame on the team (Arakelyan, 2015:1; Bucci, 2014:14).

The findings of this study suggest that the LAMs were displaying bad supervisory habits as evidenced by blaming OPMs for poor facility performance and supervision. In addition, blame by LAMs showed lack of supportive supervisory visits which confirmed that the critical aspects that should be adhered to during SS were compromised in the PHC facilities.

4.3.1.1.3 Sub-Category 1.1.3: OPMs’ Experience of Outstanding Problems Due to LAMs Failing to Analyse and Resolve Problems and Lack of and Unfair Staff Discipline

During the facilitation of the discussions OPMs experience of outstanding problems due to LAM failing to analyze and resolve problems as well as lack of and unfair staff discipline emerged. The following are the voices of participants expressing the outstanding problems due to LAMS failing to analyze and resolve problem.

The participant in the FGI (d) said:

*My clinic neh..neh it is well known that is not performing in this particular programme, and the supervisor doesn’t come and find out what the problem is, what might be the root cause of your facility not to perform, and maybe help me and come down to the staff members. Maybe it might be due to human resources maybe lack of skills or lack of equipment that maybe we... we...have to use for rendering of service.*

Another participant in the FGI (a) expressed experience of outstanding problems due to LAMs failing to analyze and resolve problems in this way:

*The problems that are there are not looked at to say what might be the cause of this*
to happen, they don’t say let’s look at this, they are piled they are waiting for you when you present at the performance reviews and PMDS. They pile up they don’t help us to analyze and solve issues in the facility. (showing by use of hands) they let them pile, pile and pile.

Another participant in the FGI (b) said:

Then the facility is not performing instead of the LAM finding out and say why are you not performing, where is the problem, what makes you not to perform she will shout.

Another participant in the FGI (c) put it in this way:

I must be supported by my supervisor to hear from me on what went wrong in order for me not to reach the target of this specific programme, and she knows very well that my facility is so weak on TB programme. So most of the time it comes back like.., like I have done something very wrong without my supervisor looking at the situation in the facility, how are we working in order to always not to reach the target, and then also in all the indicators what is going on..., in this facility the problems will just stay there and it will be like a norm.

One of the strategic objectives of the South African DoH for 2015-2020, and the objectives of the National Development Plan (NDP) vision 2030 is to reduce infant mortality and the prevalence of communicable diseases (NDoH RSA Strategic Plan, 2015:8). The current study reported experience of outstanding problems regarding poor performance in TB programme due to LAMs failure to analyze and resolve problems. These indicate that lack of SS was impacting negatively on the strategic objectives of the DoH and NDP vision 2030.

The literature revealed that good leaders are not only talking about the chronic problems of the organization, but seek to understand the root cause of the problem through intense analysis and resolution (Rooney and Heuvel, 2014:35). The current study reported that it was well known that certain clinics were not performing and were known to be weak on specific programmes. These indicate outstanding problems whereby LAMs were failing to analyze and resolve problems. In addition, the findings suggest that LAMs were not embarking on intense analysis
of the root cause of the chronic problems instead they were left to accumulate. It is reported that the problems will end up being taken like they are normal and were raised during presentations of sub-district reviews and Performance Management Development System (PMDS). According to International Aero Space Quality Group (2014:6), no problem can be successfully and everlastingly resolved unless its origins are known and understood. The findings of this study suggest that the LAMs and other senior managers were not interested in understanding the origins of the problems, hence problems were left as if they were normal to occur in some facilities. The participants also reported experience of outstanding problems related to lack of and unfair staff discipline. This emerged in FGI (c) and is reported as follows:

\[
\text{With limited staff that we have, we are also having those who are involved in misconduct in our sub-district. The same people involved in a misconduct are been shielded, we don’t know whether are they family friends to the managers or what. You will find that she did misconduct here and she will be shifted to another area.}
\]

Another participant in the FGI (d) put it in this way:

\[
\text{You will get a problematic staff member, the staff member will not be dealt with despite the disciplinary measures in place, even if you have written a report about this person. When they think now the problem is out of control, like I don’t know like when there are floods, is now all over now houses are now falling off is now then that people are coming, and they will take this person to another facility and this is shifting a problem, and shifting a problem never help my dear.}
\]

Participant in the FGI (a) had this to say:

\[
\text{Supervision cannot be sustained because people will follow what these difficult one a professional nurse for that matter is, she will be doing it deliberately because sanctions are not implemented. In this sub-district the labor relations activities like disciplinary hearing are not taking place the necessary steps like that are not implemented which is really unfair.}
\]

Another participant in the FGI (b) put it this way:

\[
\text{In general according to my experience there is lack of sanctions, people are doing}
\]
a lot of things here and I think I worked for many years in this sub-district and I have never seen someone being sanctioned seriously and there are many wrongs, things that are happening here.

The same participant continued and said:

*I have never heard that there is a disciplinary hearing and people are making a lot of misconduct.*

Discipline is an action to be taken by the management aiming at inhibiting all employees from behaviour that threatens to disrupt the functioning of the organisation (Kovane and Williams, 2015:32). In this study, necessary actions were not taken by managers to prevent behaviours that impede the functioning of the PHC facilities. The people involved in the misconduct were shielded by repeatedly moving them to other facilities without applying disciplinary procedures. These demonstrate that the longstanding problems of misconduct were not dealt with. The study conducted by Bank, Engelbrecht and Strümpher (2016:15) recommended that unfairness should be minimized, and the supervisors should apply disciplinary measures consistently to reduce unresolved issues of labour. In this study, lack of sanctions and disciplinary hearing despite a lot of misconduct suggest unresolved issues of labour and supervisors who were not applying disciplinary procedures consistently. These further indicate outstanding problems related to lack of and unfair staff discipline.

The same phenomenon was supported by Kajonga (2013:7), and pointed out that lack of fairness is related to leaders who promote laissez-faire which lead to repeated acts of misconduct that were not dealt with. The findings of this study confirm what has been found by Bank et al. (2016:15) and Kajonga (2013:7) as the participants said people who were repeatedly involved in the misconduct were not disciplined. In Karanja’s study (2013:36), the respondents indicated that strict adherence to disciplinary policies helped to strengthen supervision in the health sectors and reduced unresolved cases of absenteeism. The findings of this study suggest that there was lack of and unfair staff discipline.
In this study, there were reported instances of outstanding problems such as being known that certain facilities were performing poorly particularly on tuberculosis (TB) programme. In addition, the PHC facility problems were regarded as if they were normal, and further left to accumulate and raised during presentations of sub-district reviews and PMDS. Outstanding problems were manifested by shielding of staff members involved in acts of misconduct by continuously moving them to other facilities without applying disciplinary measures.

Furthermore, there was lack of serious sanctions and disciplinary hearing despite misconduct that were taking place which demonstrate outstanding problems. It is therefore clear that experience of outstanding problems were due to LAMs failing to analyze and resolve problems and lack of and unfair staff discipline. These indicate lack of supportive supervisory visits which shows compromised critical aspects that need to be adhered to during supportive supervisory visits.

4.3.1.1.4 Sub-Category 1.1.4: OPMs’ Experience of Lack of Guidance on Implementation of Policies and New Guidelines

In this study, the participants expressed experiences of lack of guidance on implementation of policies and new guidelines by LAMs. This emerged in the FGI (b) as follows:

_We do things on our own, you get new policies you have to see yourself through that policy, you get documents they say you can read as long as you can read they are covered they don’t care how you interpret whatever and they will tell you that I gave you this. They are forgetting that with us it is different we have to get a full understanding of policies so that we should be able tell people what to do in order to follow the policies._

The participant in FGI (a) put it this way:

_They are no longer guiding us like it happened before and there are a lot of systems that have been put on us without any formal training or whatever. With the very ideal clinic model is something very new to us they (LAMs) will be going there to attend training and then when they come back they will be just giving us the manual and as an operational manager you will see to finish how to go about not knowing
where to start and how.

Another participant in FGI (d) who was an acting OPM reported experience of lack of guidance on implementation of policies and new guidelines in this manner:

"I think even the orientation, when you are taken from one position to the other you will need somebody to come to you to say this is A or this is something new you are supposed to do like this and this. In my situation no one did that, I was just taken to the office without any orientation. I see for myself...you will see for yourself (with a frowning face), I don’t know if whether they are taking it for granted that I have been working in the PHC facility for a long period of time."

One of the participants in the FGI (c) also said:

"The programmes managers are there but I don’t know what are they doing there, they are not supportive. There are lot of programs, we need their guidance there is HIV/AIDS, there is TB, there is PMTCT there is mentor mother there are a lot a lot of programmes. You are expected to perform on those programmes without their help and the work is pilling every day."

During supportive supervisory visits, PHC supervisors are expected to offer support by observing the application of policies and treatment guidelines for specific programmes (PHC Supervision Manual DoH RSA, 2009:14; Lourens, 2013:2; Jacobs et al., 2014:9). In contrast to what is expected from PHC supervisors, in this study, OPMs were not receiving the necessary support and guidance on implementation of new TB/HIV/AIDS and PMTCT guidelines. The observation of the application of policies and treatment guidelines should be followed by a Quality Improvement Plan which include identified training needs (PHC Supervision Manual DoH RSA, 2009:14; Lourens, 2013:2; Jacobs et al., 2014:9).

In this study, some of the participants indicated that they did not receive a formal training on SS strategy of Ideal Clinic Model and the National Core Standards. This also suggests that the Quality Improvement Plan were not addressing issues pertaining to training needs. Similarly, to the findings of this study, one of the studies conducted in Gauteng Province reported that
OPMs were not trained on implementation on a strategy of PHC re-engineering (Schneider, English, Tabana, Padayachee and Orgill, 2014:11). The same study reported that during the implementation of PHC re-engineering OPMs were unable to guide and support the outreach teams in Gauteng Province (Schneider et al., 2014:11).

According to Vasan et al. (2016:438), during supportive supervisory visits appropriate guidance and support is given in order to help staff to become more competent, knowledgeable and effective in their work. This is supported by what is found in the PHC Supervision Manual and the National Core Standards as it prescribed that orientation of new staff should appear in the training schedule (PHC Supervision Manual DoH RSA, 2009:23, Lourens, 2013:2; Jacobs et al., 2014:12). In this study, OPMs on new management acting positions were not orientated, indicating lack of guidance on implementation of new policies and guidelines. The results of the study conducted in Tanzania about evaluation of the impact of SS showed positive impact on implementation of policies in the PHC facilities (Purity, Eilish, Ogenna, Honorati and Henry, 2017:7). Experience of lack of guidance and support of OPMs on implementation of TB/HIV/AIDS and PMTC new guidelines, lack of training on ideal clinic model and failure to orientate new OPMs who were in acting positions demonstrate lack of supportive supervisory visits. This therefore shows that the critical aspects that should be adhered to by LAMs during SS in the PHC facilities were compromised.

4.3.1.1.5 Sub-Category 1.1.5: Experience of Lack of Support by Programme Coordinators

During data collection it emerged that the programme coordinators were not visiting the PHC facilities to offer support regarding the specific health programmes. This emerged from the FGI (c) as follows:

Programme managers are not visiting, I am not sure if this is because of the clinics in the remote area, the condition of the road, I am not sure of the reason but I have never seen the programme manager in my clinic. They don’t visit, since March up to date (8 months) I have not seen a programme manager in the clinic, and where
Another participant in the FGI (b) registered the same concern differently and said:

*The programme managers you only meet them at the office. They will say you have to use this new form for statistics, if you compile the statistics using the very same form they will say it is wrong. They don’t come to show you that this is how you do this.*

One of the participants in the FGI (d) put it this way:

*We are expecting programme coordinators to come for support visits on monthly basis but now what I have realised is that we only see them when there is a visit from outside. Thereafter we will only see them appearing at the clinic maybe if there is a burning issue regarding the statistics and when there is a campaign that needs them.*

Another participant in the FGI (a) had this to say:

*I have last seen the MCHW coordinator early this year during the national visit no...it was a provincial visit so the coordinators come only come for monthly statistics and when we are expecting visits from outside.*

The main role of programme coordinators is to conduct an in-depth programme review on a quarterly basis (PHC Supervision Manual DoH RSA, 2009:23; Lourens, 2013:2; Jacobs et al., 2014:12). The current study unearthed that programme coordinators were not visiting the PHC facilities for six months and more. Evidently the programme coordinators visited occasionally like during a national or provincial visit or when there is a specific health campaign. It was found that lack of visits by programme coordinators resulted in challenges related to compilation of monthly statistics.

Similar findings were reported by Agoro, Osuga and Adoyo (2015:3) as they discovered in their study that nurses were not visited for the last three to six months. Agoro et al. (2015:3) reported that lack of support visits by pharmaceutical managers resulted in poor management of medicines. The report by Lambo (2015:8) showed that inadequate supervisory visits by
programme managers contributed to poor implementation of PHC strategy in Nigeria. In this study, lack of support by programme coordinators was manifested by no formal supervisory visits for a period of 8 months and occasional visits for addressing some burning issues. These indicate lack of supportive supervisory visits and further confirm the compromised critical aspects of SS in the PHC facilities of NWP.

4.3.1.1.6 Sub-Category 1.1.6: Experience of Lack of Support by Direct Observation of Service Delivery by LAMs

In the discussions with the participants, it was apparent that direct observation of service delivery during supervisory visits was lacking from the LAMs. It was discovered that during supervisory visit LAMs were focusing on asking the OPMs questions relating to service delivery instead of them making observations. These emerged in FGI (d) as one of the participant said:

> When she comes she doesn’t check and see on what we are doing in the consulting room or anywhere in the facility she doesn’t do that. They only get surprises that they are even not prepared to account for in the sub-district performance reviews.

Another participant in the FGI (a) reported lack of direct observation of the service delivery and put it in this way:

> When she comes for the clinic supervision she is supposed to check for herself and maybe say let’s go to the computer for me to see what people are doing, now she will come in and ask you, have you done this you see, their questions are really, really annoying you see.

A similar experience was reported differently in the FGI (c) and the participant had this to say:

> They will be asking what you don’t have and what you did and what you didn’t do we want them to take time to check with me, sit down, look at the indicators on where you are performing and where you are not and ask you how can I help you in this one.
As prescribed by the SS strategies of PHC facilities, assessment of quality of care should be
done by direct observation of service delivery (PHC Supervision Manual DoH RSA, 2009:24;
Lourens, 2013:2; Jacobs et al., 2014:12). This study revealed that the LAMs were not
practicing the principle of direct observation of the practice. It was found that they (LAMs)
focused more on interviewing the OPMs about what they don’t have and what they did and
didn’t do, indicating lack of direct observation of service delivery. The OPMs indicated that
lack of direct observation of service resulted in LAMs getting surprises of the things that they
could not account for during the sub-district performance reviews meeting.

Contrary to what was found in the current study, Panda et al. (2015:3) discovered in their study
that direct observation existed in immunization services during supervisory visits. They found
that direct observation of services enabled the supervisors to motivate supervisees, and to
immediately identify the mistakes, thus improving the quality of immunizations service. In
addition, it was observed that mentoring improves skills through direct, on-site observation of
case management (Vasan et al., 2016:448). It is found in literature that during supportive
supervisory visits, the supervisor from a higher level in the health system, audits and directly
observes the work of a PHC worker to ensure that the correct activities are being performed
effectively (Vasan et al., 2016:439).

In this study, LAMs were not supporting OPMs with direct observation of services which
might have contributed to poor performance and supervision in the PHC facility. Experiences
of lack of supportive supervisory visits in this study were evidenced by LAMs asking OPMs
questions about what they did and didn’t do. These indicate lack of support by LAMs by direct
observation of service delivery. These further demonstrate that the critical aspects of SS that
need to be adhered to when performing supervision were compromised in the PHC facilities
of NWP.
4.3.1.1.7 Sub-Category 1.1.7: Experience of Lack of Support Regarding Handling of Problems Related to Staff Shortage

During data collection, lack of support in handling problems related to shortage of nurses was discovered. These emerged from FGI (a) as one of the participants said:

*We don’t know what to do because now the shortage pressurizes nurses to take sick leave, people will just take off and stay at home. Is either sick leave or she stay home so you have to work, so those who are on duty will say look at the off duties this one and this one are not here and this one was supposed to work 7 to 7. So you will be compelled to take 7 to 7 because you are a manager you cannot close the clinic.*

A similar experience was reported by the participant in FGI (d) and it was put in this way:

*The managers are not supporting us on handling complains of staff regarding shortage, they should be the one to come and address staff to experience and hear what people are saying concerning shortage.*

Another participant in FGI (b) said:

*Our managers are not helping us at all and also there at the top of the hierarchy, if the client is complaining that they are waiting on the long queue, they don’t have to make a drama about it ... they should not come running to the clinic, like they normally do after receiving the complaint you will see all of their cars parked at the clinic.*

The same participant continued and said:

*They should just there and then tell the clients that but do you see that we don’t have enough nurses that there are only two nurses at the clinic that is why you have to wait longer and for that reason we cannot put more than two nurses in the consulting room.*

During supervisory visits, LAMs are to play a role of helping OPM by reviewing facility staff coverage and where necessary taking necessary actions of ensuring equal distribution of nursing personnel (A National Complaints Management Protocol DoH RSA 2014:7; PHC
Supervision Manual DoH RSA, 2009:54; Jacobs et al., 2014:14). This exercise includes the analysis of a number of categories of nurses on and off duty, as well as the type of leave offered.

In this study, OPMs were compelled to work extra hours in order to ensure facility coverage. These indicate that LAMs failed to offer support by reviewing facility coverage and by taking necessary actions to ensure equal distribution of nursing personnel. The findings suggest that LAMs were not trained on critical elements of SS that are embedded in the supervision manual and their roles in this regard. This is perceived by OPMs to have resulted in experiencing LAMs supervision as unsupportive regarding shortage of human resources.

The findings of the present study demonstrate that shortage of nurses resulted to increased sick leave and staff absenteeism. Similar to the findings of this study, Mvkovane and Williams (2015:12) reported that excessive workloads and lack of support by senior managers increase stress levels leading to absenteeism. The participants in this study, felt that the senior managers should be the ones who should handle the nurses and communities complaints regarding shortage of staff.

The same phenomenon was reported in the research findings about support needed by facility managers in one of the PHC facilities in the urban area of South Africa (Gilson, 2016:2). It was revealed that facility managers were not supported by their senior managers in handling issues regarding staff shortage and absenteeism. In this study, OPMs experienced working extra hours, repeated leaves taken, and failure of senior managers to handle issues of long waiting times. These indicate that during supervisory visits LAMs did not support OPMs regarding handling of problems related to staff shortage.

4.3.1.2 Category 1.2: OPMs experienced LAMs as Unsupportive Regarding other Human Resources Issues

During data collection it came out clear that OPMs experienced LAMs as unsupportive regarding human resource issues as reported hereunder. These are frustrations regarding the
following human resource issues.

- Delay in payments of night duty allowance
- Lack of capturing leave days increases staff absenteeism
- Delay in rank translations

The discussions of frustrations regarding human resource issues are as follows:

4.3.1.2.1 Sub-Category 1.2.1: Delay in Payments of Night Duty Allowance

The nurses reported experiences of the delay in payment of night duty allowance and one of the participants in FGI (c) had this to say:

*You will find people who are due for night duty not willing to work during the night only to find that there is a problem with payments.*

The delay in payment of night duty allowance emerged from FGI (a) and it was put it in this way:

*I will say HR section causes supervisory problems, they are not paying people on time. I have a problem with nurses when coming to night duty, I have to allocate people for night duty and they will say they don’t want to work night duty because they have not received their night duty allowance for six months. So I decided to go to HR and I asked them to check so they did that. So they managed to give payments for those months.*

Another participant from FGI (d) had this to say:

*HR is pulling us down especially with regard to payment of night duty allowance. I am raising this as a matter of concern, they...*(jumping to another statement)* it is worrying because LAMs are not taking the HR things seriously and HR is the heart of the sub-district.*

In FGI (b) delay in payment of night duty allowance was reported as follows:
I think if they can process night duty allowance on time our delegation of people for night duty could be easy.

LAMs are expected to play a supportive role by enquiring about staff problems and where necessary escalating such issues to the sub-district management team (Jacobs et al., 2014:14; PHC Supervision Manual DoH RSA, 2009:24). These include offering support to staff members who are having problems that need intervention by human resource officers such as unpaid claims (Jacobs et al., 2014:14; PHC Supervision Manual DoH RSA, 2009:24). In this study, OPMs experienced LAMs as unsupportive regarding human resources which were manifested by night duty allowance not being paid to nurses on time.

According to the Basic Conditions of Employment Act No. 75 of 1997 of RSA, night duty allowance refers to the money that should be paid to employees who worked between 18:00 and 06:00 the next day. It is stipulated that such employee will be entitled to and shall receive an allowance in respect of each night shift. The findings of the present study discovered that nurses were not willing to work night duty because they had 6 months outstanding unpaid night duty allowance. The supportive supervisory visit should show OPMs a documented support and action plan addressing problems of nursing staff that could affect provision of PHC (Jacobs et al., 2014:16; PHC Supervision Manual DoH RSA, 2009:24).

The findings of this study suggest that LAMs failed to play a supportive role by not making an enquiry about staff problems that need to be attended to by HR personnel. The findings further suggest that LAMs failed to address the problems of nursing staff that could affect provision of health care as evidenced by nurses not willing to work night duty due to outstanding unpaid night duty allowance. Such problems could have been escalated by LAMs to HR and sub-district management team for appropriate resolution. These indicate that OPMs experienced supportive supervisory visits as negative which demonstrates compromised critical aspects of SS in the PHC facilities of NWP.
4.3.1.2.2 Sub-Category 1.2.2: Lack of Capturing of Leave Days Increases Staff Absenteeism

During discussions it emerged that lack of capturing of leave days increase staff absenteeism and it was reported only in the two sub-districts. This emerged in FGI (d) as follows:

*It happened that the absenteeism in the clinic was just sky rocketing. People were signing sick leave and it was difficult to control them, until I asked and asked the HR person, and only to realize that the leave days were not captured.*

Another participant in FGI (a) put it in this way:

*You will be asking, how many days does this person have they will say 30 days, it will be 30 days always and this person you know that he has been taking leave previously and this person will fill leave and say my days will expire.*

Another one in FGI (a) said:

*Even the sick leave some people will be filling sick leave for so many times but in the computer its like she has never taken sick leave, the days are not captured so it becomes a problem* (with a raised tone of voice) *and these are the things that are frustrating.*

Another participant in FGI (d) report lack of capturing leave days and had this to say:

*The HR people should improve the capturing of leave because as we speak in our sub-district the leave days were not captured since October last year (3 months) (emphasizing her point by show of hands) so you report this to the LAM nothing is done.*

According to the supportive supervisory guideline, LAMs are expected to support OPMs by conducting a monthly in-depth analysis of a number of the nursing staff members that were granted sick, annual and family responsibility leave (PHC Supervision Manual DoH RSA, 2009:54; Jacobs et al., 2014:14).

These should be followed by making calculations of the staff absenteeism rate and the
corrective measures should be documented (PHC Supervision Manual DoH RSA, 2009:54; Jacobs et al., 2014:14). In this study, OPMs were not receiving the necessary support by LAMs leading to experiences of frustration regarding the human resource issues.

Lack of support regarding human resource issues resulted in staff members taking leave repeatedly which resulted in high rate of staff absenteeism. The Basic Conditions of Employment Act No. 75 of 1997 of RSA, states that human resource staff should keep a record of leave taken by every employee in the electronic and manual VIP system. The VIP system is a human resource system that maintains all the employees’ information regarding leave. The leave record should show the annual, sick and special leave an employee is entitled to a number of days taken, comment about the reason and the balance (Basic Conditions of Employment Act No. 75, 1997 of RSA).

In this study, the number of annual, sick and the number of leave days left for employees were not recorded in an electronic and manual system for three months. These resulted in staff members repeatedly taking annual and sick leave without any control. This situation implied that LAMs did not support OPMs on human resource issues, hence uncontrolled staff absenteeism.

These also indicate that LAMs were not considering their supervisory role of regular enquiry about staff problems in order to support OPMs (PHC Supervision Manual NDoH RSA, 2009:22). Lack of support regarding human resource issues suggest that the critical aspects that need to be adhered to during SS were not adhered to by LAMs in the PHC facilities of the NWP.

4.3.1.2.3 Sub-Category 1.2.3: Delay in Rank Translations

During the discussions with the participants, delay in rank translations emerged from three sub-districts and one of the participants in FGI (d) had this to say:
The HR is not doing justice to the newly qualified ENAs. And remember that they are very scarce because their training was discontinued. We need that person who is to be with you, now when she is dragging her feet and not supporting you, so it is a challenge. Because she will be saying even if she has finished school she doesn’t know where she stands.

Another participant in FGI (a) reported delay in rank translation this way:

Then the other thing that makes supervision a challenge is the delay in translation of people’s ranks. Sometimes you will find that there are those counselors who are taken to go to school to be nursing assistants, now they are qualified and they are still placed at the rank of cleaners, some are still in a rank of care givers. At times when you delegate her she will be saying I am still a counselor you see.

One of the participants in FGI (b) said:

Ehh...ehh you, you will be reporting to the cluster manager (meaning LAM) to say Iam working with people who completed their training and yet still at a level of a lay counselor, and the manager will just say you must tell that person to go and ask HR people.. you know is like.. (looks furious) the support from the manager about staff issues is Zero bagaetsho (meaning fellows).

One of the roles of LAMs during supervisory visits is to engage with facility staff members regarding any problems which are being experienced (Jacobs et al., 2014:9). This is supported by Lourens (2012:5), who revealed that documented evidence regarding quarterly engagement with staff members should be available when assessing staff issues.

This is also confirmed by PHC Supervision Manual DoH RSA (2009:16) as it is also prescribed that the supervisory reports should show staff problems that were attended to. In this study, OPMs claimed that they were faced with a supervision challenge due to lack of support by LAMs regarding rank translation of nurses.

These suggest that if LAMs were playing a supportive supervisory role of engaging with staff members as expected, they could have intervened on delayed rank translations. Jacobs et al. (2014:9) further indicated that other staff issues can be dealt with immediately whilst others
will be taken by the supervisor to the district office or other responsible officers.

The findings of the current study suggest that LAMs did not engage with PHC staff members, hence a delay in rank translations of newly qualified auxiliary nurses was reported by OPMs. It is indicated that LAMs should address staff issues by making specific follow-up, request and motivation to the sub-district and district offices on behalf of the facility (PHC Supervision Manual DoH RSA, 2009:16).

This delay in payment of night duty allowance, lack of capturing of leave days leading to increased staff absenteeism, and delay in rank translations indicate that LAMs failed to offer support by contacting human resource personnel on behalf of staff members. Based on the findings of this study LAMs did not adhere to the critical aspects of SS during their supervisory visits.

4.3.2 Theme 2: Factors Related to Lack of Qualities and Competencies of a Supportive Supervisor

In this study, the participants reported factors related to lack of qualities and competencies of a supportive supervisor. From this broad theme the following categories emerged:

- OPMs expressed experiences of frustrations related to a need for emotional support
- Lack of necessary skills to support OPMs
- Experiences of lack of professional behaviour and lack of respect

The categories arising from this theme are discussed in the ensuing subsections.
4.3.2.1 Category 2.1: OPMs Expressed Experiences of Frustrations Related to a Need for Emotional Support

During the discussions with the participants, experiences of frustration related to a need for emotional support emerged. These were summarised as sub-categories in the following manner—OPMs experiences of:

- Demotivation due to lack of emotional support;
- Unequal staff treatment evident in close friendship with some OPMs, PMDS rewards and Allocation of resources;
- Frustrations due to lack of appreciation of compromises made by OPMs;
- Lack of support in cases of litigations;
- OPMs frustrated by absence of LAMs evident in using non-contact communication; and
- Failure to follow channels of communication

4.3.2.1.1 Sub-Category 2.1.1: Demotivation Due to Lack of Emotional Support

The participants in the four sub-districts reported that they were demotivated due to lack of emotional support. These emerged from one of the participants in FGI (c) and it was reported in the following manner:

*We knock off being disturbed mentally.. emotionally, you come to work being demotivated that’s a problem and then we are not called to say... say what happened here before I can be pinned down (rubbing nose and with blinking eyes). So it is really traumatizing.*

Another participant in FGI (b) had this to say:
They can’t even motivate us, only prayers are keeping us together otherwise we could be falling apart, it is too much for an individual to be seeing patients, to be seeing problems of the facility, to be asked where is F, where is G where is W one person and now again we are called through gadgets” (looks angry and sad).

A similar experience was reported differently by another participant in FGI (a) and put it in this way:

As operational managers we have no peace psychologically, we are so demotivated, demoralized.

Participant in FGI (d) reported demotivation and said:

Our supervisors are like…. (with a frowning face) they don’t care they are not even sensitive to our feelings you will come back from the performance reviews meeting with your morale so down you will even feel like resigning within 24hrs.

In this study, the OPMs expressed demotivation from the work environment and PHC supervisors. These resulted in coming to work being demoralized, and going home being disturbed psychologically and emotionally. The participants reported the thoughts of resigning in 24 hours because of lack of encouragement from their senior managers. Nkomazana et al. (2016:15) agreed with what was discovered by the current study as they found that inadequate support and supervision of primary healthcare workers led to poor motivation, increased staff turnover, and poor patient care.

In contrast to the findings of the present study, Panda et al. (2015:6) noted in their study that decreased turnover and improvement in performance was influenced by staff members who were motivated by their supervisors. Contrary to the findings of this study, again, the research findings on the evaluation of the impact of regular supportive supervisory visits revealed improved and increased staff morale, clinical competencies of health care providers and improved quality of care and patient safety (Kirk et al., 2015:11). The findings of the current study suggest that there is a lack of qualities and competencies of a supportive supervisor evidenced by LAMs failing to motivate OPMs during supervisory visits.
According to Deriba, Sinke, Ereso and Badaha (2017:17), the qualities and competencies of a SS is ability to praise for any task well done. Deriba et al. (2017:17) asserted that praise should be accompanied by reminding subordinates that through the supervisors support the organization can perform better on the weaknesses identified. These suggest that, in this study, LAMs were expected to display those qualities and competencies by praising OPMs on jobs well done. In addition, it was expected from LAMs to assure OPMs that the facility could perform better through their support.

4.3.2.1.2 Sub-Category 2.1.2: Unequal Staff Treatment Evident in Close Friendship with Some OPMs, PMDS Rewards and Allocation of Resources

During discussions with the participants, it was discovered that staff members, including OPMs were not treated equally. Unequal treatment of staff members were reported differently by the participants in the four FGIs. It emerged during the facilitation of the interviews that favouritism evident in close friendship with of some OPMs hampered the continuity of care. One of the participants in FGI (a) said:

*These managers are not aware of the mess they are creating with favouritism* (looks angry). Now there is a lot of disharmony between the facility manager of health centre A and clinic B because facility manager of health centre A is aware that this one is a big favourite of a local area manager which also affects continuity of care of patients. The same participant continued and said: “For example some of the staff of health centres within the local area are not cooperative in receiving clients from the smaller clinics because of the close friendship LAM created with other OPMs.

The participant in FGI (b) reported favouritism of some OPM by LAM differently and said:

*Favouritism pull us down, because even if you try your level best you will be knowing that only so and so who is a friend to a manager her clinic will be seen as the best performing* (looks very furious). Some of us have already developed a don’t care attitude to the general performance of the clinic which also affect the clients.
Another participant in FGI (c) put it this way:

*Here in this sub-district it is like this *neh* facility manager is your friend, you are going to treat this person this way, and this one from that facility is not your friend and you are going to ill-treat her instead of supporting this person and guide this person to say, this is how this thing should be done in the facility you focus on the friendship and gossip, LAM gossiped about the mistakes found on patients referred from my facility to the facility of my colleague who is her favourite.*

The study conducted in Russia established that a supervisee may experience social alleviation and the feeling of being unneeded in the organization as a result of a manager who favours certain staff members (Safina, 2015:632). Similar to what was found in Russia, the current study exposed that social alleviation prevailed as OPMs who were not favoured by LAMs were not guided on how the facility should be managed. According to the report by Basu (2014:2), favouritism in the workplace is whereby someone or a group of people appear to be treated better than others and not necessarily because of outstanding work performance.

The local area managers of the current study created a close relationship with some of OPMs which indicate favouritism. On the other hand, LAMs were gossiping about some OPMs with those who were their close friends which suggested that close friends were treated better than others. The gossip was about mistakes found on patients referred from facilities of those who were not favoured. The current study revealed that OPMs who realized that they were not favoured by LAMs, developed a don’t care attitude which had a negative impact on the general performance of the facility.

Basu (2014:2) confirmed what was found in this study, by stating that favouritism has a negative impact on job commitment as it increases the stress level of employees and the intention to leave the job. In this study, the participants revealed that favouritism brought disharmony in the workplace. The findings of this study are supported by Pang (2015:3) as it was indicated that favouritism bring a lot of conflicts and frustrations among staff members. Unequal staff treatment was also experienced by OPMs as experiences of favouritisms related
to Performance Management Development System (PMDS) reward. This was reported by one of the participant in FGI (a) in this manner:

(With a raised tone of voice) There are these people... certain facilities whom it will be known in the sub-district that they are the ones who receive PMDS. Irrespective of low performance indicators, even if their facilities are not so perfect, they... those who are not achieving they get PMDS what is that, it does not make sense really.

Another participant in FGI (d) had this to say:

Some of the things are just happening and you wonder why. There was a time we were supposed to submit the PMDS report. Each clinic had to submit to the local area manager, surprisingly there will be this person one of the facility managers who submits her reports directly to the sub-district manager and, but we don’t have to question that and thereafter you will realise that her facility always get.

Another participant in FGI (c) had this to say:

With this PMDS like I said when you try to delegate somebody this person will say I will not do this because I am not recognized. Sometimes some people will just say repeated people will get that PMDS, so people will say so and so is the one who is working and will say go and ask Mary to do that because she is the one who is recognized by the managers.

One of the key principles of PMDS in South Africa is to enhance organizational effectiveness and efficiency in a supportive, consultative and non-discriminatory manner (Provincial Government RSA, 2015:7). In this study, the participants reported that the same facilities were getting PMDS award, irrespective of their poor performance indicating unfair treatment.

Consistent to the findings of the current study, one of the studies conducted in the two provinces of South Africa, revealed nurses complaining that poor salaries for increased responsibilities were made worse by an unfair performance management and reward system (Munyewende et al., 2014:8). It was found in the current study that staff members were concerned of the same people who will be getting PMDS repeatedly, indicating unfair
performance management and reward system. The study conducted by Kovane and Williams (2015:82) reported that most of the respondents were dissatisfied about PMDS bonuses and said it was paid on the basis of friendship. A similar phenomenon was reported in the study conducted in Nairobi as it was found that job dissatisfaction was associated with inequitable performance appraisal (Schwendimann, Dhaini, Ausserhofer, Engberg and Zúñiga, 2016:8). The current study summarised and supported what was reported by other researchers by revealing that supervisees who were dissatisfied about PMDS were not accepting the delegated duties.

In Kenya, Makhamara (2017:104) unveiled that poor quality of care was associated with unfair staff promotions. In this study, dissatisfaction of nurses regarding PMDS might be the cause of poor facility performance in some of the PHC facilities of the NWP.

One of the studies reported that the performance of health workers is negatively influenced by low levels of motivation and job satisfaction, particularly in the areas of salary and promotion (Hotchkiss, Banteyerga and Tharaney, 2015:9). In this study, the OPMs reported that staff members were dissatisfied because of unfair treatment.

During data collection unequal staff treatment also emerged as unfairness in allocation of resources was reported in FGI (a) as one of the participants said:

>> The resources are not allocated equally because what comes to the head of allocators are individuals. They don’t give the facility according to what you have ordered. If facility F has ordered 10 whatever they give them a lot of things then the remnants whatever that is left will be what you get.

Another participant in FGI (c) said:

>> Eheh allocation of human resource, you will find that the head count (meaning monthly statistics) of the facility G is far low but her staff allocation is bigger than yours. We are not getting equal treatment from our managers.
Another participant in FGI (b) had this to say:

Recently we were allocated computers, I was shocked where I was seated three days ago, the facility that is having less headcount have twice the allocation of computers than us”. The same participant continued and said: “I am trying to ask myself, are they allocating according to professional nurses because even the number of professional nurses are not five.

The study conducted in the Eastern Cape of South Africa reported that job dissatisfaction was associated with unequal distribution of resources (Sherry, 2017:6). In this study, the participants reported human and material resources that were not distributed according to the facility demands, indicating unfair treatment.

The current study discovered that OPMs were frustrated about facilities with less head count that were getting more staff and material resources like computers. The findings of this study confirmed what was found in Kenya, which reported that inefficient allocation of human resources increased the level of stress and staff turnover in one of the district hospitals (Makhamara, 2017:96).

The literature review conducted in the previous chapter revealed that decision making that is not linked to any kind of favouritism is a core element of the qualities of a supportive supervisor (Hughes, 2017:4; Resource Manual of DoH of Philippines, 2012:18). In addition, qualities of a supportive supervisor include fairness and objectivity in decision making (Hughes, 2017:4; Resource Manual of DoH of Philippines, 2012:18).

In this study, favouritism which was manifested by close friend friendship with some OPMs, unfair allocation of PMDS and resources demonstrate lack of qualities and competencies of a supportive supervisor. The findings demonstrate that lack of qualities and competencies of a supportive supervisor created experiences of frustrations related to a need of emotional support.
4.3.2.1.3 Sub-Category 2.1.3: Frustrations Due to Lack of Appreciation of Compromises Made by OPMs

During the discussions, it was discovered that LAMs did not appreciate the compromises made by the OPMs. This was expressed by one of the participants in FGI (b) and had this to say:

They don’t appreciate even ka Setswana barengwana o moaketsa ka lefura go sena nama (meaning-praise the child even if there is no token of appreciation).
At least a pad on your shoulder just to say hold on” (addition from one of the participant-well done).

The similar experience was reported differently by another participant in FGI (d) and it was put in this way:

There are many good things that we do in the facility, I don’t feel acknowledged of whatever I do that is my experience and you end up not feeling confident on what you are doing. Even if..like in case of a child, the child has collected this water (showing by holding a bottle of water) and you say thank you.. thank you. It will make the child to go higher and higher. So if your supervisor is not appreciating what you are doing it becomes a problem, you lose confidence” (looks sad).

The same experience is reported by another participant in FGI (a) and it was put in this way:

Another issue that I want to talk about is lack of appreciation. OPMs are sacrificing as much as they can but I have never heard our supervisors appreciating what we are doing.

Another participant in FGI (c) reported lack of appreciation by LAM and it was put in this way:

Our cluster manager doesn’t recognise the work that we are doing and what we do with the limited available resources. It ends up bringing the person to the point of I don’t care I come to work I do what I am supposed to do I go home. I don’t take extra work I don’t do anything” (with a lot of anger and use hands to stress a point).

In this study, the participants reported lack of appreciation by their supervisors and claimed
that they lost confidence due to failure of their LAMs to appreciate their efforts. Mazabob, Keel and Ray (2015:2) reported that the ability to genuinely acknowledge a job well done is essential for reinforcing employees’ commitment to do their best. The participants in the current study further said that lack of appreciation led to a development of a don’t care attitude and reduction in going the extra mile. Mazabob et al. (2015:2) reported that two minutes of positive and explicit detailed acknowledgement of an employee’s efforts once a month increase a person’s job satisfaction.

The findings of the current study found that lack of appreciation of OPMs by LAMs for the work well done which could lead to job dissatisfaction. The study conducted in Brazil concluded that supervisors should be skilled at using formal and informal recognition techniques, including a personal thank you and voicing verbal appreciation in staff meetings (Kurcgant, Passos, Pereira and Costa, 2015:36). The findings in this study, suggest that supervisors of OPMs were not skilled enough to use formal and informal recognition techniques.

In the studies conducted by Hisler (2016:8) and Marc, Makai-Dimeny and Osvat (2014:10), it came out clear that supervisors require additional qualities and competencies to support employees. These include the ability to recognize the efforts made, positive supportive attitudes and persuading skills. It was exposed by Marc et al. (2014: 10) that a good supervisor should be able to apply these skills in a stressful and even oppressed situation. The current study discovered experiences of frustrations related to lack of appreciation of compromises made by OPMs which indicate that LAMs were lacking qualities and competencies of a supportive supervisor.

The study also discovered experiences of frustration due to lack of appreciation of OPMs compromising by using own resources. This is reported differently by the participants and one of the participants in FGI (a) had this to say:
No they don’t force you to use your own money but the problem is that you want to meet the expectations. You want to be compliant you see indirectly, indirectly if you are a conscientious person you will feel that you don’t want clinic B or you don’t want the situation to be like you are not trying but no one will come to you to say atleast you have tried.

Another participant in FGI (d) said:

You have to buy using your own money yes you have to buy (with a raised tone of voice) we buy batteries, we buy what and what we buy the pens .we buy stationery so that ehhh just to facilitate the job. When they come from national or up there they don’t expect work not to be done...they don’t say there is no money. They expect work to be done with what? And what are you going to do. You will be forced to take out of your pocket.

Another participant in FGI (b) reported the same experience and was put differently as follows:

Some staff members refuse, they don’t understand why should they use their money so... you have to sit down with them to explain the situation you find yourself in because you will be knowing that during the performance reviews your facility will be flagged to say facility A was not clean inside and outside so some of the things you just do it for the sake of when the report is given to others atleast you are not that bad. Things that you can do you will do them like using your own money and they will never appreciate what we are doing.

The participant in FGI (c) had this to say:

You will be obliged to take something from your pocket so that when they come atleast the clinic is clean and so that atleast the cleaners can do the job.

Given the limited resources in the PHC facilities, OPMs are often forced to compromise by using their own resources. This study discovered that OPMs were making compromises by using their own money to buy cleaning materials, pens and batteries. These confirm what has been stated in the previous chapter of narrative literature review as it was found that nurses used their own money to augment resources that were lacking in the PHC facilities (Bradly et al., 2013:9).
In this study, it was found that efforts of using their own money by OPMs were not appreciated by their supervisors. Similar to the findings of this study, Kitshof (2016:65) conducted the study in Western Cape Province in South Africa, and reported that nurses were not appreciated on compromises made in compilation of reports, despite lack of resources. In Tanzania and Malawi, it was reported that financial constraints resulted in PHC supervisors using their own resources to support PHC nurses (Bradley et al., 2013:1). Panda et al. (2014:11) concluded the above findings by exposing that the DoH was not allocating sufficient funds to PHC facilities which added to more strain to nurses in India.

During the discussion, the participants reported use of own transport and airtime in facilitating facility issues. These emerged and reported by the participants in FGI (c) as follows:

*You will feel that ok the clinic is suffering because of lack of transport from the sub-district, so with your own car you will go to take things like polish *neh* things like that* (looks frustrated). *...when you come back you are frustrated heish it is just too much...and they don’t see these things.*

One of the participants in FGI (b) had this to say:

*We are sharing our salaries with the department of health; we use your petrol and car just to keep the work going, hmn you understand...look at times you will find yourself at the clinic without drugs then you will ask for help from other clinics then you will report to the manager...facility manager so and so says will help me can you please assist by requesting transport so that i should get treatment from clinic B she will say Iam in a meeting there is no transport so who is responsible to go and collect that medication or a specimen bottle or whatever is you with your own transport.*

Another in FGI (d) had this to say:

*The higher management neh it seems like abnormal things are normal to be done like using your own car, the way they are saying the management don’t want to carry responsibility they don’t ,why are they not budgeting for enough cars for the sub-district. The same participant continued and said: ‘That’s why every time they cover with this issue of charging the staff like you didn’t submit this in time, you*
It came out clearly in the previous chapter’s narrative literature review that lack of transport in the remote health facilities in Southern America was raised by nurses as a priority issue of concern (Hernandez et al., 2014:11). In this study, the participants reported that they were not appreciated for using their own cars to collect cleaning materials, medications and specimens from the sub-district and other facilities. It was discovered that the participants’ use of their own cars occurred due to lack of transport.

Similar to what was discovered in the present study, the OPMs in the Free State and Gauteng provinces of South Africa reported that their supervisors did not show any appreciation and there was lack of support in general management of the facilities (Munyewendel et al., 2014:9). The same study indicated that OPMs claimed that the senior managers didn’t appreciate their contribution in the health system because they even sacrificed by using their own transport (Munyewendel et al., 2014:9). The study conducted in Botswana revealed that nurses were experiencing a lot of frustration regarding general provision of services due to lack of transport (Nkomazana et al., 2016:5).

The participants reported that they were using their own airtime to communicate the work related issues. This is reported by the participants in the FGI (b) in the following manner:

*The clinic is not having even a telephone. They have given us.., us a cell phone and you can stay for more than three months without airtime meaning that for all these months you will be using your own airtime.*

Another participant in the FGI (d) had this to say:

*We are only given 220 airtime per month and a smaller cell phone, so the airtime is not enough to trace the patient to call for an ambulance to call for specimen results, to do everything to arrange meetings with the community, to ask something from an information officer the airtime is not enough we end up using our, our own cell phones for the smooth running of the services but nobody ever said to me that*
The use of their own airtime to communicate work-related issues was reported by another participant and it was put in this way:

*We don’t have an internet in our facility but it is our problem how we send data so it is very difficult so we go to an extent of taking out from our pockets to buy data which is very much unfair because they don’t appreciate all that we are doing with our own money and everything. I buy data for my own phone so that I can email whatever is needed urgently.*

Another participant in FGI (c) put it in this way:

*Your phone the phone that the department did not pay for and when you don’t send data the person shout like this is the department’s phone (with a raised tone of voice). I don’t understand. ehh i don’t understand (showing by shaking head and look sad).*

The current study reported that some of the clinics did not have phones and the airtime given by the department was not enough for coordination of services. This was confirmed by the findings of Nkomazana et al. (2016:5) as the managers claimed after supervisory visits that the nurses were having a serious problem regarding the mode of communication. Hernandez et al. (2014:14) reported poor communication with remote health facilities which was influenced by insufficient access to landline network facilities.

In the rural clinics of Lesotho, nurses were offered cell phone allowance on monthly basis which reduced communication problems (Matamane: 2014:66). A sense of appreciation is one of the qualities that should be displayed by a supportive supervisor (Hisler, 2016: 6). In this study, OPMs were making compromises for the provision of services by using their own resources and supervisors were incompetent to display a sense of appreciation. These indicate that LAMs were lacking qualities and competencies of a supportive supervisor which caused frustrations to OPMs.
4.3.2.1.4 Sub-Category 2.1.4: Lack of Support in Cases of Litigations

During the discussions, OPMs shared their experience of not being supported during cases of litigations that were taking place in the PHC of the NWP. One of the participants in the FGI (d) had this to say:

*During the cases of litigation the LAMs don’t start first looking at their roles no…. they will firstly be on your head. Even you the operational manager who is responsible for supervision of the person involved they don’t care about you they don’t re-assure the person and the facility affected.*

Another participant in the FGI (d) had this to say:

*The managers are not supportive during the investigations of cases of litigations especially with maternity cases.*

The same experience was reported by another participant in the FGI (d) differently and said:

*The local area manager did not want to take the responsibility honestly. She couldn’t face this people to say we were having only one professional nurse, she was busy in the maternity there was no other professional nurse to attend to this client. She blamed the nurse because the patient is dead now. The family want to sue the department now you are alone you have to answer questions.*

Another participant in FGI (d) expressed lack of support during cases of litigations and put it in this way:

*I have seen one of my colleagues going through a process of litigation, misconduct the maternity case that speaker C has mentioned. The sister was requested to write down an incident report *neh...neh* and the OPM was to facilitate the whole process so I could see that the two parties were going through a hard time. So it caused a lot of stress. So i felt that they just needed assurance from the top management, and i also felt that they needed guidance because the shortage was not created by them”*(frowning face).*

It is prescribed in the National Health Act 61 of 2003 that effective and efficient support of human resources in the health system should prevail (NDOH RSA Strategic Plan, 2015:11).
This confirms what is found in NDoH RSA (2017:1) and NDoH RSA (2009:3) in that the role of LAMs during the cases of litigation is to support OPMs in the process of incident writing and reporting of an adverse event. This support is required to enable OPMs to offer guidance and support to their supervisees in cases of litigations (NDoH RSA, 2017:1; NDoH RSA, 2009:3). The findings of this study showed that LAMs did not play their supportive role during the reported cases of litigations. These demonstrate that the prescription regarding support of human resources as outlined in the National Health Act was not adhered to.

The purpose of Patient Safety Incident reporting (PSI) is to improve the quality of patient safety, the provision of appropriate feedback to patients and families during an adverse event, and to support patient and clinicians (NDoH RSA, 2017:1). The findings of this study suggest that the main purpose of PSI reporting which is to support clinicians was overlooked by LAM as OPMs were not supported. It is reflected in NDoH RSA (2017:11) that the principle of “Just Culture” that supports a “Learning Organization” that investigates incidents instead of blaming individuals should prevail during support of nurses during incident writing and reporting.

In contrast to what is reflected in NDoH RSA (2017:11) in this study, during the incident writing process, the nursing staff members were blamed by LAMs for the deaths that occurred in the PHC facilities. The SABC News and Molope (2015:1) exposed that the North-West DoH spent more than R40-million on payouts for medical malpractices in public health facilities and an additional R30-million to cover legal costs, in the past four years. These confirm the findings of the current study as cases of litigations were reported indicating that the DoH was responsible for the legal costs.

The finding further confirms what was raised by the DoH in South Africa as a matter of concern regarding the reported cases of litigations (Human Resources for Health South Africa, 2016:61). One of the qualities and competencies of a supportive supervisor is the ability to offer emotional support and guidance to the supervisee (Hisler, 2016:6). Lack of qualities and competencies of a supportive supervisor was evident in the current study as LAMs failed to
guide OPMs during the stressful moments of incident writing and reporting of the deaths that occurred in the facility. In addition the participants reported that LAMs did not realize a need for reassuring the persons and the facility involved in the investigations. The OPMs experienced frustrations related to a need for emotional support during reported cases of litigations. It therefore came out clearly from the findings that LAMs were lacking qualities and competencies of a supportive supervisor.

4.3.2.1.5 Sub-Category 2.1.5: OPMs Frustrated by Absence of LAMs Evident in Using Non-Contact Communication

During data collection, it emerged clearly that the OPMs were frustrated by absence of LAMs. This was raised by the participants in the FGI (d) as one had this to say:

Supportive Supervision in this sub-district is just a fairy tale, a cartoon network, you will wish to be visited and supported but the only thing that you will get are frustrations by WhatsApp and text messages (looks sad).

The participant in FGI (a) put it in this way:

They are forever not being able to be with us they are forever stressed, they are forever managing the risk this and this and that...you understand like what is usually happening is that they will be just called this morning come to the meeting.

The participant in FGI (c) said:

A group chat is developed we talk on the WhatsApp then how are you going to interpret and send message to the people you are working with? Is difficult (looks furious). I don’t know if WhatsApp has replaced the meetings with a supervisor.

One of the participant in FGI (b) put it in this way:

The supportive supervision visits from the sub-district by LAMs is lacking because local area managers are always attending meetings they will always say they are..., they are busy. Hence now when coming for visits they come being frustrated and now the fault finding mission start. They rely on text message which doesn’t make sense honestly.
According to the principles of PHC supportive supervisory visits, LAMs should avail themselves to facilities regularly once a month and for a minimum of 4 hours per visit (NDoH RSA, 2009:43). In this study, the OPMs were frustrated by the absence of LAMs as evidenced by non-contact communication by a WhatsApp group chat and text message. Similar to the findings of this study, the survey conducted in Botswana revealed LAMs saying that they have been taking reports from clinic managers by phone and indicated that they never visited some of the facilities (Nkomazana et al., 2016:6).

The current study discovered that LAMs were always attending unplanned meetings which caused them to rely on WhatsApp and text messages, leading to lack of supervisory visits. A similar phenomenon was reported in Kenya as it was indicated that supervisory visits from all levels of health management were not regularly done (Agoro, 2015:7). In Mpumalanga, 9% of facilities assessed were not receiving PHC supervision visits at all due lack of resources (Jacobs et al., 2014:8). In this study, OPMs were frustrated by the absence of LAMs evident by communication through WhatsApp and text messages which relates to a need for emotional support.

4.3.2.1.6 Sub-Category 2.1.6: Failure to Follow Channels of Communication

During discussions with the participants, failure to follow the channels of communication was discovered. This was described differently by the participants as it was reported that staff members were communicating facility problems to the sub-district management. It also emerged from data that delegation of professional nurses in the PHC facilities by the sub-district was not communicated to the OPMs. Repeated complaints received from the Member of the Executive Council (MEC)’s office came out during facilitation of the interviews. It was found that some of staff members were reporting facility problems directly to the sub-district manager.

One of the participants in the FGI(c) as follows:
The experienced people in the facility they don’t go according to the channel of communication. You will find that what is done here maybe you didn’t get it well. It goes to the highest supervisor the..to the sub-district manager.

The same participant continued and said:

...and once it is there now it will come back as an instruction and now as an OPM I will feel that its like..its like eh you are being.. its not like a support but a demand or a negative criticism of why this and this is happening so we have that, and that makes everything a mess in the facility”(silent for a while, eyes blinking).

The participant revealed that the facility problems communicated to the sub-district manager will be discussed at that level without involving the OPM and it will come back as an instruction. A similar incident was reported differently by another participant in FGI (d) and had this to say:

The professional nurse can report you directly to the sub-district manager and what is worrying is that the senior manager won’t say let me have a meeting with both of you noo..(shaking head), you will just receive a call threatening you about a problem so your supervision in the facility is difficult to implement because you don’t know how and where you stand.

The participants’ reported that the senior managers do not communicate the reported problem appropriately which put them in a dilemma on how to approach supervision in the facility. Based on the above quotations, the communication channels were not followed by sub-district managers. This was evident whereby the facility problems that were supposed to be communicated to the OPM were directed to the sub-district management by nurses. The sub-district manager also failed to follow the communication channel by involving OPM in problem investigation and resolution.

The findings of this study are in contrast to what was discovered in the theoretical framework that guides this study (Resource Manual of DoH of Philippines, 2012:18). In the SS framework it is indicated that a supportive supervisor possesses good communication skills and s/he
ensures that all the communication channels of the organization are followed (Hughes, 2017 and Resource Manual of DoH of Philippines, 2012:18). It is discovered in this study, that lack of following channels of communication resulted in OPMs being criticized negatively and threatened about a reported problem. Contrary to the findings of the present study, Proctor (2014:34) in the USA discovered that communication channels were followed in problem resolution which enhanced success in achievement of the goals of the organization. These suggest that the sub-district manager was lacking qualities and competencies of a supportive supervisor which resulted in frustrations to OPMs.

Failure in following the channels of communication regarding delegation of professional nurses in the PHC facilities by the sub-district management was reported by the participants and one in FGI (d) had this to say:

I will be working with sister G and you find that she is delegated to do something that i was even not told about. Then I will see her doing something else that i will be surprised and ask why you are doing these. For example when they were electing information forum I did not delegate somebody from my facility to be part of the forum. I only heard that sister telling me that she is going for the forum meeting.

A similar experience was reported differently by another participant in FGI (d) and put it in this way:

Another thing that is frustrating is like sister A says she is saying that supervision is from above. I agree, you will find that somebody is being delegated and you don’t know as the facility manager. You will realise when that somebody comes to you and say but I have been asked to do this and that without your knowledge as a supervisor. So it makes me to have some difficulty in terms of supervision and it creates conflict.

The present study discovered that sub-district managers were delegating professional nurses working under the supervision of OPMs without informing them which created conflicts. Contrary to the findings of this study, it is found in Proctor (2014:36) that two-way communication allowed managers to delegate more effectively and organizational conflicts
were reduced. Olang (2017:95) confirmed what was discovered by Proctor (2014:36) as it was found that in Nairobi the majority (66.3%) of the respondents in his study strongly agreed with the statement that communication reduced the negative consequences of conflict. The study conducted in Nigeria summarized what was found by two studies in USA that indicated that poor communication could lead to extra frustration that can lead to serious conflicts (Femi, 2014:28).

Failure in following the communication channels is also reported by participants as repeated complaints were received from the MECs and one of the participants in FGI (a) had this to say:

As an operational manager i will be expecting the client to complain through the proper channels..eh eh because remember the principle is we display the organogram that shows the name and the contact numbers of the operational manager, local area manager as well as the sub-district manager and even the chairperson of the clinic committee who is a community member.

The participant in FGI (a) said:

(Looks furious) the rights of patients allow them to complain even to the MEC, which is a challenge because when it comes back now it creates negativity among staff as now you will be required to act on the complaint and what is worrying is that managers are not intervening on this matter (looks furious) people don’t want to follow communication channels.

Another participant in FGI(c) had this to say:

There is some confusion about a lot of complaints that go directly to the MECs office, the complaints will be coming from the MEC office down to you now everybody will be negative to the treatment we are giving to patients, they will be saying that we are not giving the appropriate medicines you know just chaos.. you see” (looks furious).

One of the participants in FGI (d) had this to say:

I think the very people who receive complaints directly from the patients they should also come down and tell the clients about the shortage of staff and
drugs. *(with a very loud voice)* Then...the roles are so confusing then you will be asking yourself who is supposed to prescribe treatment is it a professional... is it a ward counsellor and who is a patient.

The study conducted in Gauteng Province in South Africa indicated a need for orientation regarding channels of communication in the PHC settings because the facility managers and community members were confused regarding implementation of PHC re-engineering *(Moosa, Derese and Peersman, 2017:7)*. Different to what was found in Gauteng Province of South Africa in this study, failure to follow the channels of communication by the community was evidenced by complaints being directed to the MEC’s office. The participants reported that this happened despite a displayed organogram reinforcing channels of communication in the facility.

One of the roles of LAMs is to support PHC facilities by ensuring that communication problems between the community members and the upper levels of management are investigated and resolved *(NDoH RSA, 2009:24)*. The current study exposed a concern raised by OPMs as it was claimed that senior managers were not intervening on a communication challenge that they (OPMs) were experiencing in the facility between the sub-district manager and the community. These indicate that LAMs failed to play their supportive supervisory role by ensuring that communication problems in the facility are investigated and resolved.

According to the SS framework, one of the qualities of a supportive supervisor is to diplomatically mediate between his/her team’s external and internal clients *(Resource Manual of DoH of Philippines, 2012:18)*. In this study, LAMs failed to mediate on internal and external communication issues. This was manifested by OPMs experiencing frustrations due to failure in following channels of communication by community, staff members and sub-district managers. Based on the findings of this study, it was evident that the LAMs and sub-district managers in the PHC facilities of NWP were failing to display qualities and competencies of a supportive supervisor.
4.3.2.2 Category 2.2: Lack of Necessary Skills

During the discussions with the participant it was discovered that programme coordinators, OPM and LAMs were lacking necessary skills. This is summarized in the following sub-categories:

- Programme coordinators lacking knowledge regarding guidelines
- Lack of advocacy due to LAMs non-assertiveness

4.3.2.2.1 Sub-Category 2.2.1: Programme Coordinators Lacking Knowledge Regarding Guidelines

The participants reported that programme coordinators were lacking knowledge regarding guidelines and this is reported by one of the participants in the FGI (b) in the following manner:

*We phoned the MCHW coordinator *neh we wanted to know how should we give new measles vaccine it was a struggle and a struggle with a measles vaccine that was introduced you know, we ended up calling the provincial office (with frowning face). Because of this, this programme manager who is there, who is running the programme but she herself doesn’t know what should be done how are we going to be informed *Hmn (with a raised voice) what should we do and at the end of the day the programme, the facility is not performing.*

Another participant in the FGI (d) had this to say:

*We have a mental health coordinator who lacks confidence on what he is supposed to do. He is supposed to help us in the whole sub-district and even the training he had undergone I don’t think it is beyond anyone who has done the basic four year diploma. So what is that is he going to add to practice because isn’t that we want to run the programmes according to the standards of the province.*

One of the participants in FGI (a) reported the same experience differently and said:

*The programme coordinators even the one for MCWH, that one is a disaster, as Iam speaking we are sitting with the information that is confusing from the provincial workshop that she attended. I don’t know it is like sharing information*
Another participant in FGI (c) put it in this way:

*Maybe to give an example we have the other one who is coordinating mother and child but I don’t know how much support and in-service training is going to give on things concerning labor because her ...because of her level of education....because we are advanced midwives *(giggling...khi..khii)* and she is supervising an advanced midwife like me.*

It is indicated that a supportive supervisor should be technically knowledgeable because s/he will be expected to teach and train supervisees (Hughes, 2017:4; Resource Manual of DoH of Philippines, 2012:18). The same authors also stated clearly that a supportive supervisor must be well informed about public health programs, the job, and all the tasks required by it (Hughes, 2017:4; Resource Manual of DoH of Philippines, 2012:18). In this study, it came out repeatedly that some programme coordinators for Mother and Child Health Welfare (MCHW) lacked confidence and knowledge regarding the guidelines.

The literature revealed that a supervisor should possess specialized knowledge and ability in processes, procedures and techniques in a particular field (Hisler, 2016:6). In this study, OPMs indicated a need for MCWH and mental health coordinators to be empowered with necessary knowledge and skills for their specific duties. This is supported by Marc et al. (2014:10) who reported that for quality supervision, managers should receive special training and experience.

The findings of this study suggest that OPMs experienced frustrations because programme coordinators were not knowledgeable enough to support PHC facilities as evident in one of the above quotes that some supervisees are more qualified, knowledgeable and experienced that their supervisors. Based on this finding, it is clear that programme coordinators were lacking qualities and competencies of a supportive supervisor.
4.3.2.2 Sub-Category 2.2.2: Lack of Advocacy Due to LAMs Non-Assertiveness

During the facilitation of the interviews, lack of advocacy due to LAMs non-assertiveness came out differently in the four FGIs. It was reported that LAMs were unable to advocate for supportive supervisory visits and one of the participants in FGI (b) said:

> Myself I am saying they are forever saying yes they are not assertive, that’s why they have got a lot of things to do (looks angry) and now supportive supervision is suffering because they can’t speak for supervision. When it is said to them jump (showing by hands) they don’t ask how high they just say yes that’s why there is a lot in their plate, she will get a phone call... come and attend a meeting then she will quickly leave what she was doing and rush then we are always having an unfinished business because they always run for the unplanned meetings they can’t even say my apology Iam... is my supervision day they just leave us and go for meetings you see they are not assertive.

Lack of advocacy due to LAMs non-assertiveness also emerged in the form of unrealistic deadlines from the senior management. One of the participants in FGI (d) said:

> Every time we get a message today and it will be said that it is wanted tomorrow and when you request her and say can’t you tell this people that it is not possible today because of this and that it will be like you are rude to the LAM”. The same participant continued and said: “if you don’t submit tomorrow then people will start shouting at you forgetting that by the time when the message was sent to you the patient was in front of you, you see it’s just a mess. May be these managers they should give us miracle sticks for us to perform miracles.

Another participant in FGI(c) said:

> We are not getting enough support from the department of health because the deadlines of the department are always tomorrow, or a day before, when are you going to help patients that are still going to report to the MEC that you didn’t attend to them. On the other side LAM can’t tell people that you will not be able to respond to short notices (looks angry).

Lack of advocacy by LAM regarding staff members’ buying cleaning material was reported by the in FGI (d) by the participant in this way:
During the provincial and national visit, the local area manager should not expect the facility to be clean and shining when she know that there are no cleaning materials *(with a raised tone of voice)*. She should be on our side and speak on our behalf: the problem is they don’t stand for us that is why we end up buying things with our own money; she should be part of us and when we work as a team both we will understand that the clinic is dirty because there is no cleaning material.

One of the characteristics of a good supervisor is the ability to advocate for the work of the subordinates (Hisler, 2016:6). It was reported by Hughes (2017:5) that a supervisor who advocates for the supervisees is regarded as an enabler. This confirms what is found in Marc et al. (2014: 9) who indicated that in order to reach the goals of the organization, supportive supervisors should always display willingness to negotiate for the work of staff members under his/her supervision.

Contrary to what is stated by Hisler (2016:6) and Marc et al. (2014: 9) the current study revealed that LAMs failed to advocate for OPMs regarding supportive supervisory visits. OPMs were to respond to unrealistic expectations regarding short notices from the provincial office due to the lack of advocacy and non-assertiveness of LAMs. Assertiveness is the ability of team members to state and maintain a position that may oppose the point of others, until convinced by the facts, not the authority or personality of another, that their position is wrong (Garner, 2012:5).

In contrast to the literature regarding the definition of assertiveness, the current study reports that LAMs were unable to maintain a position and communicate that it is wrong to be called in the middle of the process of a supportive supervisory visit. As a result, SS of OPMs was negatively affected by unplanned meetings. The participants were frustrated about the inability of LAMs to be assertive and advocate for lack of cleaning materials, stationery and batteries which led to participants to using their own money to buy the materials. Failure to advocate due to non-assertiveness indicates that LAMs were lacking the qualities and competencies of a supportive supervisor.
4.3.2.3 Category 2.3: Experiences of Lack of Professional Behaviour and Lack of Respect

In this study, OPMs reported experiences of lack of professional behaviour and lack of respect. The OPMs reported that they were reprimanded and humiliated in front of junior staff members. They (OPMs) experienced insults during joint meetings with other staff members. One of the participants in FGI (a) expressed unprofessional behaviour in the following manner:

I expect my supervisor, my senior to be the last person to come and reprimand me especially in front of my juniors, that is the last thing you could expect because there are another platform that another person your senior can come and say let us discuss this, so it comes where there is a cleaner, clerks the reprimand will just come like that and you know it is so embarrassing so that support i don’t feel” (looks sad).

One of the participants in FGI (d) also said:

To be reprimanded in front of the people you are supervising is painful, it makes you down totally down (silent for a while) even if you want to supervise even the ENA you think twice and it makes you not to think straight ” (silent, rubbing nose, blinking eyes).

Lack of respect emerged in FGI (a) and it was reported as follows:

The performance reviews meeting now are like a slaughter house, they are always on our heads with insults and that is why the high turnover. The managers in the reviews meeting are acting like, like they are not nurses, they are acting like they are from somewhere from pick and pay and they are not nurses and is not right (looks sad).

Another participant had this to say:

The approach of the management, the way they communicate with staff members, and especially the operational managers is worrying. Somebody, a manager will just use insulting words (with frowning face) will just stand there and say you are an operational manager (with a raised tone of voice) you are earning a lot of money, on the 15th you will be taking handbags to the banks. You are useless you know, you are in the sub-district performance review meeting. The support staff
According to the SS framework, one of the competencies of a supportive supervisor is to build a professional working relationship to improve performance (Resource Manual of DoH of Philippines, 2012:18). It is emphasized in the SS framework that the professional relationship should be initiated by a supportive supervisor in order to enhance the accomplishment of the organizational goals. In this study, it was found that insulting words such as “useless” were used by senior managers to address OPMs which is unprofessional and disrespectful.

According to the Constitution of the Republic of South Africa (1996:32), every citizen has to be treated with dignity and respect. The constitution further emphasizes that the rights of everyone need to be protected. The current study exposed that the rights of OPMs as citizens of the Republic of South Africa were not protected by senior managers. The study conducted in Brazil by Kurgant et al. (2015:35) discovered in their study that the staff members were not respected as a human beings and as professionals. The OPMs were not treated with dignity and respect by the senior managers as evidenced by reprimands, insults in front of junior staff members.

Similarly to the findings of this study, Munyewandel et al. (2014:8) reported that senior managers portrayed a bad relationship towards nurses. However, Melo and Neves (2016:60) disagreed with what was found by Munyewendel et al., as they reported that there was a 83% of a positive correlation between all leadership roles, including professional relationship and nurses supervision satisfaction in Portugal. It is reported by Casey (2014:1) that the root cause of unprofessional behaviour are professionals who once were very competent, but now have not maintained their competence.

Consistent to the findings of Casey (2014:1) lack of professional behaviour and lack of respect displayed by senior managers could be associated with managers who have not maintained their competence. According to a SS framework that guides this study, one of the competencies
of a supportive supervisor is courteousness and respect of other people’s rights and dignity (Hughes, 2017:5; Resource Manual of DoH of Philippines, 2012:18). It is further indicated in the framework that a supportive supervisor does not ridicule or humiliate staff when they commit mistakes. The findings of the current study unearthed lack of professional behaviour and lack of respect of OPM by senior managers which indicates lack of qualities and competencies of a supportive supervisor.

4.3.3 Theme 3: Factors that Contribute to Poor Delegation and Supervision in the Facility

In this study, the theme regarding factors that contribute to poor delegation and supervision emerged. The two categories that emerged from this theme are shortage of nursing staff as well as lack of essential equipment and poor infrastructure. The following is the discussion of the categories that came out of factors that contribute to poor delegation and supervision.

4.3.3.1 Category 3.1: Shortage of Nursing Staff

During the interview with the participants, it emerged that staff shortage is one of the factors that contributes to poor delegation and supervision. The sub-categories that came out of shortage of nursing staff are experiences of overworked due to:

- Limited time for supervision and administrative work due to high work load;
- Small number of nursing staff;
- Increased supervision strategies;
- Nurses experience insults and blame by community members regarding long queues; and
- Lack of essential equipment and inadequate infrastructure.
4.3.3.1.1 Sub-Category 3.1.1: Limited Time for Supervision and Administrative Work Due to High Workload

The participants reported experiences of limited time for them to focus on supervision and administrative work. This experience emerged in FGI (d) as follows:

*How and when do you oversee eheeh, eheeh supervision in the facility when people know that you are supposed to take blood, to do this and do this when are you going to have time for supervision and administrative work *hmm, *when are you going to supervise them and do administration work *(shaking head)* it does not make sense honestly with this shortage.*

The same phenomenon was reported differently in FGI (a) and it was put this way:

*Eh..eh supervision in the facility is lacking especially when you.. eh..are also hands on doing consultation of clients so.. you will be depending on verbal instructions and sometimes an instruction will come after a mess has happened and because you could not check, to check on what people are doing sometimes you even forget to write down or ask somebody to write down the delegation.*

Limited time for supervision and administrative work in FGI (c) emerged in this way:

*Again another thing is.. is, if you are asked to attend workshops you are given a lot of documents. This documents are supposed to be read these are guidelines that you need to check whether people are using them during consultations now where is this thing that is called time for you to do that *(look very furious).*

One of the participant in FGI (b) said

*So like my colleagues have said with the workload, there is shortage of staff and you will be expected to do administration of the clinic and be fulltime again on the patients. You do a lot of work, double work and sometimes you get so exhausted.*

The main role of OPMs as prescribed by the PHC Supervision Manual is to ensure that their daily supervision covers the activities outlined under the 12 elements of PHC facility managers’ checklist (DoH RSA, 2009:59; Jacobs et al., 2014:9). This is supported by the guideline of the Ideal Clinic Model as it is expected that OPMs should ensure that the facility
is compliant to the norms and standards of improving quality care by dedicating 80% of their duties to administration and management activities (Ideal Clinic Manual DoH RSA, 2015:74). The supervisory role of OPMs relates to the mission of the DoH as it strives towards meeting the goal of access to health and improving quality care (NDOH RSA Strategic Plan, 2015:11).

In this study, the participants indicated that they didn’t have time to check on what people are doing because they were also expected to be hands on because of staff shortage. This indicates that OPMs did not have enough time to meet the expectations of the supervision strategies and the mission of South African DoH.

Furthermore, this demonstrates that due to shortage OPMs had limited time to ensure that the goal of improvement of quality care as outlined in the mission of the DoH is reached. Different to the findings of this study, it was reported in a qualitative study conducted in Scotland by Rankin, McGuire, Matthews, Russell and Ray (2016:6) that more supervisory time that was allocated for senior charge nurses enabled them to create a safe environment for both patients and staff. The current study revealed the OPMs saying that they don’t have time to do administrative duties, read the policies and guidelines with staff and also ensuring that people work according to the set standards.

In contrast to what is said by the participants of the current study, the findings of the study conducted by Rankin et al. (2016:6) revealed that the professional nurse-in-charge had the opportunity to delegate tasks which enabled them to focus more on priorities. It is also learned from Rankin et al. (2016:6) that delegation of tasks created opportunities to develop skills of staff members. The current study reported that because of staff shortage, OPMs were unable to oversee supervision in the PHC facilities because they were doing a lot of work resulting in exhaustion. The finding of the current study is supported by Khunou and Maselesele (2016:8) as in NWP, South Africa, it was discovered that job dissatisfaction correlated with low levels of supervision of nurses. The findings suggest that shortage of nursing staff was one of the contributory factors to poor delegation and supervision by OPM in the PHC facilities of NWP.
4.3.3.1.2 Sub-Category 3.1.2: Small Number of Nursing Staff

The small numbers of the nursing staff due to resignations emerged in the four sub-districts and it was reported by the participants in the FGI (b) as follows:

"If you look at to how many nurses have resigned and there is a moratorium on advertising post what should we do and how so... supervision and delegation becomes difficult and if you are a sister you have to do the work that was supposed to be done by five people that is too much."

Small number of nursing staff emerged in FGI (c) and it was put in this way:

"There is a very serious shortage of nurses because nurses are resigning in my facility for these year only three professional nurse have resigned and worse the remaining ones are still going to resign because they are overworked."

Another participant in FGI (a) one had this to say:

"Most of the experienced midwives are... have resigned, and now we are left with the COMM SERVE (newly qualified professional nurses on community service). So the poor new professional nurses they are not experienced they don’t get mentoring so they will be having fresh still birth, they will be handling this major complications alone."

In this study, it was found that nurses were resigning and on the other hand there was a moratorium regarding advertisement of posts leading to small numbers of nurses left in the PHC facilities. Consistent to the findings of this study, one of the studies conducted in Limpopo Province in South Africa, reported high workload due to moratorium regarding vacant posts, and lack of replacement of people who resigned (Mokoena and Nkosi, 2017:41). Thomas et al. (2017:1) and the report of Predicting Employees Success (2017:6) also agreed with the finding of the current study as it was reported that nurses’ turnover of 17.2% and 29% was associated with increased workload and lack of mentoring, respectively. In this study, resignation of nursing staff had a negative influence to the work environment as the facilities were now left with inexperienced nurses who are on community service.
This was confirmed by the findings of the study conducted by Rankin et al. (2016:371) as it was discovered that staff resignation and staff shortage influenced the working environment negatively. It was revealed in Ranken et al. (2016:371) shortage of staff contributed to work related stress and low staff morale. The findings of the current study demonstrate that small numbers of nursing staff due to resignations was a major contributory factor to poor delegation and supervision.

4.3.3.1.3 Sub-Category 3.1.3: Increased Supervision Strategies

During the discussions, the participants indicated that there a lot of supervision strategies were introduced by the DoH. These emerged only in the three sub-districts and one of the participants in the FGI (b) had this to say:

*The other thing is, there are more strategies that are implemented over and over again and when you are just in the track to say i am still checking whether people are working according to this one, another strategy is being introduced and then when you are in a ehh..ehh what i want to say is that a lot is being implemented on limited number of people and at the end of the day we cannot are unable to supervise that is emm the challenges that i have come to realise.*

Another participant in FGI (a) put it in this way:

*The strategies are increasing like...we started with ‘clinic supervision manual’, when we were still acquainting ourselves with to the clinic supervision manual, the ‘national core standards’, when we were still acquainting ourselves to the national core standards, the ‘ideal clinic’ and there are clinical things that are changing over and over like the ‘CCMDD project’ when we are still grasping the CCMDD project, the ‘mom connect’ when we are still grapping this one the ‘PHC re-engineering’ it is even a challenge to the local area managers their support is not focused.*

Another participant in the FGI (b) had this to say:

*Really there is a lot that has been introduced and let the greatest burden is felt by the operational manager and how are you going to oversee the implementation of*
In this study, OPMs experienced increasing supervision strategies that were introduced, in spite of shortage of nurses. The literature revealed SS strategies that should be used by OPMs and LAMs to ensure quality in supervision of PHC facilities (DoH RSA, 2009:22; DoH RSA, 2011:5; Lourens, 2012:2; DoH RSA, 2015:16; Operation Phakisa, 2014:8; Pillay and Barron, 2011:2).

The SS strategies are contained in the PHC Supervision Manual which was revised in 2009; the National Core Standards implemented in 2010; PHC re-engineering for 2010, Ideal Clinic Manual and Central Chronic Medication Dispensing and Distribution (CCMDD) system, both implemented in 2016.

The participants reported that these strategies were also a challenge for LAMs because they were unable to focus on one strategy during SS visits. On the basis of the researchers clinical experience, there are also clinical policies and guidelines addressing all specific health programmes that also require supervision by OPMs.

This indicates that the OPMs are expected to supervise the implementation of all the systems in place to ensure quality and smooth running of the PHC services. In the study conducted in the NWP by Khunou and Maselesele (2016: 7), it was reported that job dissatisfaction of nurses was linked with the way health policies were implemented.

The participants of the current study raised a challenge of inability to oversee the supervision of increasing SS strategies and clinical guidelines and policies due to shortage. It was discovered that introduction of one strategy after the other rendered OPMs unable to supervise by making a track record of whether each strategy is applied accordingly. The findings suggest that a lot of new strategies contributed to difficult delegation and supervision of nurses by OPM in the PHC facilities.
4.3.3.1.4 Sub-Category 3.1.4: Nurses Experience Insults and Blame by Community Members Regarding Long Queues

During the discussions, the participants reported that nurses experience insults by community members regarding long queues. These emerged in the three sub-districts and one of the participants in the FGI (d) had this to say:

*They will be saying (with frowning face) the nurses are shaking their bums, loitering and they are not helping us. Only to find that the very professional nurse will be busy with another patient maybe going to a dispensary to check on medication or whatever. so things like that, you know is very difficult to supervise because nurses are saying we are not making the clients aware that they are also suffering because of long queues and they will be saying you are not taking into account the insults we get from the clients.*

Another participant in FGI (b) put it this way:

*The situation is... the few nurses that you delegate are experiencing insults because of long queues they will also resign because it is a burden to them so is difficult.*

The same experience was reported differently in FGI (c) and the participant said:

*The local area and sub-district manager should help us on handling complains about insults because of long queues because it happens to all of us.*

The current study reveals clearly that the few nurses who were delegated experienced insults and blame from their community members because of the long waiting times in the PHC facilities of NWP. A similar phenomenon appears in a survey conducted in Western Africa in Gambia as it was reported that 62% of nurses were insulted, shouted at and intimidated by patients and escorts (Sisawo, Ouèdraogo and Huang, 2017:6). The survey in Gambia discovered that escorts and patients lacked cooperation and were refusing nurses’ requests for them to wait whilst still attending other patients that need immediate care. Other clients were evading long queues and waiting times for care and this happened mostly in outpatient department, admission ward and maternity wards (Sisawo et al., 2017:6).
Consistent to the findings of the current study, one of the studies conducted in USA discovered that 76% of nurses experienced shouting and swearing by patients and visitors (Speroni, Fitch, Dugan, Atherton and Leesburg, 2014:1). In this study, OPMs raised a concern that it was very difficult to supervise few nurses who, on the other hand, were insulted by the community members. It came out in this study, that OPMs needed help from LAM and sub-district managers regarding handling of nurses complaints of insults as results of long queues.

The findings of the current study confirm the findings of the study conducted in South Africa that showed that nurses in Free State Province were disrespected by community members and pleaded for support from senior nursing managers (Munyewandel et al., 2014:8). The findings of the current study clearly indicate that insults of nurses, blame by community regarding long queues contributed to poor delegation and supervision by OPM.

4.3.3.1.5 Sub-Category 3.1.5: Lack of Essential Equipment and Inadequate Infrastructure

The participants expressed experiences of lack of essential equipment and poor infrastructure as a contributory factor to poor delegation and supervision. Lack of essential equipment in the FGI (b) was reported in the following order:

*There is a lack of resources that one is a major, major crisis because the managers expect us to do miracles whereas you don’t have a simple thing that you can save patients life with an oxygen gauge because we are struggling with a lot of things.*

Another participant in the FGI (d) had this to say:

*The concern is the patient can die in the facility due to lack of oxygen what you are going to do who is going to be blamed, that’s where they will be saying you are not supervising. I am saying this because the patient died recently in the clinic and our local area manager said the operational manager was there and the ambulance was not called immediately and she never said that we don’t have oxygen gauge.*

Another participant in FGI (c) put it in this way:
The department from above makes our life very difficult especially on the nursing part of supervision, the department is frustrating we need resources we need that..., we cannot stay with one foetal scope and seeing a lot of patients we cannot stay with a dynamap that is not working, broken and wait for ages so that you can get another supplier.

The current study discovered unavailability of oxygen due to lack of oxygen gauges, inadequate number of foetal scopes and non-functioning dynamos. Consistent to the findings of this study, in Lesotho it was reported that there was a cylinder with no oxygen and the blood pressure machines were inadequate and in poor working condition (Matamane, 2014:94). The participants of this study raised a concern regarding some of the patients who were dying in need of oxygen while in the facilities. This indicates that lack of essential equipment impacted negatively on the health department’s vision of long and healthy life for all South Africans (NDOH RSA Strategic Plan, 2015:11).

Similar to what was found in the study conducted by Matamane (2014:94), the participants registered their worry for in case of emergency of what will happen without oxygen in the facility. One of the studies conducted in Nigeria revealed availability of essential equipment in the urban areas which was inconsistent to what was found in rural areas of the same country (Oyekale, 2017:1). It was found that there was lack of generators, batteries and solar system in rural places of Nigeria which affected facility performance. This is supported by Zoido (2014:1) as it was reported that high quality material resources was linked to good performance. The findings of this study reported lack of essential material resources which led to difficult delegation and supervision of nurses.

The findings of this study revealed poor infrastructure as a contributory factor to poor delegation and this was reported in the three sub-district of NWP. This was reported by one of the participants in the FGI (b) as follows:

There is no supervision in the facility not at all because to start with neh, neh the clinic that I am working at it does not have really space Iam not saying a big board
room (showing by hands) just somewhere I can put my head there and try to do administration work. There is no even a smaller office to say i can do administration work like auditing patients file, i have to do it in the consulting room and for me its very difficult because I cannot concentrate on administration whereas here are patients or the nurse who have to do the vital signs, i cant observe whether people are doing the right things.

The participants in the FGI (d) reported poor infrastructure and put it in this way:

Most of the clinics are dilapidated the ceiling are falling off, the toilets are not working, the windows are broken, the doors are not having handles. Then people will come out for audit and...and whatever forgetting that you cannot go and buy a handle for the clinic door using your own money.

The participants in the FGI (d) reported poor infrastructure and put it in this way:

The space we don’t have a space since I have not done an administration work since March up to date (eight months) what should i do...the office of the manager is divided again is a consulting room just a mass (looks angry). We don’t have a counselling room, we use a dressing room as an observation room again as a data officers room, if the counselling is on the data capturer must wait to give patients the file and if you have a pap smear you must take the data capturer out and do the pap smear.

The main objective of National Health Insurance (NHI) is to improve the health system performance by strengthening the under-resourced and strained PHC facilities (NDoH RSA Policy Paper, 2011:8). The current study reported toilets that were not working, small consulting rooms used as administration office, ceiling falling off, doors without handles and broken windows. In order to meet the objectives of the NHI, the findings suggest that there is a dire need for strengthening the under-resourced and strained facilities.

The findings of this study confirm what was discovered by Munyewende et al. (2014:16) in that the PHC facility had a challenge regarding maintenance as it was found that the windows, ceilings and drainage system were in poor conditions in South Africa. The same study reported that lack of adequate consulting rooms and long waiting times compromised the privacy of
patients (Munyewende, 2014:16). The finding of this study is also supported by a literature review regarding factors affecting working conditions (Manyisa and Aswegen, 2017:36). It was reported by Manyisa and Aswegen (2017:36) that public health facilities were old with ceilings falling apart, cracking walls and lack of space. The findings of this study, suggest that poor infrastructure also contributed to poor supervision and delegation of nurses in the PHC facilities.

4.3.4 Theme 4: Factors That Can Enhance Facilitation of Effective SS of OPMs

During the facilitations of the discussions, the participants expressed the factors that can enhance facilitation of effective SS of OPMs. The categories that emerged from this theme are as follows:

- LAMs to adhere to the principles of SS;
- OPMs expressed a need for in-service training;
- Management and leadership skills, including how to deal with difficult;
- Involvement of OPMs on issues of budget;
- Improvement in communication and working relationship;
- A need for evaluation of the effectiveness of SS strategies;
- OPM expressed a need for a debriefing session;
- Address staff issues;
- A clear plan of OPMs supervision in the facility; and
- Transparency and openness to facilitate community understanding.
Discussions of the categories from the theme of the factors that can enhance facilitation of effective SS of OPMs follow in the subsections.

4.3.4.1 Category 4.1: LAMs to Adhere to the Principles of SS

The participants indicated clearly that there is a need for LAMs to adhere to the principles of SS during their supervisory visits. The sub-categories that emerged from the category of LAMs to adhere to the principles of SS are discussed as follows:

OPMs expressed a need for:

- Regular SS visits
- LAMs to observe the practice and create opportunities to give feedback

4.3.4.1.1 Sub-Category 4.1.1: Regular SS Visits

During facilitation of the discussions, the participants revealed a need for regular supportive supervisory visits. This emerged in the FGI (c) where one of the participants had this to say:

*The operational managers should support us, they should come for supervision their visits in the clinic should be regular.*

Another participant in FGI(d) put it in this way:

*If they can do the monthly schedule for clinics to be visited, they will be able to support us effectively. In that way the manager will be knowing that Monday I do this and maybe Tuesday I do clinic supervisory visit and at the clinic we will be knowing that atleast the supervisor will come for supportive supervision on this day.*

The same phenomenon was expressed differently in FGI (b) and the participant said:

*The LAMs should add the clinic supervisory visit as an activity to be accomplished on monthly basis and to be prioritized.*
In this study, the participants pointed out that facilitation of effective supervision of OPMs can be achieved only when it is regular. The OPMs further indicated that LAMs can support them effectively only when the supervisory visit is included in their monthly schedule and prioritized. Nkomazana et al. (2016:1) supported what was said by the participants of this study as they indicated that supportive supervisory visits should be prioritized at all levels of the health system in Botswana. The prioritization of SS was also supported by the study conducted in Mpumalanga in South Africa (Jacobs et al., 2014:2).

It is indicated in the PHC Supervision Manual that one of the critical aspects of SS is regular visits and adherence to a set supervisory schedule (RSA NDoH, 2009:18). The findings of the current study regarding a need for regular supportive supervisory visits are similar to the recommendations of the study conducted in Nigeria (Agoro et al., 2015:1). The findings of the current study indicate a need for LAMs to adhere to the principles of SS by doing SS on a regular basis and taking it as a priority.

4.3.4.1.2 Sub-Category 4.1.2: LAMs to Observe the Practice and Create Opportunities for Feedback

A need for LAMs to observe the practice and create opportunities for giving feedback emerged during data collection.

One of the participants in FGI (b) had this to say:

*If these managers could come and do clinic visit in an acceptable manner, they should not focus on that piece of paper because what they are doing is just ticking on what you are telling them which is not effective.*

The same phenomenon was reported differently in FGI (d) and the participant said:

*We want them to take time and check the practice with me, sit down look at the indicators on where you are performing and where you are not and ask you how I can help you in this matter.*
The participant in FGI (a) said:

I wish they can spend the whole day at the clinic and see what is happening in the facility, we also need guidance on how to make our supervision easier. So when the person has spent some more time with you she can be able to give you feedback about service delivery...you see.

The participant in the FGI (c) indicated a need for LAMs to observe practice and had this to say:

When you have come to my facility for supervision you must show interest, I expect you to look at what is happening about general management of the facility. I mean she must not just come and ask me questions about the running of the facility noo..let's check together.

The participants of the current study indicated that facilitation of SS would be effective only when LAMs observe the practice and create some time for feedback. According to the SS strategies, it is stated that the OPMs should be involved in observation of service delivery so that the process should be done in a supportive and facilitative manner (DoH RSA, 2009:19; Ideal Clinic Manual, 2015:27; DoH RSA, 2009:30; ESHE, 2008:24; WHO, 2008:3). It is also revealed in SS strategies that feedback should be given immediately and corrective measures need to be implemented by both a supervisor and supervisee (Ideal Clinic Manual, 2015:27, DoH RSA, 2009:30; ESHE, 2008:24).

According to the best practices guidelines in the supervision of health workers, provision of feedback is the most significant element that requires good communication skills (Borders, Glosoff, Welfare, Hays, Dekruyf, Fernando and Page, 2014:3). The current study confirmed what was found in the literature as OPMs stated that direct observation of service delivery and provision of immediate feedback is required to enhance SS. It is therefore important to strengthen the principle of direct observation of practice and giving feedback during SS in the PHC facilities. The programme development will explicitly include direct observation of the practice and feedback as an activity to be accomplished during supportive supervisory visits.
4.3.4.2 Category 4.2: OPMs Expressed a Need for In-Service Training

The participants of the current study expressed a need for in-service training and this emerged from data as training of staff members regarding:

- Human resources and labour relations issues
- Policies and guidelines

4.3.4.2.1 Sub-Category 4.2.1: Human Resources and Labour Relations Issues

The participants indicated that there is a need for training of staff members regarding human resource and labour issues. One of the participants in FGI (b) said:

*Supervision can be effective if HR personnel can be involved. They should at least once or twice a year just come and talk about unnecessary leave how do the leave affect the work profile of a person maybe the sick leave and maybe unnecessary leave will be reduced.*

The participants in FGI (d) had this to say:

*Workers will be in need of information and is like no one will visit from HR and to just to give information concerning work related issues.*

A need for training regarding labour relation issues was also reported and it is expressed by the participant in FGI (a) in the following manner:

*When staff is not trained about labor relations issues and supervisors comes only when there is crisis…then it is a challenge. Some of these things need to be addressed immediately.*

Another participant in the FGI (a) put it this way:

*The labour relation visit should be strengthened so that he should address staff about labour and HR issues because these are the core issues in supervision. These are the things that really, really help to control the staff.*
The same phenomenon was reported by another participant differently and it was put in this way:

*If there is labor relation officer who will strengthen the issues of the code of conduct because really people also need training to be reminded about labour issues, we will not go to square zero in supervision and control of staff because the facilities are just going backwards.*

It is stipulated in the South African manual of the code of conduct that all public servants should be trained on standards of ethics in the workplace (Nagiah, 2012:55). The current study supported stipulations in the RSA manual of the code of conduct as a need for training of all staff members regarding labour issues including the code of conduct emerged. In this study, OPMs indicated that training regarding HR and labour issues could help in strengthening supervision and control of staff in the PHC facility. The findings of the current study are consistent with the survey conducted in the PHC facilities in the six provinces of South Africa which showed that training of all staff members could reduce supervisory problems (Mahomed, 2017:5).

The study conducted by Purity et al. (2017:1) reported that training of staff on implementation of human resource policies resulted in an enabling environment for managers to support staff. This study recommends training of all staff members about human resource and labour relations policies. Therefore, it is necessary for the programme development specify training that cover the aspects that address human resource issues and labour.

### 4.3.4.2.2 Sub-Category 4.2.2: Policies and Guidelines

During the discussions with the participants in service training regarding policies and guidelines, one of the participants in FGI (a) had this to say:

*The worst part training has died a silent death. We used to have. Have what do we normally call... (other two participant added-in-service training) in-service training yes it has died we no more have in-service training if that could be revived.*
A need for in-service training on ideal clinic model emerged in FGI (d) and the participant said:

_The department is fully aware of the content of the ideal clinic manual is to uplift the standard of primary health care set ups. Somebody should have taken the responsibility to ensure that the facilities are able to make use of the very thick document. Why are they not providing training on how to use the ideal clinic manual?_

Training regarding PMDS policy also emerged in FGI (b):

_People need to be trained on PMDS. HR should do an in-service training to teach people how this is supposed to be done maybe we will have a common understanding._

Another participant in FGI(c) said:

_We don’t understand the policy of PMDS I am confused right where I am sitting._

One of the basic values and principles governing Public Administration in RSA is that the public administration must be development orientated (RSA Government Gazette, 2014:13). In this study, OPMs requested that the in-service training should be revived as it was no more done, and indicated a need for formal training regarding the Ideal Clinic Model and the National Core Standards. Consistent with what was found in this study, Makhamara (2017:98) reported that in-house training was not offered to employees and, as a result, workshops and seminars were recommended.

A need for in-service training was identified in this study. In-service training could satisfy the mandate reflected in the values governing Public Administration in RSA. For enhancement of facilitation of SS in the PHC services, OPM should be trained on the National Core Standards, Ideal Clinic Model and PMDS. This implies that training activities in the programme should specify training regarding National Core Standards, Ideal Clinic Model and Performance Management Development System (PMDS).
4.3.4.3 Category 4.3: Training on Supervisory Skills

During the facilitation of the discussions, the participants expressed a need for training on supportive supervisory skills. The sub-categories that emerged from training on supportive supervisory skills are discussed as:

- Leadership and management skills including how to deal with difficult staff;
- Assertiveness; and
- Professional conduct

4.3.4.3.1 Sub-Category 4.3.1: Leadership and Management Skills, Including How to Deal with Difficult Staff

The participants expressed a need for leadership and management skills which should include how to deal with difficult staff. A need for leadership and management skills emerged in FGI (b) and it was put in this way:

_Eeh... generally our leadership should be improved like for example our sub-district manager she is not only argumentative but too directive, she cannot be defeated when coming to arguments, She is so authoritative is not easy that you say I am unable to do something. No you must do it she is the sub-district manager and will not listen._

The participant in FGI (c) expressed a need to be skilled on how to deal with a difficult staff and said:

_So actually I think we need to be helped on issues of management of employees like the ones we are having in the sub-district, or maybe they should train us on how to handle a difficult staff and to train newly appointed OPMs on how to manage the PHC facilities._

Another participant in FGI(d) put it in this way:

_You know when we are in a working environment you go there with the aim of being_
The need for training of programme coordinators regarding management skills emerged in FGI (a) and the participant said:

*Programme coordinators we really need them, and maybe they should be given a chance to go and further their studies*. The same participant reported the need for training programme coordinators and said: *“So ... the MCHW coordinator should be empowered so that he should supervise us with confidence."

The Strategic Plan for DoH RSA 2015-2020 and National Development Plan (NDP) Vision 2030 aim at filling the post with skilled, competent and committed employees (NDoH, 2015:12). A need for training on leadership and management skills that emerged in this study, could satisfy the mandate stipulated in the strategic plan. The current study reported newly appointed OPMs in acting positions requesting to be developed on how to manage the PHC facilities as well as how to handle difficult employees.

Similarly to what was found in the present study, Gilson (2016:2) showed a need for provision of newly appointed facility managers with a formal orientation regarding management of PHC facilities. This was supported by Nkomazana et al. (2016:8) as it was reported in their study that most of the managers felt that they were not well informed about dealing with difficult and uncooperative subordinates. In this study, the participants demonstrated a need for OPMs, programme managers, including sub-district managers to be trained on leadership and management skills.

Consistent with the findings of the present study, Rankin (2016:32) recommended that managers at all levels of management positions should be trained on leadership roles. The findings of this study suggest that training of OPMs, programme coordinators and sub-district managers on management and leadership roles should be explicit in the programme development.
4.3.4.3.2 Sub-Category 4.3.2: Assertiveness

In this study, the assertive manager emerged as a requirement of a supportive supervisor and was reported in FGI (c) as follows:

*We need managers that are assertive that will say if something is wrong, is wrong finish and klaar, irrespective of the colour or whatever* (emphasising by throwing both hands) *and throughout the levels of department we need very assertive managers.*

Another participant in FGI(d) said

*We need a supervisor who is assertive who can guide us appropriately, who can really supervise.*

The current study reported a need for an assertive manager who can communicate the wrong and right things and guide as well as supervise accordingly. Hopkins (2017:2) confirmed what came out in this study, as it was stated that assertive communication is the ability to state right and wrong ideas and opinions in an open, honest and direct way. This study revealed a need for an assertive supervisor for effective facilitation of SS. For enhancement of SS of OPMs, it is therefore important for training regarding supervisory skills to cover the elements of assertiveness.

4.3.4.3.3 Sub-Category 4.3.3: Professional Conduct

In this study, the participants indicated that there is a need for training regarding professional conduct. The participants in FGI (b) expressed a need for professional conduct and put it in this way:

*People need to be taught and taken privately for.....training on how to address supervisors in front of subordinates.*

Another participant in FGI (a) put it in this way:
LAMs, PHC managers they are to be professional maybe a lot of things could change like general supervision of the PHCs.

Another participant in FGI (d) put it in this way:

*Hei* professional attitude, professional attitude is required for all managers.

One of the values and principles governing Public Administration in RSA include promotion and maintenance of professional ethics (Government Gazette, 2014:14). This study revealed clearly that training of managers regarding professional conduct is a requirement that could enhance SS in the PHC facilities. It is hoped that training on professional conduct could address a directive regarding values of public administration in the PHC facilities of the NWP, South Africa. The findings suggest that it will be important for the programme development to include training that will address issues of professional ethics as this could enhance SS of OPMs.

4.3.4.4 Category 4.4: Involvement of OPMs on Issues of Budget

During the discussion with the participants, a need for involvement of OPMs on issues of budget emerged. This came out in FGI (a) and it was reported as follows:

*We OPM we are not involved in the sub-district budget, how is the money spend we don’t know, and another thing like speaker B mentioned that you will be forced to do a demand plan and at the end of the day there will be no one coming to you to say you wanted this but you couldn’t get because of the budget constraints or whatever.*

One of the participants in FGI in (b) put it in this way:

*The patients right charter if I am not mistaken the clinic committee is supposed to know the clinic budget. The community is supposed to know about the budget what now if I don’t know anything about the budget how will I tell this people about budget.*

A similar experience is reported by another participant in FGI (d) and said:
The challenge is that they never come to give us the feedback for us to know how far the budget is. maybe if they could at least on quarterly basis call us to inform us and say we received the budget by the beginning of the year we are here we managed to buy this.

Another participant in FGI (c) said:

*Previously they used to call us at the beginning of the year we will go off at eleven working on budget now I don’t know who said that should not happen.*

One of the roles of the OPMs regarding supervision in the PHC facilities is to be actively involved in the activities of budget as well as to have a clear understanding in this regard (DoH RSA, 2009:30; Ideal Clinic Model, 2015:16). In this study, the participants reported that they were not informed about issues of budget. The findings are consistent with observations made by Munyewende (2014:8) as clinic managers registered their concerns regarding lack of involvement on financial management issues. The participants of the current study indicated that they should be involved on issues of budget as this could enhance management and supervision of the PHC facilities. These suggest that the support system should be reflected on the programme and should cover the issue of participation in the activities of budget.

4.3.4.5 Category 4.5: Improvement in Communication and Working Relationship

In this study, the participants stated a need for improved communication and a working relationship in the PHC facilities. This is emerged in FGI(a) as follows:

*Is better to have a formal meeting than using gadgets for WhatsApp at times you don’t see them, people we don’t have time to read and respond to a lot of WhatsApp messages when we are supposed to supervise and help patients we need formal meetings.*

Another participant in FGI (c) put it in this way:

*The department of health should stop giving us short notices we are dealing with sick human being we cannot just jump to short notices.*
One of the participants in FGI (d) had this to say:

*We have to improve on trust for one another....respect for one another....everything should remain confidential......there should be team work...LAMs should avoid unhealthy competition.*

According to the framework that guided this study, a supportive supervisor is responsible for building a trusting, productive relationship, and to relay instructions and information very clearly (Resource Manual of DoH of Philippines, 2012:23). The present study identified a need for a formal monthly meeting with a supervisor and avoidance of communication through *WhatsApp* and letters to be clarified in a meeting. The OPMs pleaded with the department to avoid short notices. A need for open lines of communication and consistency in giving instructions is reported in this study. The participants also reported a need for improvement of trust, respect for each other, to maintain confidentiality and LAMs to avoid unhealthy competition. It is therefore important for a supportive supervisor to have excellent communication skills.

### 4.3.4.6 Category 4.6: A Need for Evaluation of the Effectiveness of SS Strategies

The participants revealed a need for evaluation of the effectiveness of SS strategies this was reported by one of the participants in FGI (c) as follows:

*Maybe if we can implement a strategy check whether its working and then after checking that is working and having the results that shows that it is working, implement another strategy unlike implementing a lot of things at the same time.*

One of the participants in FGI (d) put it in this way:

*I personally say the department should or when, when they introduce something or whatever... because Nna iam saying they should focus on one strategy and thereafter they should check to see whether is it working for them.*

One of the participants in FGI (d) had this to say:
I didn’t expect them to introduce ideal clinic model before we all become used to the national core standards as well as the PHC re-engineering.

In the absence of evaluation of the effectiveness of the strategy it is not easy to determine progress made towards set objectives (Department of Correctional Services South Australia, 2017:4; Kolartic CBC Programme, 2014:6). The participants of the current study indicated that SS could be effective if evaluation of supervision strategies can be done before implementation of other strategies.

4.3.4.7 Category 4.7: OPMs Expressed a Need for Debriefing Sessions

During the discussions with the participants, they stated clearly that they need some debriefing and counselling sessions and it was reported as follows:

*I really wish that there is this what do we call...this thing where this lay counsellors are taken for what (response from the group participant...debriefing) yes debriefing, we need debriefing because what we are going through is just not making sense to me” (frowning phase).*

The same phenomenon was put differently by another participant in FGI (a) and said:

*I think confidential counselling should be available for all OPMs that one will work for us.*

The findings of this study indicate a need for a debriefing for OPMs working in the PHC facilities of the NWP. Consistent with the findings of the current study, the study conducted by Marques et al. (2015: 3) reported a need for therapeutic support of professional nurses.

On the basis of the current study, there is a need for debriefing and counselling sessions for OPMs working in the PHC facilities of the NWP. These demonstrate that it is important for the programme development of this study to include debriefing and counselling as the activity that could enhance SS of OPMs.
4.3.4.8 Category 4.8: A Need for a Clear Communicated Plan of OPMS Supervision in the Facility

During facilitation of the discussions with the OPMs it came out clearly that there is a need for a well-defined communicated plan of OPMs supervision in the facility. These emerged in FGI (b) and it was put in the following manner:

*There is no clear plan for the operational manager honestly there is no clear plan for the OPM that at least maybe that says in the morning do this if at least we were given two to four hours to attend to admin issues to me it will be much better if I do admin work in the morning two to four hours after prayers I do admin work then I go and see patients.*

The same phenomenon was put differently by another participant in FGI (d) and said:

*The thing that...what I have picked is that there is no clear plan and support because the job description of an operational manager and a job description of a professional nurse are exactly the same. The only differences are the percentages. You will find that where they have allocated 15 to a professional nurse they give OPM 20. We are doing exactly the same thing.*

Another participant in FGI (a) said:

*I once worked at the hospital it was long ago and there was somebody who was called the senior sister. This senior she used to do administration work and everything was in place because she is there she will tell you everything that is going on in the facility. She is the senior sister she will do in-service training; she will ensure that people follow the guidelines. My wish is for us OPM to work like this sister to have ample time for supervision and administration.*

The findings of this study revealed a need of a well-communicated plan for OPMs’ supervision as this could improve supervision in the PHC facility. Contrary to the findings of the current study, it was discovered in the study conducted in USA that there was time allocated to allow senior sister-in-charge to concentrate on playing a supervisory role (Ranken, 2016:368). It was also found in Ranken et al. (2016:368) that twenty two and a half hours per week were set aside to give the sister-in-charge the opportunity to play a supervisory role.
In this study, the OPMs unearthed a need for supervisory allocation of two to four hours daily which could be ten to twenty hours per week. This suggests that it is necessary for the programme development to include supervisory allocation of hours that could enable OPMs to play a supervisory role in the PHC facilities.

4.3.4.9 Category 4.9: Address Issues of Staff Shortages

During the facilitation of the interviews, the participants indicated clearly that the issue of staff shortage should be addressed. A need for the DoH to address staff shortage in FGI (b) emerged and it was reported as follows:

*The department of health should hire more nursing staff that one is our request we are suffering*. Another one in FGI (B) put it in this way: “They are not hiring enough staff.

Another participant in the FGI (d) had this to say:

*They should allocate more professional nurses.*

The findings of this study demonstrated a need for hiring more nursing professionals in the PHC facilities of the NWP. This is supported by the study conducted in Limpopo Province in RSA as a need for putting the systems for recruiting more nurses was reported (Lebese and Maputle, 2016:7). This suggests that it is necessary for the programme development to include recruitment of nurses as a need for enhancement of SS of OPMs.

4.3.4.10 Category 4.10: Transparency and Openness to Facilitate Community Understanding

The discussions with the participants revealed a need for transparency and openness to facilitate community understanding. This emerged in the FGI (c) and the participant said:

*Openness and transparency is only on paper on the Bathopele principles but is not actually implemented as it supposed to.*
Another participant in the FGI (b) put it in this way:

*I want to say something about lack of transparency and openness* I think the community should know about the situation the department is facing about moratorium of post and shortage of nurses.

The same phenomenon was reported differently by another participant in FGI (d) and put it in this way:

*So it happened that the queue was very slow and I felt that I should explain, so I explained to say we are not having enough nurses the reason is one two three so the sub-district manager heard about it and I was reprimanded for that. So it was said you were not supposed to say that you were supposed to come up with another reason to the patient so that is why I am supporting...I am saying openness and transparency is not practiced.*

Another participant in FGI (a) put it in this way:

*If the community knows our situation and the department of health regarding advertisement of post. The community will never insult nurses or complain because they know that this is the problem of the department of health.*

In this study, the participants reported lack of transparency about moratorium of advertisement of vacant posts and staff shortage. According to the Department of Public Administration RSA (1997:13), practicing openness and transparency could build confidence and trust between the public sector and the public they serve. In addition, the fundamental aspect of transparency and openness is that the public should be informed about the success and challenges facing the departments.

Contrary to what was reported (Department of Public Administration RSA, 1997:13), the present study discovered that OPMs were reprimanded for informing clients about the main reasons for shortage. This study identified a need for strengthening transparency and openness that could enhance effective SS of OPMs in PHC facilities. This suggests that the programme development should include activities addressing issues regarding transparency and openness.
4.4 Conclusion

This chapter provided a discussion and summary of the findings that were based on experiences of OPMs regarding SS and OPMs perceptions of how SS can be facilitated effectively in the PHC facilities of the NWP. Realization of the sample was tabulated and described to give the demographic information of OPMs who participated in this study. The discussion of the findings was guided by four themes, each supported by categories and sub-categories which were also tabulated. The findings regarding experiences of OPMs and perceptions of SS can be facilitated in the PHC facilities were confirmed and contextualized with the relevant literature.

It was apparent from the findings that the critical aspects of SS that should be adhered to by the PHC supervisors were compromised. This was manifested by OPMs’ experience of supportive supervisory visits as negative. It was evident from the findings that there was lack of joint problem identification and resolution as LAMs focused more on finding faults as experienced by the participants. As experienced by the participants, Local Area Managers (LAMs) were not creating time for feedback, OPMs were blamed for poor facility performance and supervision and OPMs were not guided on implementation of policies and new guidelines. It came out from data that OPMs were not supported by direct observation of service delivery.

The programme coordinators were not coming to the PHC facilities for SS and there was lack of support regarding handling of problems related to shortage of staff. As exposed in chapter 3, the supervision steps that are integrated with elements of SS in the supervision manual explain that the SS approach should be practiced. In addition, the dearth of literature regarding a specific framework for SS is a knowledge gap which might have contributed to OPMs’ experiences of negative supportive supervisory visits. Compromised critical aspects of SS were also evident whereby experiences of lack of support by LAMs regarding human resource issues came out in the findings. These were revealed by the delay in payment of night duty allowance, lack of capturing of leave days which increased staff absenteeism. The delay in rank
translations was reported indicating lack of support regarding human resource issues.

Following experiences related to compromised critical aspects of SS, it came out from the findings that there was a need for LAMs to adhere to the principles of SS. These suggest that for enhancement of effective SS of OPMs in the PHC facilities, the framework development should show activities that addresses adherence to the principles of SS. In-service training regarding human and labour relations issues are also regarded as one of the important activities that could enhance SS of OPMs.

Experiences of OPMs regarding their SS suggest that LAMs lacked qualities and competencies of supportive supervisors. This was evident whereby OPMs expressed experiences of frustrations related to a need for emotional support. The OPMs reported that they were demotivated, experienced unequal staff treatment, experienced frustrations due to lack of appreciation of compromises made by OPMs and lack of support during reported cases of litigations.

It was apparent that PHC supervisors were lacking necessary skills to support OPMs. In addition OPMs reported experiences of lack of professional behaviour and lack of respect. In consideration of lack of qualities and competencies of supportive supervisors, it came out from the findings that training on supervisory skills could be necessary for enhancement of SS of OPMs. These suggest that training of PHC managers regarding supervisory skills should be specified during development of a SS framework.

The participants reported experiences of factors that contributed to poor delegation and supervision in the facility. It was discovered that shortage of nursing staff contributed to poor delegation and supervision. This was manifested by experiences of limited time for supervision and administrative work due to high workload, small number of nursing staff, increased supervision strategies and nurses experienced of insults and blame by community members regarding long queues.
Lack of essential equipment and inadequate infrastructure also contributed to poor delegation and supervision by OPMs in the PHC facilities. For effective facilitation of SS of OPMs, it was obvious from the findings that issues of staff shortages should be addressed, a clear plan of OPMs supervision in the facility should prevail, a need for evaluation of the effectiveness of SS strategies emerged. It was apparent that a need existed for OPMs to be involved on issues of budget so that their supervision in the facility could be enhanced. Furthermore, OPMs indicated that transparency and openness should prevail as this could help community understanding of challenges faced by the DoH.

The above discussion that represents the summary, conclusions drawn from the findings of the current study, revealed the situation regarding SS of OPMs in the PHC facilities. The requirements for enhancement of effective SS of OPMs in the PHC facilities of NWP were also stated. This implies that the summary of the findings are regarded as a point of departure for description of a conceptual framework and programme development for this study.
CHAPTER 5

A Conceptual Framework for Supportive Supervision

5.1 Introduction

In the previous chapter, the results of the experiences of OPMs regarding SS in the PHC facilities, and how SS of OPMs can be facilitated effectively in PHC facilities of the NWP and literature control was discussed. The concepts regarding SS were derived from the findings in Chapter 4. It is therefore significant for this chapter to discuss the framework for supportive supervision with guidance by the findings, and the model identified for framework development in Chapter 2. The discussion of the framework for supportive supervision focuses on identification of SS concepts and classification of the findings.

The description of the framework for supportive supervision according to the model that guides the framework development of this study is also discussed. It is therefore important to indicate that the framework for supportive supervision in this chapter is regarded as a build up for framework development. This implies that the information in this chapter provides a guideline for framework development. Therefore, the in-depth information will appear in Chapter 6. The discussion of the framework for SS is as follows:

5.2 Identification of Supportive Supervision Concepts and Classification

The concepts were identified and thereafter classified according to the steps adopted from the University of Wisconsin Extension (UWEX) Logic Model (Powell and Henert, 2008:14; Wholey, Hatry and Newcomer, 2010:56). The main reason for using the UWEX Logic Model is because words and pictures are used to show the main problem that can impair quality of a specific aspect in the work environment. The steps of UWEX Logic Model provide the
sequence of events or activities thought to bring change, and how these activities are linked to the results the framework is expected to achieve (Powell and Henert, 2008:14; Wholey, Hatry and Newcomer, 2010:56). For this reason, the researcher viewed it relevant to apply this model for development of a SS framework of OPMs in the PHC facilities of NWP. The steps of UWEX Logic Model as discussed in Chapter 2 consist of six components namely: (1) Situation and Priorities, (2) Inputs, (3) Outputs, (4) Outcomes, (5) Assumptions, and (6) External Factors.

The concepts of SS were identified and classified to show the relationship with the components of the UWEX Logic Model in the following manner:

- Experiences of factors related to compromised critical aspects of SS, experiences of factors related to lack of qualities and competencies of a supportive supervisor, and experiences of factors that contribute to ineffective delegation and supervision of OPMs in the facility are classified under the component called the Situation. The legislation and other mandates of the South African DoH are regarded as the priorities in SS of OPMs in the PHC facilities.

- LAMs, programme coordinators, sub-district managers, HR development personnel, more nursing staff and qualities and competencies of a supportive supervisor are regarded as human resources and these relate with the component named the Inputs. The essential equipment, improved infrastructure and transport are also classified as material resources under the component of the inputs.

- Adherence to supportive supervisory principles through regular supportive supervisory visits, direct observation of service delivery and creation of an opportunity for immediate feedback falls under the component of the Outputs.
Training regarding new policies and guidelines, leadership and management skills, decentralization of budget, allocation of time for OPMs’ supervision and debriefing of all nursing managers and staff also fall under the outputs.

- Evidence of regular supportive supervisory visits with direct observations of service delivery, feedback sessions, resolution of problems and quality improvement plans number of debriefing sessions, improved SS, improved quality of provision of PHC services are regarded as the Outcomes.

- Lessons learned from the literature review, experiences of OPMs and views regarding the resources, activities and participation will be the basis of Assumptions regarding SS of OPMs.

- The new and changing policies and priorities as well as staff members are regarded as the External Environment.

Figure 5.1 depicts a framework for SS according to the programme action logic model.

5.3 Description of the Framework for Supportive Supervision According to UWEX Logic Model

The following discussion represents the description of a framework for SS of OPMs in the PHC facilities.

5.3.1 Situation

According to the University of Wisconsin Extension (UWEX) Logic Model, firstly the depth of the problem and the main issue that requires an intervention by the framework should be described (Powell, Henert, 2008:14; Wholey, Hatry and Newcomer, 2010:56). It is stated that the description of the extent of the situation should address the social, political and the economic circumstances (Powell, Henert, 2008:14; Wholey, Hatry and Newcomer, 2010:56).
The situation is described by using the summary of the findings as discussed in the previous chapter which covers the social and economic circumstances regarding SS in the PHC facilities. The political circumstances are included by relating the situation regarding SS of OPMs to the *Legislation and Mandates* of the DoH which are regarded as the priorities. According to the UWEX Logic Model of Framework Development, the description of the situation should show the assessment of the needs and assets (Powell and Henert, 2008:14).

**Figure 5.1**: Conceptual Framework for SS according to programme action logic model
The next chapter of framework development includes a thorough description of the needs and the conditions of assets regarding SS of OPMs in the PHC facilities. An in-depth description of the situation and priorities regarding SS of OPMs in the PHC of the NWP is dealt with in the next chapter. For the purpose of the current framework of supportive supervision, the situation regarding SS of OPMs is briefly described as follows:

The OPMs expressed experiences of factors related to compromised critical aspects of SS in the PHC facilities. The OPMs experienced supportive supervisory visits as negative. Experiences of OPMs showed factors related to lack of qualities and competencies of a supportive supervisor as it emerged from data analysis that LAMs and programme coordinators lacked necessary skills to support OPMs.

The findings also showed experiences of lack professional conduct and respect which also demonstrated lack of qualities and competencies of a supportive supervisor. The findings showed experiences of factors that contributed to poor delegation and supervision of OPMs in the PHC facilities. These were described as shortage of staff, lack of essential equipment and poor infrastructure. The priorities that are considered by framework development are briefly described in the following order.

5.3.2 Priorities

The UWEX Logic Model states that priorities reflected in the framework developed should address, amongst other things, the vision and mission, values, mandates and resources (Powell and Henert, 2008:14). It is indicated that the reason for stating the priorities during framework development is to ensure that the developers adhere to the broad aims and objectives of a specific organization. In the current framework development, the legislations and other mandates of the DoH ensured that the framework developers observed the priorities necessary for enhancement of SS of OPMs. The legislations and other mandates that are included as priorities for framework development of this study are described as follows:
5.3.3 Legislation and Other Mandates

The reviewed literature revealed some legislation and mandates that the study identified as important priorities to be included in SS framework development. These are the Constitution of RSA, the Values Governing Public Administration in RSA, The National Health Act No. 61 of 2003, the Nursing Act No. 33 of 2005, the National Health Insurance Policy Paper for 2011, the Vision and Mission of the DoH, the National Development Plan 2030 Vision, the PHC Supervision Manual, the PHC Re-Engineering, the National Core Standards, the Central Chronic Medication Dispensing and Distributions (CCMDD) System and the Ideal Clinic Model. These are described as follows:

- **The Constitution of RSA Act Number 108, 1996**

  The results of this study revealed that OPMs were insulted by senior managers during joint meetings with other staff members which indicate violation of human rights. This is confirmed by what is documented in the *Human Rights Charter* as it is said that everyone has inherent dignity and the right to have their dignity to be respected and protected. The OPMs were also reprimanded by senior managers in front of subordinates, indicating that their inherent dignity was not protected. Furthermore, OPMs reported nurses who were insulted by community members which also indicated that violation of human rights prevailed in the PHC facilities. Based on the results of this study, it is imperative to include the *Constitution of the Republic of South Africa* as a priority in the framework development.

- **Values Governing Public Administration of RSA**

  In this study, the values governing public administration should appear as a priority in a SS framework development. According to the Public Administration Management Act of RSA, one of the values for governing public institutions is the promotion and maintenance of high standards of professional ethics (Public Administration Management Act No 11, 2014:8). Provision is also made in Chapter 2 of the Public Administration Management Act that the public administration must be development orientated. It is necessary to include the values as
the priorities in framework development as OPMs expressed experiences of unprofessional
description and lack of respect from senior managers. The unprofessional behaviour and lack
of respect suggest professional ethics as one of the values governing public institutions was
compromised during SS of OPMs. The present study discovered lack of in-service training for
all staff members which indicated that the values governing public administration need to be
reinforced for enhancement of SS of OPMs (Public Administration Management Act No 11,
2014:8).

❖ National Health Act Number 61, 2003

The act stipulates that effective and efficient management support of human resources in the
health system should prevail. The participants confirmed these by indicating a need for support
from their senior managers in order to effectively manage the PHC facilities. Therefore, the
National Health Act is another priority that should be taken into consideration during
framework development in the next chapter.

❖ Nursing Act Number 33, 2005

It is necessary to include the Nursing Act in the framework development as its main purpose
is to govern the nursing profession. These could enhance SS in the PHC facilities, thus enabling
OPMs to play their supervisory role effectively in provision of nursing services to the
inhabitants of the Republic of South Africa.

❖ Vision

The vision of South African DoH is more relevant to be one of the priorities that should be
included in the framework development. This is to demonstrate that, for the DoH to meet the
expectations for long and healthy life for all citizens, the LAMs have a major supervisory role
to play in order to effectively support OPMs. OPMs will in turn influence their staff to provide
effective service delivery to the community. It is therefore important for the vision to be
included in the current framework development as this could help OPMs to reach the targets
that are addressing the vision of the DoH (NDoH RSA Strategic Plan, 2015:11). In addition,
this is to confirm what has been experienced by OPMs as they expressed lack of supportive supervision in meeting set targets for TB and HIV/AIDS.

❖ Mission

The mission of the DoH is to ensure access to health and to improve the quality of care. In this regard, it is necessary to ensure that the mission of the DoH is addressed by a SS framework of OPMs. This entails that the activities and participation in the framework should address issues of access to health and improving quality of care (NDoH RSA Strategic Plan, 2015:11).

❖ National Health Insurance (NHI) Policy Paper, 2011

It is important to indicate that the NHI Policy should be included in the in-depth description of priorities in the next chapter (Government Gazette, 2014:6). It is indicated in the NHI Policy that strengthening the under-resourced and strained PHC facilities is the main objective for improving health system performance.

The OPMs strongly felt that shortage of staff and lack of essential equipment led to difficult delegation and supervision in the PHC facilities. This was regarded as a contributory factor to poor performance indicators in the PHC facilities in the NWP. Therefore, the findings of the current study show a need for NHI to be one of the priorities of the programme development.

❖ National Development Plan (NDP) 2030 Vision for Department of Health, RSA

As stated in the NDP 2030 Vision, the DoH is aiming at filling the posts with skilled, committed and competent employees (NDoH, 2015:12). These imply that training of health professionals should be prioritized during planning by the top managers in PHC system.

Furthermore, the main priority for achieving Vision 2030 is strengthening of the health system, especially PHC services. It is therefore necessary to include NDP 2030 Vision for DoH during SS framework development. These could guide the training needs necessary for enhancement of SS of OPMs in the PHC facilities.
PHC Facility Supervision Manual

This manual prescribes the roles of all PHC supervisors, including OPMs and the principles that should be adhered to when performing SS of the PHC facilities. In this regard, the in-depth discussion of roles of sub-district managers LAMs and programme coordinators as outlined in the PHC facility supervision manual are discussed in the next chapter.

These demonstrate that PHC facility supervision manual is one of the priorities that should not be left out when developing a SS framework for OPMs (NDoH RSA, 2009:12).

PHC Re-Engineering

This is a system that aims at improving access to quality health care and the OPMs play of supporting role for the outreach teams in provision of PHC services (Pillay and Baron, 2011:4). The in-depth description of a rationale for including this as a priority is provided in the next chapter.

National Core Standards

The National Core Standards outline the principles that are followed during SS of PHCs and are more similar to those that appear in the PHC facility supervision manual and the Ideal Clinic Model. Therefore, these SS strategies should be included as a priority of programme development of this study (DoH RSA, 2011:3).

Central Chronic Medication Dispensing and Distributions (CCMDD) System

This is another strategy that is aimed at improving the quality of care and reduces long waiting times by allowing patients to get medications without going to the clinics. The OPMs are expected to supervise the implementation of the system.

It is imperative to describe the Central Chronic Medication Dispensing and Distributions (CCMD) system in the SS framework development and link it to the outputs and the findings of this study (Operation Phakisa, 2014:8).
5.3.4 Outputs

This step describes the activities that should be done and the people who should participate in order to achieve the intended purpose of the framework (Silverman, Mai, Boulet and O’Leary, 2007:6; Powell and Henert, 2008:14; Wholey, et al., 2010:56). The output by the UWEX Logic Model is described in two dimensions which include the activities and participation that could sustain the existence of the framework (Powell and Henert, 2008:64). The outputs that are reflected in the conceptual framework are adherence to supportive supervisory principles, training and the support systems in place. The two dimensions of the outputs that appear in the framework development are described as follows:

❖ Activities

The activities describe what should be done to remedy the situation regarding SS of OPMs in the PHC facilities (Wholey et al., 2010:56). The activities that are included in a SS framework are adherence to supportive supervisory principles, training and support systems. These are discussed as follows:

❖ Adherence to Supportive Supervisory Principles

For the purpose of improving SS, the OPMs indicated that there is a need for regular supervisory visits. It is indicated by the participants that direct observation of service delivery and immediate feedback by LAMs is required. Therefore, regular supervisory visits, direct observation of service delivery and immediate feedback are the main activities that should appear in the framework.

❖ Training

According to the UWEX Logic Model as elaborated in Powell and Henert (2008:69), training is one of the prerequisites for maintaining the purpose of the programme. In this study, OPMs indicated a need for training of managers regarding health promotion policies, and guidelines and a need for training staff members regarding human and labour relations matters. The OPMs
further indicated a need for training of all managers regarding leadership and management skills. A SS framework shows all the training needs that were identified by the participants.

❖ Support Systems

The activities for sustaining the existence of the framework include counselling, partnership with community members and support within the organization (Powell and Henert, 2008:69). In this study, the support system required for the functioning of a SS framework are decentralization of budget, allocation of time for supervision by OPMs, debriefing for all managers and staff. These should be included in the framework development.

❖ Participation

According to the UWEX Logic Model, participation in the framework should be clear with regard to who should be reached (Powell and Henert, 2008:69). This is in terms of the participants, customers, decision makers and agencies. For the purpose of meeting the aim of this study, the people who should participate in sustaining the programme are sub-district managers, OPMs, LAMs, programme coordinators, HR officers, nursing staff, community members, DoH and psychologists. The framework development specified people who will participate in activities regarding adherence to principles of SS of OPMs, training and for support system.

5.3.5 Outcomes

Outcomes are referred to as the benefits and changes that occur to the people or organization as a result of exposure to the outputs (Wholey et al., 2010:56). The short-term outcomes are caused by the activities and participation stipulated by the framework. The expected outcomes for adherence to the principles of SS are regular supervisory visits with direct observation of service delivery and immediate feedback. Training is expected to take place and all the support systems are to be functional. The outcomes should be included in the framework development.
5.3.6 Assumptions

According to the UWEX Logic Model, the assumptions should be based on what is found in the literature about the area of study, what is known by framework developers as well as the participants. It is stated that the assumptions should address the resources and the activities of the framework (Powell and Henert, 2008:69). The assumptions are important to be included in development of a SS as OPMs mentioned resources and activities that are necessary to enhance SS.

5.3.7 External Factors

In framework development, it is important to describe the external aspects that influence the programme. These include the values, political environment and the changing policies. These are the aspects that affect the programme over which there is little control (Powell and Henert, 2008:69). The external factors should be included in the process of framework development.

The in-depth description of all the steps is dealt with in the next chapter.

5.4 Conclusion

This chapter identified and classified the concepts that emerged from data addressing SS of OPMs in the PHC facilities of the NWP. The concepts were classified and described in relation to the concepts in UWEX Logic Model adopted for the current framework development. It is therefore necessary to apply the framework for SS identified in this chapter in the development of a SS framework of OPM in the PHC facilities of the NWP. The next chapter provides an in-depth discussion of development of a supportive supervision framework.
CHAPTER 6

Supportive Supervision Framework Development and Description, Validation and Description of Proposed Guidelines for Operationalization

6.1 Introduction

The previous chapter addressed Objective 3 of this study which is to describe a framework for supportive supervision derived from the findings of the first phase. This chapter addresses the objectives of the second phase of this study which is divided into two stages which include framework development and validation. The description for proposed guidelines for operationalization is also discussed. This chapter will also highlight the main aim and objectives of a SS framework of OPMs in the PHC facilities of NWP. The objectives for this chapter are to:

- Develop and describe a SS framework of OPM in the PHC facilities;
- Validate a SS framework of OPMs in the PHC facilities; and
- Describe the guidelines to operationalize a SS framework for OPMs in the PHC facilities of NWP

6.2 Development and Description of a Supportive Supervision Framework Using the UWEX Logic Model

The UWEX Logic Model was adapted to develop a SS framework for OPMs in this study. In simple terms, a logic model is a presentation in the form of a flowchart showing the systematic process of events (Wilder Research, 2009:2). There are three types of logic models that are
designed for serving different purposes. The logic models found in the literature are known as theory approach, activities and outcomes approach. These are described as follows:

6.2.1 Theory Approach Logic Model

Theory approach logic models are useful for framework planning, development and overall communication of the framework (Kellogg Foundation, 2004; Shackman and Rodriguez, 2015:6). The theory approach specifies the situation or problem addressed by the framework. It provides a clear description of the reasons why it is assumed that the framework will be effective in achieving the goals.

6.2.2 Activities Approach Logic Model

The activities approach logic model is useful in framework implementation, monitoring and management (Shackman and Rodriguez, 2015:6).

6.2.3 Outcomes Approach Logic Model

The outcomes approach logic models are most useful for framework evaluation and consider the strategies and activities as they relate to the desired results of a programme (Kellogg Foundation, 2004; Shackman and Rodriguez, 2015:6). This study uses the theory approach logic model for development, overall communication and validation of the framework. It is therefore fundamental to indicate that the implementation and evaluation of the programme is not part of this study. Lessons learned from the literature review conducted in Chapter 3 revealed that the main goals and objectives that should be reached by the framework are to be stated clearly. In this study, the main goal of the current framework is to enhance SS of OPMs and to address the needs, activities and participation for effective supervision in the PHC facilities of the NWP. The objectives were to:

- Describe the needs necessary for enhancement of SS of OPMs;
Ensure adherence to SS principles; and

Improve the support systems for effective supervision by OPMs.

Figure 6.1 represents A supportive supervision framework for OPMs in the PHC facilities of NWP.

6.2.4 Components Applied for Framework Development

The components applied for framework development are the situation and priorities, input, output, outcomes, assumptions and external factors (Powell and Henert, 2008:69). The rationale and assumptions that could be effective for enhancement of SS of OPMs are integrated in the discussions. As discussed in Chapter 2, the framework is reading from the left side starting with the component of the situation and priorities moving forward.

6.2.4.1 Situation

For the purpose of the current framework development, it was important to conduct a literature review and to hold interviews with OPMs regarding SS. This was accomplished in order to get an in-depth understanding of the socio-political, environmental and economic situation regarding SS in the PHC facilities (Powell and Henert, 2008:14; Wholey et al., 2010:56). The reviewed literature in Chapter 3, and the results of the first phase of this study are regarded as the basis for describing the situation and priorities about SS in the PHC facilities. For the purpose of describing a summary of concepts that are shown in the above drawn framework, the following is the description of the situation regarding SS of OPMs in the PHC facilities of NWP.
Figure 6.1: A supportive supervision framework for OPMs in the PHC facilities of NWP as in the adopted University of Winscon Extension (UWEX) Logic Model
Critical Aspects of SS

The critical aspects of SS are supportive supervisory visits, support regarding human resources issues, qualities and competencies of a supportive supervisor as well as contributory factors to effective supervision in PHC facilities. These are described in relation to experiences of OPMs regarding SS in order to show the situation or problems that could be remedied by the current framework development. The critical aspects of SS of OPMs are further described in relation to OPMs’ perceptions of how SS can be facilitated in the PHC facilities of NWP. In this regard, critical aspects of SS are described as follows:

- Supportive Supervisory Visits

Supportive supervisory visits are reflected in the framework to show the situation that should prevail for enhancement of SS in the PHC facilities of NWP. This is justified by Operational Managers’ experience of negative supportive supervisory visits. This is also confirmed by the results that show a deficit regarding joint problem identification and resolution, guidance on implementation of new policies and guidelines and lack of support by programme coordinators. The results showed experience of being blamed for poor facility performance and supervision as well as a lack of support regarding handling of problems related to staff shortage.

According to the UWEX Logic Model, the component of the situation should to some extent reveal analysis of the needs and assets (Powell and Henert, 2008:14; Wholey et al., 2010:56). In order to remedy the problems revealed, the needs analysis of this study exposed a need for adherence to the principles of SS by LAMs in the PHC facilities. Therefore supportive supervisory visits are a critical aspect included in a SS framework of OPMs in the PHC facilities of NWP.

- Support Regarding Human Resource Issues

The results of the first phase of this study reported that there was a delay in payment of night duty allowance after the OPMs had rendered services, lack of capturing of leave days after the employees had taken leave, thus leading to lack of control and the delay in rank translations of
nursing staff. The results showed a need for support regarding labour relations issues as this could help to strengthen staff discipline and reduce staff absenteeism. Based on the findings of this study, support regarding human resource issues is one of the critical aspects that appear to address the component of the situation.

- Qualities and Competencies of a Supportive Supervisor

In assessing the available assets, experiences related to lack of qualities and competencies of SS showed up in the results and it reported lack of necessary supervisory skills. This is further reported as experiences of lack of knowledge regarding guidelines, lack of advocacy non-assertiveness and lack of professional conduct and respect. Therefore, the results of assessment of assets indicate that the qualities and competencies of a supportive supervisor is one of the resources needed for enhancement of SS of OPMs in the PHC facilities of the NWP.

- Contributory Factors to effective Supervision in PHCs

The contributory factors to effective supervision are reflected as critical aspects of SS, and it include adequate staff and essential equipment as well as infrastructure. These is based on the findings that reported experiences of shortage of staff, lack of essential equipment and poor infrastructure that makes it difficult for the nurses to provide effective services. These are reflected in the framework in order to ensure that the assessment of assets was accomplished for the purpose of framework development (Powell and Henert, 2008:14).

This study exposed that OPMs were unable to effectively supervise the emergency procedures due to lack of well-functioning oxygen machines, too few foetal scopes and dynamaps and shortage of staff. This indicates that the condition of the assets that were available contributed to ineffective delegation and supervision by OPMs. In this regard adequate staff, essential equipment and infrastructure are reflected as one of critical aspects that could improve supervision by OPMs. It is mentioned in Shackman and Rodriguez (2015:8) that a framework is developed in response to a situation. In order to respond to the situation regarding SS, it is important to describe the priorities in the PHC setting.
Priorities

In this study, the legislations and other mandates of the South African DoH influenced framework development of SS of OPMs in the PHC facilities. This implies that the Constitution, Values Governing Public Administration, National Health Act of RSA, Vision and Mission of the DoH helped the researcher to stay focused on the broad aims of the PHC settings. These were to support what is found in the UWEX Logic Model (2003:39) as it is documented that, as soon as the situational analysis is completed, it will be necessary to describe the priorities of the specific aspect that influence management of the organization.

In addition, the priorities should be set because they are important for sustaining the framework and are linked to the strategic objectives of the organization (UWEX, 2003:39). There are several factors that influence framework developers to be more focused. It is learned from UWEX (2003:39) that the priorities should include the vision, mission, values, resources, expertise, history, what the framework developers know about the situation and what other people are doing in relation to the problem (UWEX, 2003:39). Furthermore, the National Health Insurance Policy Paper of 2011, National Development Plan Vision 2030, PHC Facility Supervision Manual, PHC Re-Engineering, National Core Standards, Central Chronic Medication Dispensing and Distributions and Ideal Clinic Model were the priorities for the current framework development. The description of the priorities that guided researchers during framework development is as follows:

Constitution of RSA Act Number 108, 1996

For the purpose of addressing issues of human rights for South Africans, the non-material resources in the framework include training regarding professional conduct. This could remedy the situations of lack of respect towards OPMs by senior managers. The outputs in the framework include community involvement and participation. It is hoped that if the community members are involved in issues pertaining to management of PHC facilities the principle of transparency and openness could be met. This could be a solution to what emerged in this
study, as it was patently clear that OPMs were reprimanded for informing the clients about the moratorium regarding the posts and shortage of staff. The framework shows sub-district managers as participants under components of the output. This is to show that if sub-district managers could play a supportive role on issues of community involvement and participation transparency and openness could prevail.

- Values Governing Public Administration in RSA

For complying with the values that govern the public administration, a SS framework indicates activities and participation that could maintain high standard of professional ethics (RSA Government Gazette, 2014:12). This is revealed in the framework as lack of professional conduct which could be remedied by appropriate training of all managers. The training of the health care providers is included in the framework so that the SS of OPMs should be development orientated (RSA Government Gazette, 2014:12). It is hoped that SS by LAMs can be development orientated if in-service training could appear in the Quality Improvement Plan after conducting a SS (RSA Government Gazette, 2014). This is justified by the SS strategies of RSA as it is outlined that in-service training needs should be determined by observation of service delivery and assessments of clinical records (Ideal Clinic Manual DoH RSA, 2015:10; Jacobs et al., 2014:3; NDoH, 2009:12).

- National Health Act Number 61, 2003

The DoH is mandated by the Act to ensure adequate distribution of human resources. As the results of this study exposed a dire need for increase of nursing staff, it is necessary for a SS framework under component of the input to addresses the problem of staff shortage. Training is also included in the framework because the situation in the PHC facilities revealed lack of in-service training for nursing and support staff. Therefore, the framework development responds to the issue of provision of appropriately trained staff at all levels as prescribed by the National Health Act.

- Nursing Act Number 33, 2005
It is stated in the Act that the SANC should protect the public in matters involving health services particularly nursing. The findings of this study revealed lack of essential equipment and inadequate infrastructure, shortage of staff and patients dying in the PHC facilities. These suggest that the inhabitants of the RSA were not protected by the working environment which nurses were exposed to. In addition, it is stated in the Nursing Act that the SANC should conduct inspections and investigations of institutions, including the PHC facilities. It is therefore necessary for the Nursing Act to be one of the priorities as these could have an influence on enhancement of SS of OPMs in the PHC facilities of NWP.

- **Vision of the National Department of Health, RSA**

  The DoH strives for ‘A long and healthy life for all South Africans’ (NDoH RSA, 2015:12). The researcher assumed that the resources, activities and participation prescribed by the current framework development could enable the DoH to meet the desired endeavour. If LAMs could adhere to the principles of SS, joint identification and resolution of problems could be done early. These could lead to reduction in cases of litigation and patients’ dying in the PHC facilities as discovered in the findings of this study. Therefore, the findings in Phase 1 confirmed that a SS framework for OPMs in the PHC facilities have an influence on the vision of the DoH. This also justified what is indicated in the UWEX Logic Model as it is mentioned that the priorities result in realization of the desired outcomes within the organization (Hatry and Newcomer, 2010:56).

- **Mission of the National Department of Health, RSA**

  The OPMs need regular supportive supervisory visits in order to satisfy the mandate of the mission of the DoH. Regular supervisory visits by LAMs could strengthen OPMs supervision in the PHC facility, thus enhancing promotion of healthy life styles to the communities (NDoH RSA, 2015:12). The OPMs are expected to fully participate in improving the health care delivery system by addressing issues of access, equity, efficiency quality and sustainability (NDoH RSA, 2015:12).
If the resources reflected in the framework are made available for intended activities, the objectives stated in the mission of the DoH could be achieved. This is confirmed by the findings of this study, as OPMs revealed a need for supervisors who possess adequate knowledge regarding health promotion policies and guidelines.

- **National Health Insurance (NHI) Policy Paper, 2011**

The resource that appears in the framework as well as the activities and participation of all stakeholders addresses the main aim and objectives stated in NHI Policy Paper. It is therefore assumed that implementation of what is reflected as inputs and outputs could strengthen the under-resourced and strained public sector, improve health system performance, and enhance access to quality services (Government Gazzette, 2011:5).

- **National Development Plan Vision 2030 Department of Health, RSA**

The output of the framework addresses issues of adherence to the principles of SS, including training regarding policies and guidelines. This is to strengthen SS of OPMs by LAMs and programme coordinators. The availability of support of OPMs by LAMs and programme coordinators, could lead to the achievement of the goal of improving quality by evidence, and strengthening of the health system (Strategic Plan NDoH RSA, 2015-2020:12).

- **PHC Facility Supervision Manual**

The inputs and outputs that appear in a SS framework could enhance compliance to the set norms and standards of supervision of PHCs by LAMs and programme coordinators (NDoH, 2009:12).

- **PHC Re-Engineering**

In order for OPMs to play a supportive role regarding implementation of the PHC re-engineering, the framework specified training regarding policies and guidelines. This is to ensure that supervision in the PHC facilities is integrated with the principles regarding PHC
re-engineering system as prescribed by the Ideal Clinic Model (DoH RSA, 2015:16; Pillay and Baron, 2011:4).

- National Core Standards (NCS)

The seven cross-cutting domains of the NCS that are aimed at improving the quality of care includes, amongst others, patient rights, leadership and corporate governance, operational management, and facilities and infrastructure (DoH RSA, 2011:3; Lourens, 2012:2). The activities and participation shown under outputs relate to the seven domains of the NCS. It is believed that execution of the activities and participation that are shown in the framework could enhance SS of OPMs and thus address the prescriptions outlined in the NCS.

- Central Chronic Medication Dispensing and Distributions (CCMDD) System

This system improves the quality of services by reducing long waiting time, and the OPMs are the main implementers of this strategy (Operation Phakisa, 2014:8). Despite shortage of nursing staff, OPMs indicated increased supervision strategies to implement and patients complaining of long waiting times. It is therefore important to include the CCMDD system as it is believed that the stated resources could improve the implementation of the CCMDD system.

- Ideal Clinic Model

The situation regarding SS that is shown in the first step of the development of a framework reveal factors that relate to non-compliance to the nine components stated in the Ideal Clinic Model (DoH RSA, 2015:16). The enhancement of SS of OPMs could remedy the situation shown in the framework, thus contributing to compliance to the directives of the Ideal Clinic Model. The activities and participation in the framework could also have a positive influence on accreditation of the facilities to NHI.

6.2.4.2 Inputs
These are resources that are expected to be available for execution of a framework’s activities. The inputs include human, financial, organizational and the community resources. It is stated that the rationale for including a specific resource should be well-clarified by the programme developers (Shakman and Rodriguez, 2015:8; Wilder Research, 2009:5; Kellogg Foundation, 2004:12). The inputs for this framework development are classified into human, non-material and material resources.

Human Resources

The human resources that are available for a SS framework in the PHC facilities in the NWP are as follows:

- NWP DOH

- Managers on permanent positions:
  - Sub-district managers
  - LAMs
  - Programme coordinators
  - OPMs

- Qualities and competencies of a supportive supervisor

- HR development personnel

- Nursing staff

- Clinic committee members

The rationale for including the abovementioned resources is based on the reviewed literature and the findings of the first phase of this study. The rationale for including the above stated human resources in the current framework development is discussed as follows:
North West Department of Health

It is assumed that the DoH is the pillar regarding the needs and assets that could maintain a SS framework of OPMs in the PHC facilities. This entails that the situation regarding SS could be remedied through application of the legislation and mandates of the DoH (National Strategic Plan DoH RSA, 2015-2020:14). It is believed that the DoH could be responsible for provision of all the resources reflected in a SS framework of OPMs in PHC facilities (National Strategic Plan DoH RSA, 2015-2020:14; Ideal Clinic Manual DoH RSA, 2015:101). The activities and participation that are stated in the framework will be carried out following the policies and guidelines of the DoH. Based on the available literature and the findings in the first phase of this study, the DoH is regarded as one of the resources to maintain the framework.

Permanent Positions for PHC Managers

The findings in Chapter 4 revealed that most of the OPMs were in acting positions for more than a year. In addition, it also emerged from the findings that some of the OPMs were expected to act as LAMs. On the other hand, LAMs were also supposed to rotate in acting position of a sub-district manager. Therefore, OPMs were expected to attend district meetings, workshops and other activities on behalf of LAMs. The OPMs reported that these affected their supervision and delegation and overall performance of the PHC facilities. These indicate a need to include permanent positions for PHC managers when developing a SS framework. Therefore if a permanent position could be created, rotation of managers could be avoided thus improving supervision. According to a policy for acting allowance for senior management on service, the staff member may only act in a higher post for a maximum uninterrupted period of six months (Department of Public Service Administration, Annexure A 2003:2). These suggest that the supervision challenges in the PHC facilities of North-West Province led to failure to adhere to a maximum period of acting allowance. This was evident whereby OPMs were found to be in acting positions for more than a year.
**Sub-District Manager**

It is necessary to include sub-district managers as they oversee general management and improvement of PHC services. The sub-district managers are to receive a regular monthly and quarterly report from LAMs and programme coordinators (DoH RSA, 2015:16; DoH RSA, 2009:24). The supportive supervisory visits report are used by the sub-district manager for managing and improving provision of PHC services, and the activities of the supervisors and support staff (DoH RSA, 2015:16; DoH RSA, 2009:24). The findings in the first phase of this study demonstrated sub-district managers lacking professional conduct and respect of OPMs during sub-district review. These indicate a lack of support of OPMs by sub-district managers. Therefore, the sub-district manager is included in order to oversee general support of OPMs by LAMs, programme coordinators and support staff.

**Local Area Manager (LAM)**

On the basis of the researcher’s clinical experience, a LAM is the immediate supervisor to an OPM. According to the Ideal Clinic and PHC Supervision Manual, LAMs together with OPMs are expected to regularly review certain administrative aspects in the facility. These should be done in order to ensure compliance to the departmental norms and standards (DoH RSA, 2015:16; DoH RSA, 2009:24). The review of administrative aspects should include human resource issues and financial matters as well as condition of the clinic building and equipment. In the findings of the first phase, OPMs expressed frustrations regarding human resource issues and indicated a need for support by LAMs in this regard.

LAMs are included in the framework as they could play a role by reviewing issues of day and night duty delegations, rank translations and leave days for staff members. It is revealed in the PHC Supervision Manual that LAMs should support OPMs in identification of the staffing and training needs (DoH RSA, 2015:16 and DoH RSA, 2009: 24). LAMs are included in the framework as they could play a role of advocacy by motivating for a need for increased nursing staff. It is specified in the PHC and Ideal Clinic Manual that there should be educational
sessions at every supportive supervisory visit (DoH RSA, 2015:16; DoH RSA, 2009:24).

This was confirmed by the findings of the first phase as the participants demonstrated a need for in-service training of all staff members to enhance supervision by OPMs. LAMs are included in the framework so that they could ensure that regular in-service training is taking place during their supervisory visits. It is revealed in literature that LAMs should support OPMs on issues pertaining to community involvement such as clinic committee meetings that should take place on a regular basis (DoH RSA, 2015:16; DoH RSA, 2009:24).

During supervisory visits, LAMs could support OPMs on handling issues of shortage of nursing staff during clinic committee meetings. This could improve transparency and openness regarding management of the PHC facility. It is revealed in the PHC Supervision Manual that communication of problems between the PHC facility and higher levels should be investigated by the LAMs (DoH RSA, 2009:24; Jacobs et al., 2014:3). The OPMs reported lack of following channels of communication as staff members were communicating facility problems to the sub-district manager. The delegation of professional nurses in the PHC facilities by the sub-district manager was not communicating to the OPMs, and lot of complaints were received from the MEC’s office. It is assumed that if LAMs could fully play their supervisory role in this framework, communication problems between the PHC facility and higher management could be reduced. LAMs are included in the framework in order to ensure that joint identification and resolution of problems occur at an early stage (DoH RSA, 2009:24; Jacobs et al., 2014:3).

Programme Coordinator

The main role of programme coordinators in SS of PHC facilities is to conduct an in-depth review of a specific health programme (DoH RSA, 2009:24; Jacobs et al., 2014:3). The in-depth review of health programmes should be executed in order to ensure that facilities adhere to protocols and treatment guidelines. The health programme includes TB, Maternal Child and Women Health (MCWH), non communicable diseases, HIV/AIDS and STI and mental health
Thus, programme coordinators play a significant role regarding support of OPMs in the PHC facilities. The findings in the first phase of this study indicated lack of support by programme coordinators and poor facility performance. The programme coordinators are included in the framework development because their support could improve adherence to treatment guidelines thus improving PHC facility performance.

Operational Managers

It is important for OPMs to appear in the programme because they should be visited monthly for SS by LAMs and programme coordinators (DoH RSA, 2009:22; Gilson, 2016:1; Jacobs et al., 2014:2). OPMs should receive support visits from other support structures like HR and labour relations when a need is identified by LAMs and OPMs. OPMs are also visited by district health support team twice a year for assessment of the implementation of the departmental priorities (DoH RSA, 2015:102). The district health support team comprises of, amongst others, the district and sub-district managers, LAMs and coordinators of health programme. It is therefore imperative for a framework to reflect OPMs as they are the main stakeholders of SS in the PHC facilities.

Qualities and Competencies of a Supportive Supervisor

A theoretical framework that guides this study showed the qualities and competencies of a supportive supervisor that could enable the organization to achieve its goals (Resource Manual of DoH of Philipines, 2012:18). This was also confirmed by the findings reflected in the first phase as lack of the following qualities and competencies emerged: (1) Knowledge of Policies and Guidelines, (2) Advocacy and Assertiveness, (3) Professional Conduct, (4) Communication and Motivation Skills, (5) Sense of Appreciation, and (6) Fairness. This shows that qualities and competencies of a supportive supervisor is one of the resources that are needed to sustain a SS framework for OPMs.

Human Resource Development (HRD) Personnel
According to the Ideal Clinic Manual, the staff members should be knowledgeable about leave policy (Ideal Clinic Model DoH RSA, 2015:52). This confirms what has been said by OPMs in the findings of the first phase of this study as it was revealed that there was a need for support by human resource development personnel. The OPMs emphasized that human resource development personnel should be involved in order to facilitate in-service training regarding leave policy and how unnecessary leave could affect work profile. For this reason, it is necessary for human resource development personnel to be included in a SS framework of OPMs in the PHC facilities of the NWP. The issues of labour relations should be addressed by the framework—their findings are based on the findings reflected in Phase 1 of this study and the literature review.

The findings of the first phase demonstrated a need for staff members to be reminded on issues of labour with specific reference to the code of conduct. This is justified by what is outlined in the supervision manual whereby SS approach is embedded in the process of assessment of the training needs. OPMs indicated that knowledge regarding code of conduct can reduce acts of misconduct and could improve their supervision in the PHC facilities. A need for support by labour relations officers was overemphasized by OPMs. The findings of the first phase of this study confirmed what is stipulated in the manual of the code of conduct for the public service (Nagiah, 2012:55).

The manual put emphasis on a need for short courses for all employees on standards of ethics in the workplace. The manual of the code of conduct points out the importance of creation of an environment where values and good examples are set for employees (Nagiah, 2012:55). There it will be important for HRD personnel to involve labour relations officers in training of staff members regarding code of conduct. Therefore, it is necessary to include HRD personnel in a SS framework in order to address training needs regarding issues of labour.

**Nursing Personnel**

The reason for including the nursing staff in the framework is because the framework
developers assume that nurses are an essential resource of an ideal clinic. An ideal clinic is described as a clinic with good infrastructure, adequate staff, medicines and supplies, good administrative processes that use applicable clinical policies, protocols, guidelines as well as partner and stakeholder support to ensure the provision of quality health services to the community (DoH RSA, 2015:14). These affirm the findings in the first phase as OPMs indicated a dire need for more nurses to improve their supervision of implementation of an Ideal Clinic Model. Due to shortage of nurses, OPMs were unable to ensure adequate delegation of professional nurses to provide quality health services to communities. It is therefore important for nursing staff to be reflected as a resource in the framework.

- Clinic Committee Members

It is prescribed by the Ideal Clinic Model that the community being served must support the facility management and staff through involvement on service planning and taking ownership and pride of their facility and its functioning (Ideal Clinic Model DoH RSA, 2015: 52). On the other hand, the theoretical framework that guides this study revealed the factors related to work situation that affect supervision, including attitudes of the community towards the nursing supervisees (Royal College of Nursing, 2013:5).

The first phase of this study reported that nurses were insulted by community members which contributed to poor delegation and supervision of the nursing staff. The insults by community members suggest that the clinic committee members were not playing a supportive role. It is therefore necessary for the clinic committee to be included in the programme as they are expected to support the facility management through involvement and participation in planning for good service delivery.

- Material Resources

The reviewed literature in Chapter 3 and the findings in the first phase of this study indicated factors that make delegation and supervision difficult in the PHC settings (Resource Manual of DoH of Philipines, 2012:18; Royal College of Nursing, 2013:5). The factors include time,
equipment, infrastructure, transport and funds. For this reason these material resources appear in the framework as they could enhance SS of OPM in the PHC facilities.

❖ Availability of Funds

The UWEX Logic Model clarified that funding is one of the most significant resources that should be available to maintain the framework (Hatry and Newcomer, 2010:56). These confirm what is reported in the first phase of this study as OPMs reported a need for transport, essential equipment, time for supervision and improved infrastructure.

❖ Transport

According to UWEX Logic Model, allocation of resources like transport is regarded as fundamental to facilitate the achievement of the expected outcome (Silverman et al., 2006: 8). The finding in the first phase revealed that OPMs were augmenting outcomes by using their own transport in the provision of PHC services which indicated a need for transport. Therefore, transport is required to enhance SS of OPMs in the PHC facilities.

❖ Essential Equipment

A SS framework showed the factors that affect work performance and supervision in the PHC facilities. It is emphasized in the framework that technical support of nurses in rural areas should include availability of essential equipment (Royal College of Nursing, 2013:5). The findings reflected in the first phase of this study indicated that lack of essential equipment contributed to poor delegation and supervision in the PHC facilities. For this reason, essential equipment is one of the resources that appear in a SS framework of OPMs in the PHC facilities of NWP.

❖ Time for Supervision

Time is one of the resources required in a SS framework of OPMs in the PHC facilities of NWP. This is to ensure that LAMs and programme coordinators adhere to the SS principles during supervisory visits (DoH RSA, 2009: 22; Gilson, 2016:1; Jacobs et al., 2014:2). In the
findings of the first phase of this study OPMs registered a need for their supervision time allocation in the facility. In addition, all the activities stipulated by the framework require time. It is therefore important for time to be reflected as a resource in a SS framework of OPMs in the PHC facilities.

- **Improved Infrastructure**

In the findings of the first phase of this study, OPMs reported dilapidated clinics and limited space which was not conducive for execution of administrative and supervision activities. This is also cited in a SS framework as it is reported that conducive environment affect supervision in a positive way (Resource Manual of DoH of Philippines, 2012:18).

### 6.2.4.3 Outputs

According to the UWEX Logic Model, the framework should show activities and participation as the sub-component of the output (Powell and Henert, 2008:15). Activities are what the framework does to reach the intended purpose or changes to a given situation. Participation should describe the people to be reached in order to remedy the situation, and these include facilitators of activities, attendants or customers, agencies and decision makers. The component of the output is addressed by the framework as follows:

- **Activities and Participation**

In order to address the issue of lack of supportive supervisory visits, the programme listed the activities required for adherence to SS principles. The participants for ensuring adherence to the principles of SS are also displayed in the framework and this is described as follows.

- **Adherence to SS Principles by LAMs and Programme Coordinators**

In order to enhance SS of OPMs adherence to SS principles is one of the activities that should be achieved by LAMs and programme coordinators. This is shown in the findings of the first phase as a need for regular supportive supervisory visits, observation of service delivery,
immediate feedback and joint problem identification and resolution were reported. These appear as activities in the framework and are described as follows:

**Regular SS Visits**

The supportive supervisory visits are regarded as regular when conducted on a monthly basis and following the PHC SS guidelines (Ideal Clinic Manual DoH RSA, 2015:101; Jacobs et al., 2014:2). The responsible and designated persons for conducting monthly SS in the PHC facilities are LAMs and programme coordinators (DoH RSA, 2009:12). Regular supportive supervisory visits are included in a SS framework as an activity to be accomplished monthly by LAMs and programme coordinators.

**Observation of Service Delivery**

According to the guidelines in the National Core Standards and Ideal Clinic Model, observation of service delivery is a critical aspect of ensuring quality of care (DoH RSA, 2015:10). The finding of the first phase of this study showed lack of support of OPMs through direct observation of service delivery by LAMs. For this reason, observation of service delivery is reflected in the framework as one of the principles to be adhered to by LAMs and programme coordinators.

**Immediate Constructive Feedback**

A SS framework guiding this study revealed that immediate constructive feedback by the supervisor is one of the critical aspects of SS in the PHC facilities (Resource Manual of DoH of Philippines, 2012:1; Jacobs et al., 2014:5). This was confirmed by the findings in the first phase of this study, namely, that OPMs did not receive feedback after supervisory visits by LAMs. The findings indicate a need for creation of opportunities for feedback. Immediate feedback is included in the current framework as an activity to be accomplished by LAMs and programme coordinators.
Joint Problem Identification and Resolution

The literature reviewed indicated that joint problem identification and resolution of problem is one of the critical aspects of SS of PHC facilities (Resource Manual of DoH of Philippines, 2012:18). In the findings of the current study, OPMs experienced lack of supportive supervisory visits that were manifested by lack of joint problem identification and resolution. This activity appears in the framework as an activity to be accomplished during supportive supervisory visits by LAMs and programme coordinators.

Training

As according to the UWEX Logic Model, the component of the output include training as an activity that could help the framework to reach the desired outcome (Powell and Henert, 2008:15). The findings of the current study identified a need for training regarding specified policies and guidelines, human resources and labour issues as well as leadership and management skills. All the training needs that are identified in the first phase of this study are described as follows:

Policies and New Guidelines

A supportive PHC supervisor should be technically knowledgeable about the health programmes so that s/he should be able to train supervisees (Resource Manual of DoH of Philippines, 2012:18). This confirms the findings of the current study as a need for formal training of OPMs regarding the Ideal Clinic Manual and the National Core Standards was reported. Appointed acting OPMs were not orientated indicating a need for training. Programme coordinators were lacking knowledge regarding new treatment guidelines also indicated a need for training in this regard. Therefore, training regarding policies and new guidelines appear in a programme as an activity to be achieved. The DoH should participate by providing training as this could lead to enhancement of effective SS of OPMs in the PHC facilities. The programme coordinators and OPMs also appear under the component of participation to ensure that they receive formal training and orientation regarding policies and
new guidelines.

**Human Resource Issues**

A SS framework should include training regarding human resource issues as an activity to be accomplished. This is to address a need of training regarding leave policies and PMDS as it could improve supervision by OPMs as revealed in the findings of the first phase. The sub-component of participation in the framework includes human resource personnel as they are the ones who could train all staff members on leave policy and PMDS. The training could increase knowledge regarding the effects of repeated personal record of absenteeism due to sick leave and short leave, thus easing staff control and supervision by OPMs.

Training could increase knowledge regarding PMDS policy which could lead to a fair reward system, improved performance and motivated staff. Since the findings of the current study reported a need for staff members to be trained about the code of conduct, training regarding labour relations issues is included in the framework. Therefore, labour relations officer could participate by training all staff members regarding the code conduct. This is to ensure that all staff members receive training so as to get a better understanding of processes of misconduct, rights of employees during such cases and various ethical guidelines of labour (Nagiah, 2012:55).

**Leadership and Management Skills**

According to a SS framework that guides this study, leadership and management skills are one of the qualities necessary for enhancement of supervision and performance (Resource Manual of DoH of Philippines, 2012:18). Training regarding leadership and management skills included in the framework cover the aspect of induction of newly appointed OPMs’ advocacy and assertiveness, professional conduct, communication and motivation skills. This is to support the findings of the first phase as it was reported that training in this regard could enhance supervision and performance in the PHC facilities.
Support System

According to the UWEX Logic Model, activities include the process of putting systems in place in order to sustain a framework (Silverman, Mai, Boulet and Leary: 2006:8). The findings of this study revealed support systems that are necessary for enhancement of SS of OPMs in the PHC facilities. The support systems required by the current framework development are (1) Decentralization of Budget, (2) A Clear Plan of Time Allocated for Supervision by OPMs in the facility and (3) Debriefing for All Staff Members.

Decentralization of Budget

Decentralization of budget refers to delegation and transfer of responsibility regarding finances to a lower organizational level (Saltman, Bankauskaite and Vrangback, 2007:12). In this study, decentralization of budget to a facility level could lead to a sense of ownership by OPMs in management and supervision of the PHC facilities. This implies that creation of a cost centre for each PHC facility could lead to direct participation of OPMs on issues of budget. Component 5 of the Ideal Clinic Model addresses issues of support services, and included are processes that should be followed to ensure the availability of key resources through application of good financial management and supply chain practices. Step one of the process of component 5 revealed that the district manager should ensure that the OPMs have the capacity for managing the finances in line with the delegation (Ideal Clinic Manual DoH RSA, 2015:62).

The processes stated in component 5 of the Ideal Clinic Model suggest that decentralization of budget at the facility level should be implemented. According to the Public Finance Management Act (PFMA), the accounting authorities must ensure that public institutions have and maintain an appropriate procurement and provisioning system which is fair and cost-effective (Government Gazette RSA, 2010:46). These further suggest that OPMs as accounting officers of PHC facilities should be involved in procurement processes. This is confirmed by the findings in the first phase of this study as OPMs claimed a need for them to be involved in
the activities of the budget.

This study revealed lack of essential equipment which contributed to poor supervision and delegation. In order to respond to the situation of lack of essential equipment, it is necessary for OPMs to be supported in application of all the steps and processes of component 5 of the Ideal Clinic Model (Ideal Clinic Manual DoH RSA, 2015:62). This imply that OPMs as accounting officers should be actively involved in procurement of emergency equipment by adhering to the prescriptions in the PFMA (Government Gazette RSA, 2010:46). These could only be achieved if budget could be decentralized so that OPMs could take full responsibility in ordering of essential equipment.

The findings of this study reported poor infrastructure which led to inability to execute supervision activities. These suggest that if OPMs could be actively involved in allocation of financial resources and budget breakdown they could identify renovation of the facilities as a priority need (Ideal Clinic Manual DoH RSA, 2015:62; Government Gazette RSA, 2010:46).

According to the Ideal Clinic Model, component 4 addresses human resources for health which specify staff allocation and use as a priority (Ideal Clinic Manual DoH RSA, 2015:52). The Ideal Clinic Model further specifies that staffing needs should be determined in line with Workload Indicators of Staffing Need (WISN) (Ideal Clinic Manual DoH RSA, 2015:52). According to WHO (2010:8), WISN is a human resource management tool that determines how many health workers of a particular type are required to cope with the workload of a given health facility. WISN also assesses the workload pressure of the health workers in that facility. Lessons learned from WHO (2010:8) indicate that WISN implementation strategy must be translated into an operational plan and budget. As it is revealed in the findings of the second phase of this study that OPMs experienced a very serious shortage of staff which contributed to poor delegation and supervision. The decentralization of budget and active participation of OPMs in budget could have an influence in recruitment of staff according to the facility needs.
These further suggest that OPMs should be supported by PHC managers so as to enable them to assess staffing needs according to WISEN.

It emerged from the findings of the second phase that transparency and openness should prevail to facilitate community understanding. In addition, OPMs reported nurses who were insulted because of long queues that were aggravated by the small number of nurses. All these demonstrate that decentralization could lead to clinic committee involvement on issues of budget, thus improving transparency and openness regarding shortage of nurses (Ideal Clinic Manual DoH RSA, 2015:52; Clinic Supervision Manual DoH RSA, 2009:12). These further indicate that decentralization of budget could help OPMs in sharing information related to staffing needs and recruitment with clinic committee members.

The Literature review conducted in Chapter 3 demonstrated that the availability of emergency equipment and good infrastructure contribute to job satisfaction and improved performance (Munyewendel et al., 2014:12). These further demonstrate that active involvement of OPMs in financial management could contribute to job satisfaction and improved supervision in the PHC facilities. The people who are included in the current framework as the participants for supporting OPMs regarding issues of budget are sub-district managers, LAMs and community members. Further clarification of roles in this regard is dealt with in objective 3 of this chapter, which are the guidelines for operationalization of the framework.

分配时间给OPMs的监督

The main role of the operational manager is to oversee the supervision of health care programmes in the PHC facility (Ideal Clinic Manual DoH RSA, 2015:10). The findings in the first phase of this study indicated a need for a clear plan of time allocated for OPMs’ supervision in the facility. Time allocation for OPMs’ supervision is included as an activity to be achieved by this framework. It is hoped that the sub-district managers, local area managers and OPMs will be the participants of this activity. Time allocation for OPMs supervision is necessary as it could help them to perform daily supervision activities as outlined in the PHC
facility managers’ checklist. The daily supervision activities that need allocation of time is outlined in the description of objective 3 of this chapter.

- **Debriefing of All Managers and Staff**

The OPMs revealed a need for debriefing that could assist them to survive the emotional stress, a feeling of demotivation and lack of appreciation in the workplace. Signs and symptoms of emotional burnout include an ongoing feeling of not being appreciated and an expression of being demotivated (Loyola University, 2018:2). One of the methods of coping with emotional burnout include formal debriefing and counselling.

OPMs further claimed that their local area managers are always shouting on the other side, they revealed staff members who are demoralized which indicate a need for a formal debriefing and counselling. Debriefing is included as an activity that could be achieved by a current SS framework. In this study, all managers and staff members are expected to be the participants in the debriefing sessions and the psychologist could be responsible for facilitating the whole process.

6.2.4.4 Outcomes

As in the UWEX Logic Model, the outcomes during framework development focus on the expected results and benefits should resources and activities be accomplished (Powell and Henert, 2008:15). The outcomes should address the behavioural changes for individuals, groups or systems (Powell and Henert, 2008:15). The expected outcomes for a SS framework of OPMs are classified into short-, medium- and long-term outcomes. According to the UWEX Logic Model, the outcome should be specific, measurable, attainable, result orientated and timed (Bernard, 2009:1). The outcomes of the current framework development are described as follows:
Short-Term Outcomes

The short term outcomes indicate the benefits such as changes in awareness, knowledge, skills, attitudes, opinions and intent (Shackman and Rodriguez, 2015:8). Adherence to SS principles by LAMs and programme coordinators could yield the following short term benefits:

- Supportive supervisory visits will be conducted monthly according to the guidelines of SS of PHC facilities;
- Direct observation of service delivery will be practiced monthly by both supervisors (LAMs and programme coordinators) and OPMs;
- Opportunity for a constructive feedback will be created immediately;
- Joint problem identification and resolution will be done on monthly basis; and
- Quality Improvement Plan for monthly visits will be available for closing the identified problems.

It is envisaged that training of OPMs, LAMs, programme coordinators, sub-district managers and all staff members could result in the following:

- Increased knowledge on policies and guidelines with specific reference to the Ideal Clinic Model, National Core Standards, PMDs, leave policy and code of conduct for South African public servants. Increased knowledge will be evidenced at the end of training.
- Induction of newly appointed OPMs will lead to OPMs being aware of (1) Their roles of ensuring that supervision in the PHC facility is carried out according to the guidelines stipulated in the PHC supervision manual, (2) Their roles during monthly supportive supervisory visit by LAM, (3) their roles during quarterly supportive supervisory visits by programme
coordinators. Awareness of roles will be manifested after a one week of induction; and

- Application of knowledge in leadership skills including management of a difficult supervisees will be manifested after three months of training.

The implementation of all the activities described as support systems could result into the following short-term results:

- Decentralization of budget will make OPMs to take full responsibility of delegated duties regarding facility management of funds;

- OPMs could be directly involved in procurement of essential equipment and recruitment of staff;

- OPMs could prioritize facility renovations as she/he will be directly involved on budget breakdown;

- OPMs will be fully involved on sub-district quarterly budget meetings;

- OPMs could share knowledge regarding budget with clinic committee thus improving transparency and openness;

- A clear plan of time allocated for OPMs’ supervision in the facility will be in-place on monthly basis; and

- Debriefing of all managers and staff could take place on quarterly basis.

Medium-Term Outcomes

The behavioural change is one of the benefits that occur after implementation of remedial activities in response to a problem (Shackman and Rodriguez, 2015:10). In addition changes in decision making and actions should exist after execution of activities prescribed by a
programme (Shackman and Rodriguez, 2015:10). The expected medium-term outcomes for the resources, activities and participation needed in this framework are well motivated OPMs and enhanced SS in the PHC facilities.

- **Long-Term Outcomes**

Improved quality in supervision and provision of primary health care could be the long-term benefits of the current programme. This could happen only if the resources and execution of activities and participation required by this framework exist (Powell and Henert, 2008:15).

6.2.4.5 **Assumptions**

Assumptions are the views about participants, staff, and the programme, as well as how improvement may be realized. Being clear about assumptions is one of the most important considerations during programme design (Shackman and Rodriguez, 2015:24). It is believed that after the use of the recommended resources activities and participation of all the stakeholders the following are what may be achieved by the framework.

SS of OPMs will be enhanced by:

- **Adherence to SS principle** by LAMs and programme coordinators which will be evidenced by regular supportive supervisory visits with direct observation of service delivery. The immediate constructive feedback by LAMs and programme coordinators will lead to improvement in joint problem identification and resolution. This could reduce long outstanding problems due to LAMs failing to help OPMs with analysis and resolution of the problems in the facility;

- **A clear plan of OPMs supervision** in the facility could be in place which may improve delegation and supervision by OPMs in the PHC facility;
 Availability of essential equipment and good infrastructure which may also improve supervision and delegation by OPMs;

 Guidance on implementation of policies and guidelines which will be manifested by (1) Well-orientated newly appointed OPMs, (2) Improvement regarding facility performance, (3) PHC facilities reaching the set departmental targets of health promotion and access to quality care and (4) Support during cases of litigations may prevail;

 Improvement on leadership and management skills which will be evidenced by (1) Good professional conduct, (2) LAMs advocating for SS of OPMs, (3) Good communication skills, (4) Prevailing fairness, and (5) Improved skills of handling difficult staff.

 Improvement in support by human resource and labour relations personnel which will be evidenced by (1) Night duty allowance paid on time, (2) Decreased staff absenteeism, (3) Early implementation of rank translation and (5) Reduced cases of misconduct;

 Transparency and openness which may be brought about support of OPMs on involving community representatives by sharing information regarding staff shortages and budget;

 Involvement of OPMs on budget breakdown, review of expenditure and planning; and

 Debriefing and a fair reward system which could lead to motivated staff, improved performance and decreased turnover.
6.2.4.6 External Factors

External factors are the aspects external to the framework that influences the way the programme operates, and are influenced by the framework. These include values, political environment, background and experiences of participants, media, policies and priorities (Powell and Henert, 2008:15). The current framework could be influenced by the changing policies and priorities of the DoH. The condition of the available resources which include demotivated staff and increased staff turnover, lack of equipment could affect the work of the framework.

6.2.5 Framework Validation

According to Wholey et al. (2010:72), validation or verification is the last stage of framework development. In the context of this study, framework validation was completed in order to ensure that the concepts outlined in the framework were relevant and clear to the stakeholders. In this study, the validation of the framework took place in the four sub-district of the NWP. This was accomplished by convening a meeting in each sub-district with OPMs who participated in the first phase of the current study. The validation process was guided by a drawn picture with concepts representing a framework of SS of OPMs in the PHC facilities of North-West Province. Therefore a diagram of Figure 6.1 of this chapter was used for framework validation. The validation process was carried out in the following manner:

- Scene Setting

The research meeting should begin with a scene setting phase in which the topic and the aim of the meeting is clarified (Henning, Rensburg and Smith, 2009: 75). The researcher explained to the participants that the aim of the meeting was to verify a SS framework that was developed from the findings of the first phase. It was further explained to the participants that everything discussed in a meeting should remain confidential. The researcher opened the validation by describing the situation regarding SS which is the first step in the framework development.
Thereafter the participants were given a chance to comment about the concepts that appear in the framework by responding to the following validation questions.

- Is the framework clear enough to create understanding of the components and their interrelationship and is the framework simple and complete?

The above questions were therefore simplified and one central question was asked as follows: “Tell me how you understand the concepts outlined in the framework, and do the framework indeed a SS framework based on the characteristics and principles of SS”. The following were the responses from the participants.

- Priorities

The participants indicated that the concept CCMD system is not clear and not complete they said that it should be read as CCMDD system. The participants also felt that it is necessary to include the nursing act as it is considered it as a priority in regulating the nursing profession.

- Inputs

A consensus was reached regarding the concept DoH and it was agreed that since the framework is developed for OPMs in the North-West Province the concept should read as NWP DoH. The participants said that the framework should be more specific with regard to the PHC managers that appeared in the framework. As a results it was agreed that PHC managers to be replaced by PHC managers on permanent positions. In addition these should be unpacked by putting the concepts sub-district manager, LAM, programme coordinator and operational manager under the sub-heading of PHC managers on permanent positions.

The participants indicated that it will add logic if the concept qualities and competencies of a supportive supervisor could be placed immediately after specifying or naming the managers. The participants agreed that an HR personnel was not clear and specific enough and as a result it was refined to HR development personnel. The participants felt that the community members to be replaced by clinic committee so that it should be more specific. Furthermore the
participants felt that the concept availability should be added to the following concepts: funds, transport and essential equipment so that it should be clear and specific. This implies that the programme should specify the availability of funds, transport and essential equipment.

- **Outputs**

The participants stated that the concepts under the sub-heading of the support systems are not clear enough to address the prevailing situation regarding SS in the NWP. Therefore the concept budget was refined so that it should read as decentralization of budget. Allocation was added so that the next concepts after budget should read as allocation of time for supervision by OPMs. The participants reached consensus regarding debriefing and said that the concept should read as debriefing of all managers and staff. The participants raised no comments and inputs regarding the outcomes, assumptions as well as the external factors. Finally the participants agreed after an intense review process that there is a relationship between the components, the concepts in the framework are listed logically and are easy to understand.

Following inputs and comments by the stakeholders, the following questions were used by the researcher to complete the whole process validation of the framework.

- **Is the framework logic theoretically sound and do all the components fit together logically?**

The goal and objectives of the framework were spelled out in order to ensure that all the steps of framework development address the problems regarding SS in the PHC facilities. The framework development applied a theory stipulated in Wisconsin logic model and all the components were addressed in this regard. A table was used to reveal that all the components that were addressed for framework development. The first step shown in the framework development is the component named as the situation and priorities, and this is whereby a summary of situational analysis is illustrated as the basis for framework development. The component of the situation is followed by the inputs, outputs, outcomes, assumptions and external factors appear logically in the framework picture and description. Arrows were used to ensure that all the components fit together logically. The important human and material
resources that are required for enhancement of SS are listed and described logically. The activities and participation for enhancement of SS is listed and described by the framework in a logical order. The outcomes are specified in the table, the assumptions are listed logically and external factors are clarified. For logic and soundness all the concepts were verified by OPMs who participated in the current study.

- Have all the key external contextual factors been identified and their potential influences described?

The political environment such as changes in SS strategies and policies, and demotivated staff for operationalization of the framework as well as increased staff shortage are discussed. Therefore all the key external contextual factors have been identified and their potential influences are described.

6.3 Proposed Guidelines to Operationalize a SS Framework for OPMs in the PHC Facilities of NWP

The guidelines for operationalization describe the manner in which the framework can be used to produce a change (Wilder Research, 2009:10). This is to show how the developed framework could be applied in the PHC setting for enhancement of SS for OPMs. The PHC supervision manual, national core standards and the ideal clinic manual and CCMDD system will guide the process of operationalization of a SS framework of OPMs. These is to ensure that the activities and participation in the framework are within the norms and standards prescribed by the department of health (Ideal clinic manual DoH RSA, 2015:62, PHC supervision manual DoH RSA, 2009: 24 and Jacobs et al., 2014:3). Therefore the situation regarding SS could be remedied by applying the prescriptions in the SS strategies of National Department of Health. These is to ensure that the mandates stipulated in the constitution, National Health Act, values governing public administration, vision and mission, national development plan vision 2013 and NHI for RSA are met.

The guidelines for operationalization of the framework focus on the inputs, outputs, outcomes, assumptions and external factors (Shackman and Rodriguez, 2015:10).
6.3.1 Inputs and Outputs

The inputs describe the application human resources, activities and participation, support systems. The application of inputs and outputs that could be applied to remedy the situation regarding SS of OPMs is described as follows:

✧ Activities and Participation

The human resources that are required to participate in accomplishing the activities in the framework include North West Provincial Department of Health. The managers on permanent positions should also participate in the framework, and these are the sub-district manager, LAM and programme coordinators. The human resource development and nursing personnel as well as clinic committee members should participate in the framework. The activities and participation for each human resource are described in the following order:

✧ North West Provincial Department of Health

The department of health should maintain the current framework by providing human and material resources so that SS of OPMs in the PHC facilities is enhanced. Therefore for operationalization of this framework the health department should:

- Maintain the framework by filling vacant post for Sub-district Managers, LAMs and OPMs as these could lead to regular SS of OPMs.
- Should employ more nursing personnel
- Ensure adequate transport allocation in PHC facilities
- Decentralise budget by creating a cost centre for each PHC facility to enable OPMs to participate actively on issues of budget
- Ensure induction of newly appointed OPMs
Ensure that all managers are trained on leadership and management skills

Ensure that all staff members are trained on the policies and guidelines that are prescribed by the current programme

Ensure that debriefing of all managers and staff members takes place

Sub-District Manager

As the sub-district manager is responsible for overseeing the SS in the sub-district it will be necessary for him/her to support the supervisory activities in the PHC facilities. This implies that the sub-district manager should ensure that supervision by OPMs in the PHC facilities should be supplemented with monthly SS by LAM, SS visits by programme coordinators on quarterly basis and after every six months by district SS teams. In order to fully operationalize a SS framework the sub-district manager should provide support by:

Approving a recommendation that should be done by LAM regarding a clear plan of allocation of time for supervision by OPMs in the PHC facility

Ensure that OPMs receive a formal signed financial delegation letter from the district

Ensure that all OPMs are trained on budget and PFMA

Ensure that OPMs are involved in all activities of budget

Should ensure that monthly and quarterly supportive supervisory visits by LAMs and programme coordinators are taking place

Support the quality improvement plans and activities of LAMs and programme coordinators in SS of OPMs
Local Area Managers

For the purpose of support of OPMs regarding participation on the activities of budget, the Local Area Manager should ensure that:

- OPMs obtain a formal delegation letter from the district manager that allows him/her for managing funds according to PFMA (Government Gazette RSA, 2010:46 and Ideal Clinic Manual DoH RSA, 2015:62).
- Ensure that facility manager has the capacity for managing finances by motivating for regular training in this regard.
- Ensure that OPMs are invited and attend district budget meetings.
- Support OPMs so that they allocate financial resources in-line with the facility needs.
- Help OPMs to develop control measures for rational budget utilisation and expenditure.
- Support OPMs in using the monthly expenditure report as received from sub-district, compare the report to the monthly commitment register she/he has in the records for the relevant month.

For the purpose of adhering to the principle of SS through regular SS visits, observation of service delivery and immediate feedback the following should be accomplished by LAMs:

- Draw and recommend a clear plan of OPMs time of supervision in the facility.
- Local area Managers should communicate with OPMs regarding the scheduled visits so that it should appear in the PHC facility plan.
- Supportive supervisory visits by LAMs should be done on monthly basis.
Supportive supervisory visits of PHC facilities by LAMs should appear as a priority in their monthly schedule as it emerged in the findings of the current study.

The LAMs should adhere to the principles by completing 4 hours as it is the prescribed time of SS of PHC so that all the activities should be completed (Jacobs et al., 2014:5 and DoH RSA, 2009: 24).

For compliance with the prescriptions of the red flag and regular review check lists, regular direct observation of service should be done by both LAMs and OPMs. Both red flag and regular review check lists to be completed on monthly basis (Jacobs et al., 2014:5 and DoH RSA, 2009: 24).

Feedback should be given immediately, and it should be coupled with joint resolution of problems that were identified during observation of service as well as quality improvement plan. Comments regarding training needs should appear in the quality improvement plan (DoH RSA, 2009:24; Ideal Clinic Manual DoH RSA, 2015:101).

Quarterly supervisory support check list should be completed once every three months to provide a more in-depth perspective on the functioning of the PHC facility. The filling of quarterly supervisory support check list should also follow the principle of direct observation of service delivery.

Local Area Managers should provide support of OPMs during district visits for assessment for compliance to the ideal clinic model.

Programme Coordinators

The programme coordinators for TB and HIV/AIDS and other communicable diseases, MCWH, non-communicable diseases and mental health are expected to focus on in-depth
reviews of specific programme (DoH RSA, 2009: 26). Therefore, programme coordinators should adhere to the principle of SS by conducting regular supportive supervisory visits, observation of service delivery and immediate feedback by:

- Communicating with OPMs regarding supportive supervisory visits so that it should be displayed in the facility plan of visits.

- Supportive supervisory visits by LAMs should be done on quarterly basis.

- For compliance with the prescriptions in the check list of the specific in-depth programme review, regular direct observation of service should be done by both programme coordinator and OPMs (Jacobs et al., 2014:5 and DoH RSA, 2009:24).

- Feedback should be given immediately, and joint resolution of problems that were identified during observation should be documented in the quality improvement plan.

**Operational Managers**

The OPMs are to ensure that their supervision of the facility is carried out according to the guidelines outlined in the PHC supervision strategies. For the purpose of operationalization of the current framework the OPMs should:

- Perform daily supervision in the facility using PHC facility managers’ checklist to ensure adherence to the activities stipulated under the following sub-headings (1) General facility environment (2) PHC internal environment (3) General leadership and planning (3) Personnel management (4) finance (5) Transport and communication (6) Visits to facility by LAM (7) Visits to facility by programme coordinators (8) Quality care (9) equipment (10) Medicines and supply (11) Information and documentation (12) Security room
Ensure that the process of community engagement is used by: (1) working together with the chairperson of the clinic committee in developing a schedule of monthly meeting (2) request training for clinic committee members from the district (3) Attend clinic committee meetings and ensure that the agenda is developed (4) follow up actions arising out of clinic committee meetings (Ideal Clinic Manual DoH RSA, 2015:100).

Ensure that the facility complete self-assessment regarding ideal clinic model and the national core standards.

Human Resource Development Personnel

The situation regarding lack of competencies and qualities of a supportive supervisor, and a need of training of staff members regarding labour and human resource issues could be remedied by using the resources, activities and participation stated in the programme. Therefore human resource development personnel should facilitate the following activities:

- Induction of newly appointed OPMs should be accomplished (Annexure R, proposed induction programme of newly appointed OPMs).
- Training of OPMs on management of facility finances, ideal clinic model and the national core standards
- Training of programme coordinators on implementation of new guidelines with specific reference to new immunization schedule
- Training of all staff members regarding leave and PMDS policy
- All nursing managers including programme coordinators should be trained on leadership and management skills. These should include training on how to
handle a difficult staff

- MCWH and mental coordinators to be trained advanced midwifery and psychiatry courses
- Training of all managers and staff members regarding code of conduct and disciplinary procedure

Human resource officers should visits PHC facilities for training when a need arise and depending on OPM and LAMs’ quality improvement plan (Jacobs et al., 2014:5 and DoH RSA, 2009:24).

♦ Clinic Committee Members

Community involvement is defined as a process whereby community members are supporting the health system in a voluntary capacity through carrying out tasks outlined by the health facility (Harichan, 2014:2). Community participation is conceptualised as an active engagement in identifying problems, finding solutions and taking part in decision-making (Harichan, 2014:2). For the purpose of enhancement of SS of OPMs through community involvement and participation the clinic committee should:

- Convene monthly clinic committee meetings to discuss facility issues affecting provision of PHC services
- In order to strengthen transparency and openness clinic committee members should be involved in budget meetings and facility performance reviews.

♦ Support Systems

The support system that should be part of the operationalization of the programme are decentralization of budget, time allocation of OPMs’ supervision in the PHC facilities, debriefing and transport allocation. These could be applied as follows:
Local area manager as well as sub-district managers should ensure that training regarding budget and management of facility finances is provided to OPMs.

Clinic committee members to be involved by attending sub-district budget meetings

4 hours should be an allocated time for daily supervision by OPMs in the PHC facility. These should be clarified in the job description and to be communicated to all staff members.

The psychologists should be involved in order to offer debriefing and counselling to OPMs and these should be done on quarterly basis

The department of health could commit more funds to transport so that transport allocation in the sub-districts be increased.

6.3.2 Outcomes

The outcomes are linked to the resources, activities, participation that are hoped to be applied for enhancement of SS of OPMs in the PHC facilities (Bernard, 2009: 3). Short term outcome include learning and improvement in certain skills and midterm describes the actions and behaviours resulting from knowledge gained. The long term outcomes are conditions that change as a result of the actions (Bernard, 2009: 3). The outcomes for operationalization of the framework are described as follows:

- **Short-Term Outcomes**

  The short term benefits that could occur as a result of application of resources, activities and participation are outlines as followed.

  - Adherence to SS principles by LAMs and programme coordinators could lead
to improvement on (1) supervisory visits (2) Direct observation of service delivery (3) constructive feedback (4) Joint problem identification and resolution (5) support regarding compliance to the prescriptions in the ideal clinic model.

Induction of newly appointed OPMs will lead to increased awareness of roles regarding supervision in the PHC facilities and during supportive supervisory visits.

Allocation of time for daily supervision of OPMs in the facility will lead to improved supervision in the facility.

Training that should be provided to all managers will lead to increased knowledge on policies and guidelines and improved leadership skills.

Training that should be received by all staff members will lead to increased knowledge on code of conduct.

Improved support systems will lead to involvement of OPMs in the sub-district budget meetings and increased awareness facility budget, procurement of essential equipment nursing staff will be increased, debriefing of OPMs will take place.

Transport will be allocated to meet the facility needs and facility renovations will be initiated and community involvement and participation will prevail.

Medium-Term Outcomes

Due the resources that are specified in this programme as well as activities and participation that should take place, it is hoped that in three months time SS of OPMs will be enhanced in the PHC facilities. This will be followed by improvement in supervision by OPMs in the PHC
facilities within a period of three months.

Long-Term Outcomes

The application of all specified resources and activities will lead to improvement of quality of care within a period of 12 months.

6.3.3 Assumptions

According to the UWEX Logic Model the assumptions should clearly show the series of connections or logical relationship of how resources, activities, participation and outcomes are linked (Bernard, 2009:10). The assumptions for the guidelines of operationalization of a SS framework of OPMs in the PHC facilities of the NWP are described as follows.

- If the stated resources, activities and participation could be applied to remedy the situation regarding lack of supportive supervisory visits, and lack of support regarding human and labour relations issues.

- These could also lead to enhanced SS of OPMs. If SS of OPMs is enhanced delegation and supervision by OPMs in the PHC facilities will also improve and thus also enhance the quality of provision of care.

- If the department could advertise vacant posts for sub-district managers, LAMs, hire more nurses, decentralize budget for procurement of essential equipment and renovations of the facilities as well as allocation of funds for debriefing sessions OPMs will be motivated.

- If all these are met, supportive supervisory visits by LAMs could be improved, and OPMs delegation and supervision in the facility by OPMs could be improved.

- If leadership and management training could be ensured by NWP, DoH
qualities and competencies needed for supervisors could be acquired, then enhancement in SS of OPMs will exist.

6.3.4 External Factors

The political factors that should be considered are the evaluation of effectiveness of strategies implemented for SS in the PHC facilities. This could have an influence on improvement of SS of OPMs.

6.4 Conclusion

This chapter described the drawn framework of SS of OPMs in the PHC facilities of the NWP. A supportive supervision framework is being validated in the four sub-districts of the NWP province. A description of guidelines for operationalization is included in this chapter. The following chapter focuses on the evaluation, limitations, conclusions and recommendations regarding the whole study.
CHAPTER 7

Evaluation, Limitations, Conclusions and Recommendations

7.1 Introduction

The previous chapter focused on framework development and description, validation and proposed guidelines for operationalization of the programme. Chapter 7 focuses on evaluation, limitations, conclusions drawn from the study and recommendations.

7.2 Evaluation of the Study

The evaluation of the study is accomplished by presenting an overview of the chapters and reflecting on the purpose and objectives.

Chapter 1 focused on the background of the study which was supported with literature citations. The literature provided in the background revealed the knowledge gap regarding a SS framework of OPMs in the PHC facilities of the NWP. It was evident from the discussion of the background that, despite the reported challenges regarding SS of OPMs, there was limited published information regarding a SS framework of OPMs in the PHC facilities of NWP. The significance of the study was discussed as well as the paradigmatic perspectives which included the theoretical, methodological assumptions as well as the central theoretical statements. The preliminary literature review conducted appears in Chapter 3.

Chapter 2 was devoted to the in-depth discussion of the research design and methods. A qualitative descriptive, explorative and a contextual design was adopted. The population of the study comprised of OPMs who were working at the PHC facilities of the four sub-districts in
the NWP. The study was divided into two phases. The first phase focused on describing the experiences regarding SS of OPMs in the PHC facilities of NWP. The first phase also described how SS could be promoted effectively in the PHC facilities of the NWP. The second phase was divided into two stages, the first stage focused on framework for supportive supervision and development of supportive supervision framework. The second stage focused on framework validation and description of proposed guidelines for operationalization of the framework. The study applied the components of the UWEX Logic Model in Framework Development and Validation.

Chapter 3 embodies the narrative literature review which was conducted in order update this study about existing knowledge regarding SS and framework development. The databases used for literature search were Google Scholar, Scopus, Med-line, Elsevier, Chochrane, Science Direct, Ebscohost and Google. The search was guided by the concepts supportive supervision in the PHC facilities, supervision for nursing managers, and framework for supportive supervision in the PHC facilities, supervision models, supervision programmes and supervision for nurses. The information was analysed for relevance, appropriateness for to be used for this study. In this regard, an in-depth discussion of the meaning of supervision and SS was accomplished. The review of existing supervision programmes, models of SS in the PHC services were also discussed. The narrative literature review ended with strategies used for SS in PHC facilities and a framework of SS which guided the whole study. It is necessary to indicate that lessons learned from Chapter 3 of the literature review were used in framework development description and validation.

Chapter 4 assembled and discussed the findings of the first phase of this study and the discussion included a literature control. Four focus group interviews were conducted in the four sub-districts of the NWP. In this chapter, the sample realization was discussed whereby demographic information was tabulated. Twenty three OPMs participated in the study. Three
were three males and twenty were females. Only eighteen OPMs were in permanent positions and five were acting. It came out clearly from the demographic information that there were times when OPMs in permanent positions were acting for LAMs who, in turn, will be acting as sub-district managers. The four main themes discussed in the findings are experiences of factors related to compromised critical aspect of SS and experiences of factors related to lack of qualities and competencies of a supportive supervisor. These also included experiences of factors that contribute to poor delegation and supervision in the facility, and OPMs perceptions on how effective SS of OPMs can be facilitated.

**Chapter 5** dealt with a discussion of the framework for supportive with specific focus on identification of SS concepts and classification. This was followed by description of the framework in line with the UWEX Logic Model. These chapter informed framework development.

**Chapter 6** exemplifies the framework development and description following the guidelines of the UWEX Logic Model. The findings of Chapter 4 and the literature review were the basis of the process of framework development. The developed framework was validated in the four sub-districts of the NWP. The participants were OPMs who participated in the first phase of this study. The participants refined the framework and finally reached consensus with regard to the relationship between the components. The participants agreed that the concepts in the framework were listed logically and easy to understand. The validation process came to a conclusion that the framework logic is theoretically sound and all the components fit together in a logical order. The validation process identified all the key external contextual factors and their potential influence to the success of the framework. The description of the proposed guidelines for operationalization of the framework was addressed in Chapter 6.

**Chapter 7** (this chapter) is the culmination of the processes describes in the foregoing chapters,
and represents the evaluation, limitations, conclusions and recommendations of the study.

7.3 The Purpose of the Study

The purpose of this study was to develop a SS framework for OPMs in the PHC facilities of the NWP. The objectives for a SS programme development were as follows:

7.3.1 Objective 1

The first objective focused on exploration and description of experiences of OPM regarding SS in the PHC facilities of the NWP. In order to address the Objective 1, the participants in the four sub-districts were requested to relate their experiences regarding SS in the PHC facilities. Three broad themes came out from the discussions that addressed Objective 1. In the first theme, the participants expressed experiences of factors related to compromised critical aspects of SS. The two categories that emerged from the first theme are OPMs’ experiences of supportive supervisory visits as negative and OPMs experience LAMs as unsupportive regarding human resource issues. These categories were supported by sub-categories.

The second theme addressed experiences of factors related to lack of qualities and competencies of a supportive supervisor and three categories emerged from these theme. These were reported as OPMs expressed experiences of frustrations related to a need for emotional support, lack of necessary skills to support OPMs, and experiences of lack of professional behaviour and lack of respect. These three categories were also supported by sub-categories.

The third theme focused on experiences of factors that contribute to poor delegation and supervision in the PHC facilities. The two categories that came out from the third theme were shortage of nursing staff, lack of essential equipment and poor infrastructure. The sub-categories that addressed shortage of staff were discussed.
7.3.2 Objective 2

Objective 2 described perceptions on how effective SS can be facilitated effectively in PHC facilities of the NWP. For the purpose of addressing this objective, the participant responded to the question which said ‘How can SS be facilitated effectively in the PHC facilities of NWP.’ Through Objective 2, the participants expressed the factors that can enhance facilitation of effective SS which is the fourth theme that appears in the table of themes. The categories addressing the fourth were discussed using the following subheadings:

- LAMs to adhere to the principles of SS;
- OPMs expressed a need for in-service training;
- Training on supportive supervisory skills;
- A need for involvement on issues of budget;
- Improvement in communication and working relationship;
- A need for evaluation of the effectiveness of SS strategies;
- OPM expressed a need for debriefing sessions;
- A need for a clear plan of OPMs supervision in the facility;
- Address staff shortage issues; and
- Transparency and openness to facilitate community understanding.

7.3.3 Objective 3

The third objective focused on the description of a supportive supervision framework of OPMs
in the PHC facilities of the NWP. The SS concepts were identified from the findings, the concepts were further classified according to the UWEX Logic Model of framework Development. The six components of the UWEX Logic Model which are the situation and priorities, inputs, output, outcomes, external factors and assumptions were applied to classify the concepts. The identification and classification of concepts were further shown in a diagram representing a SS framework.

7.3.4 Objective 4

A SS framework development and description was informed by a framework discussed in Chapter 5. The main goal of the framework is to enhance SS of OPMs and to address the needs, activities and participation for effective supervision in the PHC facilities of the NWP. The objectives of the framework were stated as follows:

- To describe the needs necessary for enhancement of SS of OPMs;
- To ensure adherence to SS principles; and
- To improve the support systems for effective supervision by OPMs.

In order to ensure that the purpose and the objectives of the framework were met, the components of the UWEX Logic Model were applied in framework development as follows:

- **Situation and Priorities**

The critical aspects of SS, qualities and competencies of a supportive supervisor and contributory factors to effective supervision in the PHC, were discussed as the situation that should prevail in SS of OPMs by LAMs. In this regard, the critical aspects were described in relation to OPMs’ experiences of negative supportive supervisory visits, and the reported OPMs’ experiences of LAM as unsupportive regarding human resource issues. The critical
aspects of SS was also discussed as qualities and competencies of SS whereby it was related to experiences of lack of necessary skills, lack of professional conduct and respect. The contributory factors to effective supervision were discussed as a critical aspect of SS, and it was discussed in relation to experiences of lack of essential equipment, poor infrastructure and shortage of staff.

The priorities that influenced framework development were discussed and these included: (1) Constitution of RSA, (2) The Values Governing Public Administration, (3) National Health Act of RSA, (4) South African Nursing Act of 2005, (5) Vision and Mission of the DoH, (6) National Health Insurance Policy Paper of 2011, (7) National Development Plan Vision 2030, (8) PHC Facility Supervision Manual, (9) PHC Re-Engineering, (10) National Core Standards, (11) Central Chronic Medication Dispensing Distributions (CCMD) System, and (12) the Ideal Clinic Model were the priorities for the current framework development. The rationale for including each priority was elaborated. In addition the priorities helped the researcher to focus on the broad aims and objectives of the DoH.

**Inputs**

The framework development and description specified the human and material resources needed for enhancement of SS supervision of OPMs. The NWP DoH is stipulated as resource and a pillar for enhancement of SS of OPMs working in the PHC facilities. Therefore, it is prescribed by the framework that the department should ensure that managers in permanent positions should participate in the framework. This is to ensure consistency and regularity in SS of OPMs. Other resources specified for DoH could ensure availability of funds, transport and increased staff.

The managers that are to participate in the framework are sub-district managers, LAMs, programme coordinators and OPMs. Qualities and competencies of a supportive supervisor are
also included as a pre-requisite for enhancement of SS of OPMs the PHC facilities. The HR development personnel, nursing staff and clinic committee members were discussed as important human resources that are included in the framework. The material resources that are important for sustaining the framework were specified as availability of funds and transport, essential equipment, time for supervision and improved infrastructure.

❖ Outputs
The framework development and description stipulated the activities that should be accomplished to ensure adherence to SS principles. These included regular supervisory visits, direct observation of service delivery and creation of the opportunity for constructive feedback. Training regarding policies and guidelines, management and leadership and induction of newly appointed OPMs were included in the framework. Policies and guidelines that were specified that needed an immediate attention were code of conduct, PMDs, Ideal Clinic Model and National Core Standards. The support system necessary for improvement of supervision by OPMs were prescribed by the framework. These include decentralisation of budget, a clear plan for allocation of OPMs’ time for supervision in the PHC facilities and debriefing of all PHC managers and staff.

❖ Outcomes
The short-, medium- and long-term outcomes that were discussed include Adherence to SS principles and Enhanced SS of OPMs within twelve months. Improved quality care is one of the long-term outcomes stated in the discussion of framework development.

❖ Assumptions
The assumptions regarding the resources, activities and participation of all the stakeholders were discussed. The general assumption is that if all the resources, activities and participation could be ensured SS of OPMs could be enhanced.
External Factors

The external factors that could influence the success of the current framework are political environment such as policies, staff motivation and the community at large.

7.3.5 Objective 5

The validation of a SS framework of OPMs took place in the four sub-districts in the North West Province. The people who validated the framework were OPMs who participated in the first phase of this study. The question that was asked enabled the participants to comment about the framework logic and their understanding of concepts. As a result the OPMs reached consensus with regard to the priorities, human and material resources, and activities that could sustain the framework.

The validation was continued by the researcher and the questions that completed the process were as follows “Is the framework logic theoretically sound and do all the components fit together logically? And “Have all the key external contextual factors been identified and their potential influences described? These key questions helped in the validation of the components applied during framework development.

7.3.6 Objective 6

The sixth objective addressed the description of the guidelines of operationalization of the framework. The description of the guidelines was directed by the components of the UWEX Logic Model and the strategies of SS of PHC facilities. Therefore, the Ideal Clinic Model, PHC supervision manual and the National Core Standards served as guidance for description of the proposed guidelines for operationalization of the framework. The guidelines included the proposed induction schedule of newly appointed OPMs.
7.4 Justification of the Study

The current research is an original contribution to the body of knowledge that is relevant to nursing education and nursing management. The development of a SS framework of OPMs in the PHC facilities of NWP is a contribution to policy making, practice, education and research. This is based on the following reasons:

- The study described and explored experiences of OPMs regarding SS in the PHC facilities;
- The research described how SS can be facilitated effectively in the PHC facilities;
- The data that came out of the first phase of the study was analyzed applying Tesch’s method of analysis and open-coding;
- The concepts derived from the first phase were used to describe the SS framework applying the UWEX Logic Model. These was regarded as a buildup for framework development;
- Framework development and description was informed by the findings from Phase 1, literature review, framework of supportive supervision and the UWEX Logic Model;
- A visual representation depicting the structure and contents of a SS framework of OPMs in the PHC facilities was illustrated;
- The OPMs who participated in the first phase validated a SS framework; and
- The South African DoH strategies of SS of PHC and the UWEX Logic Model
7.5 Limitations of the Study

This study was conducted in the PHC facilities of the NWP, therefore, the findings cannot be generalized to other health facilities of South Africa. Some of the sub-districts in the NWP were not included as that required time and a huge budget. A SS framework of OPMs is a one-sided view of the situation, the Local Area Managers as the immediate supervisors were not included. In this regard, the framework needs to be refined and piloted for implementation.

7.6 Conclusions Drawn from the Study

Based on the findings, the following are the conclusions drawn from the current study: It was apparent from the findings of the first phase of this study that the situation regarding SS of OPMs needs an immediate intervention through framework development. This was evident whereby the OPMs reported experiences of factors related to compromised critical aspects of SS in the PHC facilities. These included a revelation of OPMs experiencing supportive supervisory visits as negative, hence OPMs experienced LAMs as blaming them for poor facility performance and supervision. The OPMs experienced lack of guidance on implementation of policies and new guidelines. These included lack of orientation of newly appointed OPMs on acting positions.

It was also evident from the findings that LAMs failed to support OPMs regarding human and labour relations issues. Lack of support In this regard, was shown by delay in payments in terms of night duty allowance, delay in rank translation, and lack of capturing leave days which increased staff absenteeism. The reported experiences of factors related to compromised
critical aspects of OPMs, warrant a remedy through operationalization of the SS framework derived from the current study.

Experiences related to lack of qualities and competencies of a supportive supervisor is regarded as an immediate call for attention to the training needs that are specified in a programme. This immediate call is supported by the findings of experience of lack of support in cases of litigations, experiences of demotivation, unequal staff treatment and lack of appreciation. Experience of failure to follow channels of communication and a revelation of programme coordinators who were lacking knowledge indicated a dire need for training of all managers. Furthermore, experience of lack of advocacy due to non-assertiveness as well as lack of professional behaviour and lack of respect also require immediate attention to strengthen the required qualities and competencies of a supportive supervisor.

The reported experiences of factors that contributed to poor delegation and supervision are issues that require the DoH to operationalize the framework without delay. This was manifested by shortage of staff which led to limited time for supervision and administrative work due to high workload. The shortage of staff resulted in experience of insults and blame by community members regarding long queues. Regardless of small number of nursing staff which happened because of a lot of resignation, OPMs experienced increased supervision strategies that were put in place by the DoH. In this regard, OPMs were expected to supervise the implementation of the increased supervision strategies which required time and more nursing staff.

In addition, experience of lack of essential equipment and poor infrastructure contributed to poor delegation and supervision by OPMs in the PHC facilities. Experiences of factors that contribute to poor delegation and supervision require an immediate intervention by the DoH. Given the conclusions drawn from the findings of the current study, the following are the
recommendations.

7.7 Recommendations

The recommendations address nursing education, nursing practice, research and policy making. These are as follows:

7.7.1 Nursing Education

- The elements of SS that both a supervisor and a supervisee should adhere to during supervision and management of health facilities should be included in the nursing curriculum. This could enhance general supervision in the health facilities.

- In-service training regarding the concept and critical elements of SS should be conducted for Local Area Managers and OPMs.

- A SS programme of OPMs should be presented in the conferences and workshop by the researcher to inform relevant stakeholders about the findings of this study.

7.7.2 Nursing Practice

- All PHC managers should receive in-service training regarding guidelines for operationalization of the framework;

- The human resource development personnel and clinic committee members should be included in the in-service training.

- Shortage and retention of nursing staff needs urgent attention.
The DoH should advertise vacant posts for PHC managers responsible for supervision of PHCs so as to close the gap of acting positions.

Decentralization of budget to allow PHC facilities to be a cost centre so that OPMs should be actively involved in the management of financial resources in order to effectively implement programmes as outlined in the ideal clinic model.

7.7.3 Nursing Research

A SS framework for OPMs should be refined and piloted by conducting another research that could include the views of LAMs.

A SS framework OPMs working in PHC facilities should be replicated in other provinces in South Africa and other countries.

7.7.4 Policy makers

A SS framework of OPMs in the PHC facilities of NWP should be adopted for operationalization

7.8 Conclusion

This chapter discussed evaluation of the study, limitations the conclusions drawn from the whole study and the recommendations. The evaluation briefly reflected on the chapters as well as the purpose of the study and the objectives. The recommendations addressed education, research, nursing practice and policy making.
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Webina. City of Raleigh Parks, Recreation and Cultural Resources


ANNEXURE A

North-West University Ethics Clearance Certificate

[Image of the certificate]
ANNEXURE B

Request to North-West Province Department of Health to Conduct the Study

[Logo]

The Head of Department
North West Provincial Department of Health

Request for permission to conduct research

This communiqué serves to request permission to conduct research in the primary health care institutions of North-West Province.

I am presently pursuing doctoral degree in nursing at the North-West University (Mafikeng Campus). I am engaged in a research study titled: Model of supportive supervision for nurses in primary health care facilities in the North-West Province.

The study will be conducted in Mafikeng sub-district, Kagisano Molopo, Rustenburg sub-district and Medlicott sub-district in the North-West Province.

The prospective participants of this study will be assistant and operational manager nursing, professional nurses, enrolled and auxiliary nurses.

The study will be conducted under the supervision of Dr. M.E. Manyedi. The proposal has been approved by the Ethics Committee of the North-West University.

The proposal and the certificate of approval is attached.

Yours faithfully

[Signature]

Ms. M.G. Sampalwana ........................................... Date: 17.01.2016
ANNEXURE C

Permission from the North-West Province Department of Health
to Conduct the Study

This letter serves to inform the Researcher that permission to undertake the above mentioned study has been granted by the North West Department of Health. The Researcher is expected to arrange in advance with the chosen facilities, and issue this letter as proof that permission has been granted by the Provincial office.

This letter of permission should be signed and a copy returned to the department. By signing the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards

Dr. FRM Rechel
Director: PFRM&LE

Researcher

Date

11.02.2016

Date
ANNEXURE D

Sample Letter to the PHC Facilities North-West Province

The Deputy Director Primary Health Care Services
SUB-DISTRICT

Request for permission to conduct research

This communiqué serves to request permission to conduct research in the Primary Health Care facilities of.................. Sub-district

I am presently pursuing a doctoral degree in nursing at the North-West University (Mafikeng Campus). I am engaged in a research study titled: Model of supportive supervision for nurses in primary health care facilities in the North-West Province.

I therefore request permission to conduct the interviews in Primary Health Care facilities of.................. as it is one of the four selected sub-district in North-West Province. The prospective participants of this study will be Operational Managers.

The study will be conducted under the supervision of Prof M.E. Manyodi. The permission to conduct the research is being granted by the Department of Health North-West Province.

The permission letter from the Health Department is attached.

Yours faithfully

[Signature]

Miss M.G. Serpehume Date:_______________
ANNEXURE E

Permission from Mahikeng Sub-District to Conduct the Study

TO : MS M G SERAPELWANE
     NORTH WEST UNIVERSITY

CC : ALL ASSISTANT MANAGER NURSING - PHC
     ALL OPERATION MANAGER NURSING - PHC

FROM : MS L FMOLAPONG
       ACTING PHC MANAGER

RE : REQUEST PERMISSION TO CONDUCT RESEARCH

This communiqué serves to inform you that your request has been approved.

Permission has been granted by Director Policy, Planning, Research, Monitoring and Evaluation.

Please note that relevant managers will be informed.

Hope this is in order

Regards

[Signature]
MS L F Molapong
Acting PHC Manager

Date: 2016/11/08

Healthy Living for All
ANNEXURE F

Permission from Matlosana Sub-District to Conduct the Study

MATLOSANA SUB DISTRICT - OFFICE OF THE PHC MANAGER

TO: MS M.G. SERAPELWANE
NORTHWEST UNIVERSITY

CC: AD: PHC's
OPERATIONAL MANAGERS

FROM: MEC LEBEKO
ACTING PHC MANAGER
MATLOSANA SUB DISTRICT

DATE: 04 MARCH 2016

SUBJECT: RESEARCH APPROVAL LETTER - MODEL OF SUPERVISION FOR NURSES PHC FACILITIES IN NORTH WEST PROVINCE

Dear Madam,

The above subject has reference.

Approval is hereby granted for M.G. Serapelwane to conduct research study on the above mentioned topic within Matlosana facilities. Kindly liaise with the AD: PHCs of the facilities for further arrangement on the dates when you will be conducting interviews within their facilities.

Attached please find a copy of the list of facilities, addresses and responsible AD: PHC/Operational Managers for further arrangements.

Hope the above is in order.

Regards

MEC LEBEKO
ACTING PHC MANAGER
MATLOSANA SUB DISTRICT

Healthy Living for All
ANNEXURE G

Permission from Kagisano Molopo Sub-District to Conduct the Study

KAGISANO MOLOPO SUB-DISTRICT

09 January 2017

TO: MS G M SERAPELWANE
NORTH WEST UNIVERSITY

CC: ALL OPERATIONAL MANAGER NURSING - PHC
MS M SEGOMANE (Acting Operational Manager Tlapeang Clinic)
MS I MAGANDA (Acting Operational Manager Morolweneg CHC)
MS D GASEROTSE (Acting Operational Manager Ganyase CHC)
MR K Z KANANYANE (Acting Operational Manager Tlakagameng CHC)

FROM: MS G J LEGALAMITLWA
ACTING SUB DISTRICT MANAGER

RE REQUESTING PERMISSION TO CONDUCT RESEARCH

This communiqué serves to inform you that your request has been approved. Permission has been granted by Director Policy, Planning, Research, Monitoring and Evaluation.

Please note that relevant managers will be informed.

Hope this is in order

Regards

Ms G J Legalamitlwa
Acting Sub District Manager

Healthy Living for All
ANNEXURE H

Permission from Rustenburg Sub-District (Bojanala District) to Conduct the Study

[Image of a letter from the Department of Health, North West Province, granting permission to conduct research.]

To: Ms P. Bango
Mr L. Tihowe
Mr P. Dikobe
Dr K. Segwai
Mr L. Mokotedi

From: Mr I. M. Moloi
Acting Director: District Health Services
Bojanala District

Date: 08 November 2016

SUBJECT: PERMISSION TO CONDUCT RESEARCH

The department has granted Ms M.G. Serapewane permission to conduct research. (Attached find approval letter from Department).

You are kindly requested to allow Ms M.G. Serapewane to conduct research and support the process.

Your assistance in this regard is highly appreciated.

Thank you,

[Signature]

Mr I.M. Moloi
Acting Director: District Health Services
Bojanala District
ANNEXURE I

Informed Consent Form

I __________________ (name of participant) on this day of ---(date) of---(month) 20---hereby consent to:

1. Being interviewed by ______________ (name of researcher) under the topic: A Supportive Supervision framework of OPMs in the primary health care facilities of North-West Province.

2. I understand that the follow-up interviews will be conducted when necessary.

I also understand that:

1. I am free to end my participation or to recall my consent to be involved in this research at any stage.

2. Information given up to the point of my termination of participation can, however, still be used for the purpose of this study.

3. Anonymity is granted by the researcher that data will under no conditions be reported in such a way as to reveal my name.

4. More than one interview might be needed

5. No compensation will be made by the researcher for information given on my participation in this study.

6. I may refrain from answering questions should I feel these are an invasion of my privacy.

7. I will be given the original copy of this agreement once I have signed it.

8. I hereby acknowledge that the research interviewer has:
   • Discussed the aim and objectives of this research project with me.
   • Informed me about the content of this agreement.
   • Pointed out the implications of signing this agreement.

9. In co-signing this agreement I, the researcher, undertake to:
   • Maintain confidentiality, anonymity and privacy when recording the interviewees’ identity, and the information given by the interviewee.
   • Arrange in advance a suitable time and place for an interview to take place.
   • Safe guard the duplicate of this agreement.

Signatures: Participant ................................   Researcher..........................     Date………………..
ANNEXURE J

Request to Act as a Co-Coder in Qualitative Data

Work protocol for data analysis of a supportive supervision programme for operational managers in the Primary Health Care (PHC) facilities of the NWP

Dear Prof Ken

I am a PhD student in the North West University, Mafikeng Campus and I am conducting the above mentioned study. The data collection was guided by the following research questions and objectives:

Research questions:
- What are experiences of OPM regarding supportive supervision in PHC facilities of the NWP?
- How can supportive supervision be facilitated effectively in PHC facilities of the NWP?

Objectives:
- To explore and describe experiences of OPM regarding SS in the PHC facilities of the NWP;
- To describe how supportive supervision of OPMs can be facilitated effectively in PHC facilities of the NWP

Your participation is as follows:
There are four transcripts derived from focus group interviews from which you are expected to conduct co-coding. The study used eight steps of Tauch’s method (Cresswell, 2006:184) analysis and open-coding. The themes, categories and sub-categories are identified from data.
After the process of analysis and decoding, I will appreciate it if we can agree on a date on which we can meet to discuss our findings and reach consensus regarding the analysis of this data.

Yours faithfully

M.G. Sempelweze
14.06.2017
DEVELOPMENT BY THE CO-CODER

I, Vicki Koen, hereby declare that I have analysed and co-coded the focus group interviews of the study by MG Serapelwane focusing on a supportive supervision program for operational managers in the Primary Health Care facilities of the North West Province. I further declare that I had a discussion with MG Serapelwane on 29/8/2017 to discuss coding themes and to ensure consensus with regard to data analyses pertaining to her study.

V. Koen

29/8/2017

Date

Research Psychologist (PS 0121169)
Field Notes for Focus Group Interview of Sub-District-A

Descriptive notes
The focus group interviews took place on the 12th January 2017 in sub-district A which is divided into three local health areas. Each local health area comprises of PHC facilities that are operating for 8 to 24hrs which meet the selection criteria. The sub-district communication officer organised convenient venue and time as a result the interviews started at 9:00 in the sub-district boardroom. The communication officer reported to the researcher that the two operational managers could not avail themselves because of shortage. The total number of operational managers available for participation were only five and all the local health areas in the sub-district were represented. The representation from each local area is described as follows:

- **Local Health Area G**
The local health area G was represented by a 42 years female professional nurse, who is appointed as an Acting OPM in a 24hr PHC facility. He is being acting in this position since 2015 February (one year eleven months) and she worked in the same facility for the past eleven years. The local area G is also represented by a 36 years old female professional nurse who is an Operational Manager on a permanent position of 8hour clinic.

- **Local Health Area M**
The local health area M was represented by a 52 years old female professional nurse who is on permanent Operational Managers position of a 24hr PHC facility. She is being supervising the facility for the past eight years. The OPM of local area M reported that she was delegated to act as local area manager during October to December (3months) while her supervisor was acting as a sub-district manager.

- **Local Health Area T**
The local health area T is represented by a 49 year old male professional nurse who is on permanent position in a 24hr PHC facility. He occupied the current position for the previous three years and he also worked as an operational manager at local health area G and M in 8 hour facilities of the same sub-district. The local area T also is represented by a female professional nurse who is on an acting position of an operational manager. She is placed in a PHC facility that is operating for 8hrs. She is been in an acting position for the previous eighteen months. She worked as a professional nurse in a 24hour PHC facility for the previous five years. Before that she was working as an auxiliary nurse in a 24hr PHC facility.

Non-verbal cues
During the discussions there were non-verbal cues that were observed and it was captured as follows:

One of the participants had a tendency of clearing throat before speaking. The participants presented with low and high tone of voices and showing some anger, frowning faces and looking sad during description of their experiences. Some were keeping quiet in middle of description of experiences regarding SS in the PHC facilities.

Methodological notes
Immediately after asking the first central question Mr T a male participant raised the hand and was given a chance to express his experiences. It was observed that all other participants were repeatedly raising hands whilst the first participant was still talking. In this regard, the researcher decided to have the first round for everybody to express experiences, and the second round was used for follow up questioning and probing on what was said by each.
Therefore all the four participants had an equal chance of expressing their experiences. The researcher was made aware before the interviews that some of participants were to attend the district performance reviews meeting. The interviews started at 09:00 lasted for two hours forty minutes, and the participants were already running late for the reviews because the participants had to travel a distance of 70 kilometres. At the end of the interviews the researcher requested the communication officer to forward an apology to the sub-district manager regarding an inconvenience caused.

Personal feelings

The researcher had some guilt feelings because after the end of the interviews some the participants were expressing some anxiety about the meeting they were to attend.

Theoretical notes

The participants reported lack of supervision in the facilities because they are expected to be hands on for the rest of the day. They reported lack of supervisory visits from the local health area managers as well as programme coordinators. OPMs said that they are always blamed for not supervising the subordinates. Those who were on acting positions reported lack of orientation. The participants reported numbers of factors that makes delegation and supervision to be very difficult. Those factors were reported as being belittled and reprimanded in front of junior staff members, Lack of openness and involvement in problem identification and resolution, favoritisms related to PMDS and granting of study leave, lack of discipline and lack of uniformity regarding writing of PMDS, lack of training and support regarding labor and human resource issues, difficult staff moved from one place to another, poor communication between the supervisors and supervisee, demoralized staff, shortage of staff, lack of appreciation from top management, lack of orientation, demoralized staff, difficult staff to supervise. The participants reported a need for help regarding resolution of problems and conflicts that relates to shortage of nurses, lack of following policies and treatment guidelines. The participants expressed a need for help to enable them to reach the set targets and a need of support from the provincial office of the MEC.

Generally, the five participants showed a lot bitterness and frustrations. They were able to ventilate the problems faced and in between the discussions the participants were able to console, comfort one another.
Field Notes for Sub-District B

In sub-district B the focus group interview took place on the 29th November 2016. The interviews started at 8:30 the venue was the boardroom of one of the community health centres.

The number of participants recruited and volunteered for participation were six but only five availed themselves. The participants consist of four females and one male professional nurses. The four local health areas of the sub-district are represented. The description of the representation from each local area is as follows:

- **Local health area A**
  
  The local health area A is represented by two professional nurses: The professional nurse A is appointed as an operational manager of a 24hr PHC facility. She is being supervising the facility for the past 10 years. Participant I is also appointed as an acting operational manager of an 8hr facility and she is been in the position for one and a half year.

- **Local health area B**
  
  The local health area B is represented by male professional nurses. Participant F is appointed as an acting operational manager of an 8hr facility. She is being supervising the facility for the past twelve months.

- **Local health area C**
  
  The local health area B is represented by male professional nurses. Participant F is appointed as an acting operational manager of an 8hr facility. She is being supervising the facility for the past twelve months.

- **Local health area D**
  
  The local area D is represented by Professional nurse C. Professional nurse C is an operational manager of an 8hr clinic since eight years back.

**Non-verbal cues**

During the discussions there were non-verbal cues that were observed and it is written as follows:

The participants presented with low and high tone of voices and stammering, and showing some anger and frustrations, frowning faces and looking sad during description of their experiences. The participants were using hands and shaking shoulders and hands to show their anger, sadness and their frustrations. During the discussions the participants were agreeing with the speaker by completing, adding some words and making some interruptions.

**Methodological notes**

Participant A was talkative, having a pressure of speech and added to what was said by almost all participants. All of the 5 participants had a chance to freely express their experiences. One of the participants had to leave because
he received an urgent call from his supervisee. This happened after introducing the second question. The interviews lasted for two hours 30 minutes.

**Personal feelings**

The researcher feels that the OPM are experiencing burnout and they are bitter

**Theoretical notes**

The participants are reporting that they don’t have time to supervise staff. Lack of guidance in reporting of PMDS and sub-district performance reviews is reported. The operational manager’s reports lack of uniformity regarding PMDS. Favoritisms are reported in allocation of resources as well as in PMDS. They reported that supervisory visits from the local health area managers are ineffective. It emerged that programme managers are not visiting the PHC facilities for supportive supervision. They are experiencing insults especially during performance reviews and disrespected in front of support staff. Lack of support from other structures like human resource and labor relations officer. They report a need for help from management in addressing issues of staff shortage with the communities. The operational managers are experiencing a lot of litigations regarding maternity cases and feel that they are not receiving the necessary support. They report frustrations related to problems related to lack of discipline of staff members.

The operational members reported a need for debriefing session, effective supportive supervision from their immediate supervisors, assertive capable managers, managers need training regarding professionalism. A need for orientation in a new position, more staff, essential equipment, need time for attending to administrative work and to supervise staff on implementation of policies and guideline.
Field Notes for Sub-District C

Descriptive notes
In the sub-district C the focus group interview took place on the 08. March.2016. The interviews started at 11:30 in the sub-district boardroom. This happened immediately after a meeting held with the sub-district manager. The operational managers had a meeting with their local health area managers, as a result the sub-district manager the opportunity was used by recruiting the operational managers immediately after the meeting.

The number of operational managers available for recruitment was ten and those who volunteered to participate were eight. The participants are females and all the four local health areas in the sub-district is represented. The description of the representation from each local area is as follows:

• **Local health area A**
The local health area A is represented by two professional nurses as follows. The professional nurse H is appointed as an operational manager of a 24hr PHC facility. She is being supervising the facility for the past 13 years. The professional nurse I is also appointed as an operational manager of a 8hr facility. She is being in this position for the previous five years.

• **Local health area B**
The local health area B is represented by two female professional nurses. Professional nurse F is appointed as an operational manager of a 24hr facility. She is being supervising the facility for the past eight years. Professional D she is been acting as an operational manager for the past 12 and a half month.

• **Local health area C**
The local health area C is represented by professional nurse B who is appointed as an operational manager and she is placed in a 24hr facility. She is being supervising the facility for the previous 9 years. He also worked as an operational manager in an eight hour clinic at health area A in the same sub-district. Participant J is also representing local area health are C and she is in an acting position for the previous 13 months.

• **Local health area D**
The local area D is represented by Professional nurse E and J. Professional nurse E is an operational manager of a 24hr clinic since eight years back. Professional nurse J is placed in a PHC facility that is operating for 8hrs. She is been in an acting position for the previous eighteen months.

During the discussions there were non-verbal cues that were observed and it is written as follows:
The participants presented with some stammering voices, low and high tone of voices and showing some anger and frustrations, frowning faces and looking sad during description of their experiences. The participants were using hands and shaking shoulders and hands to show their anger, sadness and their frustrations.

Methodological notes
After asking the first question the participants were silent and the researcher was forced to simplify, rephrase the question. Participant H was talkative, having a pressure of speech followed by B and F. All of the eight participants had a chance to freely express their experiences. The interviews lasted for two hours 20 minutes. After the interviews
the participants indicated that it was good for them to be given a chance to ventilate their frustrations. The participant said that it was like a therapy for them.

**Personal feelings**

The researcher feels that some of the information was not well explored because of the discussions are felt with a lot of bitterness. The OPM are experiencing burnout.

**Theoretical notes**

The participants reported supervision that is finding faults and most of them feels that there is no sense of appreciation regarding the good things that they are doing. Some supervisors are shouting nurses in front of the clients. OPM are saying that they are blamed for not supervising the staff members. They reported lack of supervisory visits from the local health area managers as well as programme coordinators. One participant appreciated support received from the immediate supervisor. The participants reported poor identification and resolution of problems, Lack of support regarding the discipline of the staff members. Lack of resources includes shortage of staff, equipment, and cleaning materials. Problems related to lack of discipline of staff members shifted from one place to another. The participants reported a lot of systems implemented without a formal training. Lack of transparency and openness regarding shortage of staff, clients are insulting nurses. The negativity from community members makes supervision in the facility very difficult. The OPM reported a need for assertive managers, regular supervisory visits, resources, support from the provincial and national levels of government.

Generally, the eight participants showed a lot bitterness, frustrations and burned out.
ANNEXURE O

Field Notes for Sub-District D

Descriptive notes
In sub-district D the focus group interview took place on the 7th December 2016. The interviews started at 13:00 in the sub-district boardroom. The total number of operational managers available for participation were five and all the three health clusters in the sub-district were represented. The description of the representation from each local area is as follows:

Cluster A
The cluster health A is represented by a female professional nurse who is an operational in a 24hr PHC facility. She is being in this position for the previous 12 years.

Cluster B
The cluster health B M is represented by a female professional nurse who is appointed as an operational manager of a 12 hr PHC facility. She is being supervising the facility for the past five years.

Cluster C
The cluster health C is represented by a female professional nurse who is appointed as an acting operational manager and she is placed in a 8hr PHC facility. She is being acting in the position for one and a half year.

Non-verbal cues
During the discussions there were non-verbal cues that were observed and it is written as follows:

One of the participants showed excessive anger and burnout throughout the discussions. The participants presented with some stammering voices, low and high tone of voices and showing some anger, frowning faces and looking sad during description of their experiences.

Methodological notes
All the four participants were given the opportunity to express their experiences and thereafter the follow up questions were made immediately. The probing questions were not adequate because time allocated that was limited because the participants were also attending the workshop.

Personal feelings
After the interviews the researcher felt that some of the nurses are experiencing a very serious burnout because of lack of supportive supervision.

Theoretical notes
The participants reported favouritism leading to poor supervision and support from their managers. Shortage of staff, lack of appreciation, blamed for poor facility performance, use of own resources, Not helped in problem identification and resolution, lack of staff discipline and lack of openness in communication.

The participants reported a need for reshuffling of managers, a platform where OPM can express their concerns and communication to be improved and be helped in problem identifications and resolution. Generally the four participants showed a lot bitterness, frustrations and burnout.
ANNEXURE P

Interview Guide

Question number 1
Can you tell me your experiences regarding SS in PHC facilities?

Question number 2
Can you tell me how can SS be effectively facilitated in the PHC facilities?

Developed by researcher: MG Serapelwane
ANNEXURE Q

Sample of a Focus Group Interview Transcript

Focus group interview of sub-district A

R-Researcher

A, G E etc.-Participants names

All—all participants

R-Good morning ladies and gentleman and how are you

All – Good morning Mam

I thank you very much for agreeing to participate in this research and also for signing the consent form. My name is Masego Serapelwane I am a professional nurse, lecturer and a PhD student in the North West University in Mafikeng campus. You are welcome in this interview session. Our discussion will be based on a framework of supportive supervision for operational managers in the PHC facilities of the North-West Province. The discussions will be based on the two broad questions which are what are your experiences regarding supportive supervision in the primary health care facilities, and How can supportive supervision of operational managers be effectively facilitated in the primary health care facilities of the NWP. I will facilitate the whole discussions and the official language for this research is English. The conversation is audio taped. There are cards with alphabets in front of you, so if you want to say something you just raise a card and you will be given a chance to talk. So feel free and let’s respect each other’s point of view. Remember that you are allowed to withdraw yourself from the interviews when you feel that your privacy is invaded. The information from this study is going to be published in such a way that it does not reveal your identity as well as the facility and sub-district name. No one will have access to the raw data meaning that audio tape as well as transcripts will be kept safe under lock and key. The people who will have access to the data before actual publication are me and the promoter of this study.

Okay now can we start with the interview are you already can we start with the question

All-Yes mam we can start

R-Tell me your experiences regarding supportive supervision in the PHC facility. Okay Participant H your hand is up

H -Thank you (clearing throat) eh..(looking down) eh…mmm Ms Serapelwane. My experience in terms of supportive supervision eh-mmm.. is lacking.
H continues-(clearing throat) my supervision in the clinic is lacking especially when you are alone. also hands on and consulting clients because most of the time you will be depending on verbal instructions and sometimes an instruction come after a mess has happened and because you could not check, to check on what people are doing sometimes you even forget to write down the delegation. you will only realise when a mistake has happened.

H continues-So in terms of eh eh when I compare the institutions eh eh I think operational managers in our sub-district who are working in 8hr clinic with enough staff, eh eh they are able to supervise unlike 24hrs clinic with limited staff they are unable to supervise.

R-Mmm okay Participant A and G you are noted. Can we agree that we allow Mr H to finish then you will be given your time to talk and thereafter I will make follow up questions.

All-that okay yes mam

H continues-supportive supervision visits from the sub-district is also lacking because local area managers are always attending meetings they will always say they are…, they are busy. So in terms of health centers (voice pitched) there is a mess because a health center is big, has got different sections that you are to supervise, all of them, and you cannot focus on primary health care only. You have to look at the administration and this is a serious challenge that…, that I think it needs an intervention. Like when I started at CHC (community Health Centre) B (not the real name given by participant) I wanted to divide the work so that there should be somebody working for PHC somebody working for IMCI, or somebody working in MCWH, but I could not eh…, eh do that because of lack of staff and there was no one willing to supervise MCWH.

R-Mmm

H continues-There was in fact no trained eh….eh PHC professional nurse except the TB coordinator where I am working so the supervision is lacking. Sometimes when you are OPM at CHCs you are also acting as local area manager, so you will be supervising other clinics, peripheral clinics so which is a problem sometimes you don’t do any supervision, all the day you are on telephone phoning other institutions that are not complying with the requirements of the department of health so there is really lack of supervision in the clinic and in general.eh…, eh…let me give others a chance to say something.

R-Okay thank you participant H if you don’t mind I will come back to you for follow up questions.

H-I won’t mind

R-Participant A let me give you a chance to express your experiences about supportive supervision

A-Eh….Yaah supportive supervision is lacking in most of the areas because sometimes..eh..eh I agree with him. Sometimes you want to…. to make sure that this programme is running smoothly because there are so many programmes from the department. Whereby we have set targets and we want to reach them but the manpower and then the experience like you will be talking about NIMMART.
A continues - If you want to do something in NIMMART, they stopped training the staff and that programme is not yet reactivated so with few staff that we are given, so when you want to do support supervision in the clinic you need to be hands on and train at the same time. When you turn your back you don’t know what the person is… is doing. And some of the programmes as they come to us they don’t tell us before what is it that we have to supervise on. You understand, you are just told that you must reach the target but you don’t know how to go about… you don’t understand. Then it gives a challenge also to make people you are working with… with to buy in so that they cooperate. Most of the staff they know about making the people to leave the clinic or to push the long queue. So if you come with other issues it becomes a challenge to make other people buy in.

Researcher: Mmm

A continues - The other issue, ehh… the other issue about supportive supervision is that sometimes I… I… don’t know whether it can be a sort of, I don’t know a gap whereby the experienced people in the facility they don’t go according to the organogram of communication channel. You will find that what is done here maybe you didn’t get it well. It goes to the highest supervisor the… to the sub-district manager, and once it is there now it will come back as an instruction, and now as an OPM I will feel that its like… its like eh you are being… its not like a support but a demand or a negative criticism of why this and this is happening so we have that, and that makes everything a mess in the facility (silent for a while, eyes blinking).

R-Okay Okay

A continues - I will stop there for now (with a very low tone of voice)

R-Okay participant A I will come back to you for a follow up questions. Participant G your card was up do you want to say something.

G-Yes thank you madam chair, I am experiencing a lot… lot of challenges (voice very low ) and I also agree with colleagues. I am allocated as a facility manager since… let me say I am one and a half year old in the acting position. I am not having a management course. I am put on the post I am acting. I am just… just put on the post but I am acting. I am experiencing a lot of challenges (voice very low ). I work with one professional nurse who is inexperienced, she is doing community service. When I am not at the clinic like today the performance indicators will suffer because she is not having enough knowledge of the indicators so the facility is not doing well.

R-Mmm

G continues - During the performance reviews in the sub-district we are asked so many questions regarding the indicators so I am suffering. I am not supported (with a raised tone of voice) I am not getting supervision and support at all. I also work with an assistant nurse and you know assistant nurses they just do the vital signs and work in the dressing room. The most of the work is on the shoulders of the operational manager so I think we should be placed on a post when we do have management course. I think when one has management certificate will know what to do. Just imagine been taken and put on the post and being told that you should act so… (with a frowning face) the staff members are so difficult and what worries me is that I have never received a visit from programme managers since last year march (9months) until now. I worked as a facility manager for more than a year but I have never received a support visit even from LAM (with a frowning face).
G continues.... I have written so many letters of a staff member who doesn’t want to work I am experiencing a very very serious challenge at my clinic, and I think maybe is because I don’t have management course I don’t know how to handle a difficult staff, how to discipline. I don’t know how to manage a difficult staff...(with a frowning face). You can ask for support they just say you are not supervising so its so painful to me (with a low, hesitating voice).

R-Mmm

G continues-The clinic is not having even a telephone. They have given us... us a cell phone and you can stay for more than three months without airtime meaning that for all these months you will be using your own cell phone (shaking head). I will pause here (looks sad)

R-Okay, okay remember I should make some follow up questions and lets give participant E a chance to express her experiences regarding supportive supervision.

E-eh...eh...mm I think colleagues have said a lot but I think I can add. With supportive what supportive supervision I think... I don’t know, even support from other structures other workers like for example like HR (human resource)...neh, people will be in need information and is like no one will visit from HR and say...just to give information concerning work related issues. People will be doing things wrongly because they are not informed they don’t know what they are supposed to do. They don’t know some of the things the rules so you will be like suffering because your manager is always saying that we don’t discipline and you are not supervising. How are you going to discipline a person who is not having any information?

R-Mmm

E continues....So like my colleagues have said with the workload, there is shortage of staff and you will be expected to do administration of the clinic and be fulltime again on the patients. You do a lot of work, double work and sometimes you get exhausted because even the supporters those who are supposed to support you they cannot just come and help with some of the things especially staff discipline....

R-Mmm

E continues.....The managers will give you information, you are supposed to take it to staff, I think the staff members also need managers to come and express themselves because they will be asking questions that you alone cannot answer. Maybe if they can come to explain some of the things and handle some issues. More especially during the beginning of the year so that people can work properly. The managers should also be involved in giving information to staff members. I think that can make supervision on my side as an operational manager very easy.

R-Mmm

E continues......I think even the orientation, when you are taken for from one position to the other you will need somebody to come to you to say this is A you are supposed to do like this and this. In my situation no one did that, I was just taken to the office without any orientation I see for myself...you will see for yourself (with a frowning face), I don’t know if whether they are taking it for granted that I have been working in the PHC facility for a long time. I think that is all that I wanted to say.
R-Mmm, Okay, okay I will come to you with follow up questions. Maybe I should go back to participant H. you are noted participant A let me first make some follow up questions I will come back to you.

R-Eh participant H I seem not to understand when you mentioned you being working alone, what do you mean.

H-When I say working alone I mean working alone at the clinic as a professional nurse with an assistant nurse or two assistant nurses and being appointed as the OPM and doing professional nurses work duties at the clinic being alone.

R-Can you describe the professional nurse duties, what do you mean

H-Rendering PHC services all the services of PHC..ANC, general cases, there is IMCI, including all human conditions.

R-Okay, okay I do understand. You also mentioned some verbal instructions can you describe that for me

H-Verbal instructions you will be… as you will be alone you only can supervise when you give instructions because you can’t go physically to supervise a particular person you will also be doing PHC services so the only time is when that particular person has done wrong you go and correct her you can’t move from one subordinate to another subordinate

R-Tell me more about the verbal instruction you are talking about

H-I said let’s take all the vital signs including measurement of weight then the person decided to take some and I reprimand and I gave an instruction and said I have said you must take all the vital signs.

R-Okay, okay and you also mentioned some mistakes that will be happening can you describe that experience for me

H-Can you come again?

R-You mentioned some mistakes

H-If there is no supervision there is going to be some mistakes and as a supervisor who is experienced you can correct that but if somebody comes from outside or just new from school you can’t work alone and if you work alone there is going to be a mistake, and we are having a lot of programmes coming whilst she/he is still at school so we have to make him learn those programs, but if you are working alone you can’t, you only say verbally that this programme work like this, but you can’t supervise it. You are expected to do this and this in this programme but you can’t supervise and then you will realize that there is a problem when a mistake has occurred.

R-You also mentioned some lack with regard to supervisors what do you mean. What do you mean by supervisors?

H-Like I am a supervisor, at times lam acting as a local area manager , as a local area manager so lam unable to supervise other clinics because of lack of time, in most cases lam acting and I will be in the sub-district… eh maybe attending management meeting so I don’t have time for supervision of my own clinic.

R-Okay, okay so you are also acting as local area manager
H: Yah.. Yes

R: You also said that they can’t go for supervision. Can you describe they for me what do you mean

H: They I am including myself I can’t go for supervision because of work. I am doing a lot of work

R: Can you tell me more with regard to they can’t go for supervision

H: They I am including other people like programme managers, local area managers it is also expected for them to do all clinic supervision every month. I don’t know if I have answered it like you wanted.

R: Okay, okay and you also mentioned that no one willing to supervise MCHW can you tell me more with regard to that

H: I think it was just an example gore (meaning like ) if maybe you have four sections and in order to have professional nurse in each section you will find that the person is working at the IMCI and expected to do other consultations. That is where is going to be lack of supervision because you will realize that there is a particular person in the other section not supervised like a COMM.SERVE (referring to a professional nurse on community service).

R: Okay, okay I understand participant A your hand was up

A: I just wanted to add on what he was talking about. I will just fall in the middle there. He was talking about the COMM SERVE with support and supervision in the facility they will be the sole people you are depending on. Then you want to supervise them, then you are working in a CHC sometime you have an emergency on the other side and you are also having a delivery on the other side. So it is difficult for you to divide and say let me go and see how is she delivering or how is she conducting an emergency or how is doing this procedure or just in the consulting room. It becomes a problem and then you are only told when the problem has happened because you couldn’t reach everywhere.

R: Mmm

A continues...... Then the other thing is about... let me say we have people who are placed on programmes that which is difficult for us to get inside to supervise them. They will be saying they report to the sub-district manager and now they are staying in the CHC. Let me give an example of PHC re-engineering you will find that the whole week you want to know how this person is working because is a senior sister. She can give a hand because she is reporting beyond you, you don’t know how to touch these person and how you can help her. you will realise that she is roaming inside the facility and you don’t know how to deal with that, because when you talk you want to reprimand that person it means that whatever you will be saying to this person it will go beyond the highest level of management and when it comes back it is a demand and you will be threatened of how do you supervise other people.

R: Mmm

A continues...... But you are going to be reported directly to the PHC manager and it comes back like you are wrong. This makes the facility to suffer because you will be afraid to talk the right thing because you don’t know how they are going to take it. It happened that I reprimanded sister Dineo (not a real name that was said by the participant) before even the end of that day I was called by the sub-district manager she questioned me about that. So when it
comes back it will be like why do you do this so your supervision in the facility is difficult to implement because you don’t know how and where you stand.

R-Mmm

A continues...the other thing is about programme coordinators we need support from them, and maybe they should be given a chance to go and further their studies because we can’t..., maybe to give an example we have the other one who is coordinating mother and child but I don’t know how much support and in-service training is going to give on things concerning labor because her …because of her level of education because we have advanced midwives and she is supervising an advanced midwife like me. (giggling...khi..khii..) I don’t know which information she is going to give us the midwives or will she call us to train us on what… (voice raised, showing with both hands) that brings a challenge because she is coordinating MCHW programme without advanced midwifery skill.

R-Mmm

C-let me add on what A has said neh, we are also having a mental health coordinator who lacks confidence on what he is supposed to do. He is supposed to help us in the whole sub-district and even the training he undergone I don’t think is beyond anyone who has done the basic four year diploma. So what is that is he going to add to practice because isn’t that we want to run the programmes according to the standards of the province so we need that they should be empowered so that they should supervise us with confidence. The Programme coordinators even the one for MCWH that one is a disaster.

R-Mmm

C continues......So we are sitting with the knowledge that is confusing, are we adding on practice or are we still moving with what we have that is a challenge. The other challenge is that we are expected to plan and implement, to monitor and at the same time we are hands on. it is difficult to supervise something whereas the whole day we are in a tick register (referring to E-tool-head count register) you are consulting the patient, you are to supervise...how many patients are to be screened for TB and sometimes we knock off being disturbed mentally psychologically, you come to work being demotivated that’s a problem and then we are not called to say… say what happened here before I can be pinned down (rubbing nose with and blinking eyes). So it is really traumatising.

R-Mhmm

C continues......I must be supported by my supervisor to hear from me on what went wrong in order for me not to reach this. So most of the time it comes back like..., like I have done something very wrong without my supervisor looking at the situation in the facility, how I was working in order to reach this performance, and then also in all the indicators what is going on…., in this facility, We expect the supervisor to come with this advice to say how about doing it in this way in order to reach your target or try it in this way. The only thing that we get are reprimandments or instructions to say do these do that which is a problem.

R-Mhmm

C continues......The other thing is that we don’t get enough time for supervision because we are overloaded with a lot of work. There is IRCM, the clinic have to perform according prescribed standards of IRCM and at the same time I have to see that the staff are working according to the National core standards, and the very same facility manager
is hands on. You understand Even the local area manager I don’t know she will be using clinic supervision manual and there and then she will be saying something about the National core standard, there is IRCM you see she don’t know which one to start with. In the facility now which one to implement? all of them. Everyone is asking that information and the programme coordinators are also asking for something, you understand so the support is little and all this it is coming on the heads (pointing head with a finger) of the facility manager. That’s why the performance of a normal human being it’s a little bit down.

R-You talked about confusing information what do you mean participant C

A-The thing is let me say this is January at the end of the month I have to give information as required by DHIS (District Health Information System) and I have to report on what is it that I have done with regard to National core standard, IRCM everything is expected from me. You are not given a chance and say ok this time you are going to push this programme you understand, everything you have to do at the same time so it becomes too much and overwhelming. We have a lot of programmes and you have to cover a lot of things and if maybe somebody can say this is how you can implement this guideline, or to discuss other things that should be done with somebody and to give you a morale of focusing on one thing. So everything is like the facility manager is alone and too much is expected to be reported at the same time.

R-Okay, okay what do you mean by IRCM

C-Ideal clinic realization model

R-You mentioned that you will be reprimanded can you describe that experience

C-A professional can report you directly to the sub-district manager and what is worrying is that the senior manager won’t say let me have a meeting with both of you noo...(shaking head), you will just receive a call threatening you about a problem. I understand that we solve certain problems at a certain level and when it cannot be solved it goes to the higher level like to the sub-district managers’ level. At the same time when you talk about something in the facility at the end of the day or before the end of the day you will get a call the senior manager asking you about that issue this is a problem (frowning face).

R-Now can you tell me the experience with regard to that what happened

=C-(with a very low voice) What i mean is that there are many things that we do good in the facility I don’t feel acknowledged of whatever I do that is my experience (looking down) My experience (blinking eyes, rubbing nose and voice low) my experience, it has taken me very bad and it has broken my morale it has made me not to work or perform at my best because i don’t feel confident,

R-You don’t feel acknowledged on what you are doing

C-I feel I am incompetent (looks sad)

R-What do you mean by acknowledgement? Participant A answered

A-you know what mam I expect my supervisor, my senior to be the last person that comes and reprimand me especially in front of your juniors, that is the last thing you could expect because there are other platform that another person your senior can come and say let us discuss this one…I understand that your junior came to me and say this
and I think we can handle it in this way but instead it comes where there is a cleaner, clerks the reprimand will just come like that and you know it is so embarrassing so that support I don’t feel it (looks sad).

R-You look sad when you talk about a reprimand

A-(With a very low voice) It is painful and embarrassing to be treated like these

R-Mmm… okay, okay I see but participant C I seem not to understand when you say you feel like you are incompetent can you tell me more with regard to that

C-(voice raised) I don’t feel like I am competent because minor issues, because minor issues I feel I can handle it on my level. I don’t expect my senior to come in and ask me in front of my juniors if I managed to solve minor problems. Is better in the way that I will be able say ohoo that’s where I went wrong then I think I can correct it myself. In the sub-district the manager will come from above and tell you that she heard or asking why is this not being done at this level. It will be coming in like this and it becomes too much in the head of the facility manager (frowning face).

R-You mentioned that you were reprimanded in front of juniors can you describe your experience with regard to that

A-That is what I am saying that, to be reprimanded in front of the people you are supervising it’s painful, it makes you down totally down (silent for a while) even if you want to supervise even the cleaner you think twice and it makes you not to think straight (silent, rubbing nose, blinking eyes) you don’t go and say I will work beyond because you work (jumping to another statement). Even if like in case of a child, the child has collected this water and you say thank you.thank you. It will make the child to go higher and higher. So if your supervisor is not appreciating what you are doing it becomes a problem (looking sad).

R-Mmm. Maybe I should give participant E your hand was up remember I still need to make a follow up questions

R-E you mentioned orientation can you tell me more with regard to orientation

E-I think when you are new you are supposed to be given some information about some things that you have never experienced before

R-What happened can you narrate your experience with regard to that?

E-I was just given an office and there was no one there. I am expected to perform, they expect me to do the work, how can I do the work, (with a raised voice and looks sad) how can I do the work that I have never done. I was supposed to see myself through. So sometimes the supervisors may think that you are not doing the work, only to find that they didn’t take you through what you are expected to do. they should say you are expected to supervise and do one, two and three.

R-Okay, okay I don’t understand when you saying there was no one there

E -I think when you are given a post you will need somebody for some days even if it can be two weeks, this person should take you through so that you should have an idea of what is expected from you.

R-You also mentioned that maybe managers should come and handle some issues. Can you tell me more with regard to that?
E-Yes with regard to staff shortage it causes conflict and the staff they will be saying go to the management and say this and that. Management will send you back to them and say maybe we will give you nurses maybe after sometime next year. So I think the management is not supporting us on handling staff complaints, they should be the one to come and address staff so that they should experience and hear what people are saying concerning shortage. The staff members think that they are not treated properly because they are overworked. So the management will just say tell them that I will give them the nurses after financial year or what, and sometimes the staff has something that they want to tell the management something that they want to communicate to the management.

R-Tell me more about the conflicts that you mentioned

E-We need help on how to handle this because now the shortage pressurize nurses to take sick leave, people will be just take off and stay at home. Is either sick leave or she stay home so you have to work, so those who are on duty will say look at the off duties these one and these one are not here and this one was supposed to work 7 to7. So you will be compelled to take 7to7 because you are a manager you cannot close the clinic.

R-What do you mean by you are supposed to take it.

E-They will say I work from to seven to seven I will not make another 7to7 so you will see as an operational manager what to do.

R-You will see as a manager what to do.

E-Mmmm... and it will mean that you have to take those hours just to maintain clinic coverage. So we also need help on handling certain issues clinic coverage is a big problem because of shortage of staff.

R-You mentioned some lack of information from HR what do you mean

E-Okay, lack of information like PMDS people are not getting PMDS and are always saying I have been working so hard for about years so I don’t get this PMDS so it means that I am not doing anything I am not working. It is like their morale always goes down.

R-Its like their morale goes down

E-Yes yes

R-What do you mean with regard to that?

E-I think akere like myself I don’t know how it is done. Who is supposed to get it that is why I say I think those people sometimes they can go and attend the staff and give the information about the leave and about PMDS.

R-I heard you saying that you don’t know how PMDS is supposed to be done. What do you mean actually?

E-Mm it’s like meaning even me as a professional nurse i have been working for so long i think i got the PMDS when I was still an ENA long ago. This is my ninth year I have never received or get a PMDS. I don’t know how it is done who is supposed to get it I don’t know (raised voiced)

R-Who is supposed to get it you don’t know...
E-I don’t know

R-Can you tell me more with regard to PMDS?

E-With this PMDS like I said when you try to delegate somebody this person will say I will not do this because I am not recognized. Sometimes some people will just say repeated people will get that PMDS so people will say so and so is the one who is working and will say go and ask Mary to do that because she is the one who is recognized by the managers.

R-What do you mean by she is the one who is recognized by the managers

E-Like they are rewarded, people will be taken to training, sometimes they do not take long again they will go for training again. Somebody is just here in this waiting list.

R-What do you mean by somebody is just here in the waiting list

E-What is happening is that the same people will get PMDS and be the ones who are taken for study leave. Some will remain in the waiting list.

R-Okay, okay I understand

E-Yes mam

R-Participant C your hand is up

C-I like to add with regard to PMDS she is very right it brings a lot of confusion because apart from a person who will go for training time and again. You will find that the same people the same names are getting PMDS each year and they get a lot of money, which could have probably be shared, be shared maybe by ten people but this person is always getting this bulk (showing by hands) this bulk every time. I wish that they should be advised by somebody and tell them that if the person deserves an incentive they take her for training or if you go for training you will not get PMDS. But in this sub-district there will be people who will be at the training and she also get PMDS

R-Mmm

C continues...So, it becomes a confusion for those who are remaining in the facility, they have been applying, and they are not granted a study leave and because for study leave you also get PMDS. So this one is also a challenge and people are really booking themselves sick and some are requesting leave time and again. I have been working in the PHCs since 2010 or I have never received a PMDS, and I am myself I have not ever said I will not work but I see same people getting PMDS. So far the picture I see especially nurses...people are so demoralized.

R-Ok still there participant E I heard you talking about delegation and PMDS can you describe the experience with regard to that

E-Like there is one cleaner that person is like she is always followed for her to work. She will come in the morning she will disappear and you will look for her until you get her chatting with the clients but she will get PMDS. But those who are struggling and trying by all their best they will not get. So they will say go and ask that person because she is the one who is getting PMDS. So it is difficult to delegate because of these PMDS.
R-Okay it’s difficult to delegate okay is it all that you want to say with regard to delegation and PMDS.

E-Even for the professional nurse they will say we are not getting PMDS and you expect us to fill up the space for shortage. They will say I am not reporting the things like these and with shortage they will say to me…you are enjoying this type of shortage, you are enjoying this type of shortage, I am knocking at 04:00 even if there is no one to relieve like yesterday (looks sad). The patient came to call me in the meeting in the sub-district performance review, the patient came and knock and asked for help. I had to leave the meeting and go and to attend them. They were just… the two professional nurses just left the clinic at 04:00 and directed the patient to where I was attending the meeting (with a raised voice). You see is because people think that I am not reporting on what is happening at the clinic.

R-Mmm

E continues..... I also need help from my supervisor that’s why I am saying they should come and address some of the issues especially shortage of nurses. The next thing they will be saying I am not supervising (looks angry).

R-Okay, okay I do understand. I saw participant G smiling when participant E was talking do you have something to say.

G-I am smiling because I was there when the patient knocked at the meeting and this are the challenges that our supervisors are not taking them into consideration. They just focus on the patients, the patients should be helped. That is why she was to leave the meeting because the patients can’t wait.

R-Mmm

G continues...Those are the challenges mmm...like I have said previously we are only two at the clinic with a COMM serve and I am experiencing a challenge more especially with the immunizations. The immunizations are not done appropriately according to the tick register (E-tool). I don’t have time to supervise the COMM serve because I am also hands on, he can’t do work alone unless I am there to show him, on how to immunize and to record...(with a frowning face) he continues doing the wrong things. He can’t accept even when I correct his mistakes, he can’t accept the mistakes and he makes he is very difficult.

R-Mmm....

G continues.....So the other thing is a grounds man since, I have written report for him several times because he is not cleaning the yard. We get zero every now and then in clinic assessment on ICRM and this person is travelling everyday but not doing his job. I reported him several times to the sub-district manager so sometimes she release two people to talk to him and after that and after that they will say I have to write a report about this person. So it is unfair because they know him that it’s very difficult to manage this person, you can talk and talk even the person the way he is he can just keep quiet, you will talk alone and he will be just looking at you like this (showing by raising eyebrows) and he will not do what he is supposed to do.

R-What do you mean by they know this person can you describe that for me

G-(raised voice) the… the reason for me to say, to say they know him, this person was working in clinic A, he worked at the hospital now they decided to move him to my clinic the managers know that this person is troublesome, he will be taken from one facility to the other
R- You also mentioned that you wrote some reports about this can you describe that

G- I wrote the report about this person because I have given him a verbal warning and again I warned him. He always absent himself from work with no apparent reason. I recommended leave with no pay last year and even this year so it didn’t help. He is so troublesome

R- You also mentioned that there is this person who is not accepting on the wrongs he did can you describe the experience for me

G continues........This person is a COMM serve i did an in-service training to show him how to treat the TB clients. But still when I audit the card of TB patients co-infected patients are given rifafour, rinfah, pyridoxine and he will not give cotrimoxasole. How can we treat patient like that because it is not according to the guideline. When you call him to show him the right thing to do he can’t even accept that he has done wrong. This person he is very difficult to supervise he will not listen and is because he is always on a hurry to finish the clients. He will frustrate you.

R- Okay, okay, and you also mentioned that you are acting in a post

G- I was just delegated on an acting position without any orientation, I don’t know what is supposed to be done, I even don’t have an office. There is no support because after delegation they don’t even come to check whether you coping or not (looks sad).

R- Mmm

G continues........(with a raised voice) they will be knowing that you don’t know nothing about management issues, and you have been a professional nurse for so many years but that post you don’t know nothing about it. At least if they could train us on how to manage the facility and how to deal with a difficult staff. Even acknowledgement, they can’t acknowledge you I have been a professional nurse but I have never received PMDS. Really this thing is frustrating us we are two professional nurses in the clinic and they expect you to do the management but when they come there...have you done this have you done this (looks angry and sad).

R- What do you mean by and when they come there have you done this, have you done this

G- They will come to you and say have you prepared for ideal clinic, have you done this have you done this, are you prepared for that but knowing that you are always in the consulting room, you don’t have enough time to do administration because the professional nurse you are working with complains of being working alone when on the other hand you trying to push administration work.

R- Mmm…mmm

Can you tell me more with regard to the preparations for ideal clinic what have you experienced with regard to that.

G- There are lots of files for ideal clinic that need to be updated every month. There are no instruments and what I have realised is that every time during the assessment you will always talk about the problems. The assessment team came knowing that previously there were no instruments, but when they come again they will still find the same problem and we will talk about the same problem you understand.
R-What do you mean by instruments?

G-We don’t have instruments but these ideal clinic assessments they want like a delivery pack to, we don’t deliver at the clinic but they insist that we should have that pack

R-So you don’t have instruments for delivery pack

G-The instruments are there but they are few, so every time when the team comes they want to see all the instruments.

R-Mmm

G continues.....There is no phone at the facility, how are you going to communicate with others so that they can help you. They gave us a cell phone loaded with 250 airtime and it is not enough for three months because it is long being finished. We just refer patients to hospital without communicating, the internal policy states that you should communicate with the doctor when you refer to the hospital. So we don’t have airtime and landline phone now we have to use our cell phones.

R-Okay, okay

G-Really this post is frustrating me (with a voice very low )

R-I can see that it’s really frustrates you Mmm

G-Heish (looks down)

R-You also mentioned the policy for referral what is your experience with regard to that

G-Sometimes when we,,we call the doctors they don’t pick up their phones, now when you refer without calling she is going to shout at you and the person you hand the patient to.

R-Can you describe the shouting that you are talking about?

G-Why are you referring the patient without calling me just like that (silent, and eyes blinking)

R-Okay okay

A -getting into the discussion...Can I come in there she was talking about the delivery pack it is because of the standard of the ideal clinic. They can have like before what we have is what you use maybe two receivers with artery forceps. But know with the ideal clinic is a list of things that should be in the delivery pack that is what she is saying she is not having it. She might have the instruments that can bring a baby out safely but its not within a required standard. So she is frustrated of not having the whole full pack. if you have some and borrow other things from a bigger clinic the same clinic will not have.

R-Can you tell me more with regard to borrowing?

A-Borrowing means that if clinic A can have an extra will give to…to Tlapeng clinic. but now Ganyesa is delivering a lot may be they can have full packs maybe let me say five. They cannot afford to take permanently from the other side. Then they will short when the delivery is coming. With the phones she is not the only one there are clinics that
they don’t have. What is happening is that the bigger have the landlines telephones they help the smaller clinics.
what they do they just notify us that we are sending the patient so the patient comes in your clinic now its a burden.

R-Mmm.

A continues.....

So you will have to start phoning because we have the landline to book for the hospital. So for them they will have
to phone without talking to the doctor. So the doctor will pick up the phone, and phone back the sister and will talk
to you in a rough way and you will feel now what i did wrong i wanted this patient to be in the safe hands of the
doctor, and the doctor doesn’t feel like that he will be feeling that you could have discussed the patient before referral
so that’s where the shouting come.

R-Okay, okay I understand

R-Yes participant H your card is up

H-I will also come in with my experience with regard to the delivery pack, is a challenge to us because in the past
we used to just make a tick and autoclave the pack. Now with the new system even if you have sealed the pack they
will just open the pack to see if all the instruments you have listed are in the pack. So is a challenge because you will
never be green on assessment you will be red or orange.

R-Mm…

H Continues.. I have the experience with the grounds man of clinic B because I was an operational manager there
before. With regard to the particular grounds man i am the one who started to discipline him. He is a very difficult
gardener he will, will just come stupor not answering any question not standing up where he seated doing nothing is
a very troublesome worker. I wrote her two letters but nothing was done because according to my experience,
professional experience when I wrote a warning letter about an employee or a supervisee, I have to take it to the
labor relations officer, and the labor relations officer must make sure that maybe the necessary actions are taken. In
this sub-district those labor relations activities are not taking place (showing by hands) the necessary steps are not
implemented.

R-Mm…

H Continues..... My experience with the workers there is one of them who does not want to be supervised she is
used to say sir leave me alone so that i do as I please. Even yesterday he told me that after finishing the work she
will go home. this person was supervised by the other manager who resigned. The director knows about her I know
about her eeh she is well known even the student who attended with her knows that she is a trouble maker. So
actually I think we need to be helped on issues of difficult supervisees like the ones we are having in the sub-district,
or maybe they should train us on how to handle a difficult staff

R-Mmm

H continues......So with this one, she is able to influence everything when I come with something even if she knows
that it is right she will influence other workers negatively. So she is making supervision for health center D very
difficult. She called the media MEC came to health center D. Nothing will be done to them because I heard in the

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corridor that **ech ech** the province do not have the policy for media. Some of the things of supervision my experience with regard to that is they are so difficult. Because of this supervision cannot be sustained because people will follow what these difficult one is doing deliberately because sanctions are not implemented. Even if she can hear that somebody has done something and I do not take action she does it she is so problematic.

**R-Mmm**

**H continues**......Another experience is availability of trade unions and maybe the rights of workers sometimes workers do wrong you supervise you come up with sanction and the union win the case. but in general according to my experience there is lack of sanction people are doing a lot of things here and I have been in this sub-district for more than three years and I have not seen someone being sanctioned seriously and there are many wrongs things that are happening here.

**R-Mmm**

**H continues**......Another thing I don’t know what happened in the past **ma** where I supervise I have seen people have developed a dependency syndrome. Most of the things are done for them and I can’t do things for my supervisee, I have to check as to what you are doing is right. so there is a lot of dependency in my clinic. and that’s what makes the situation worse am unable to do what am hired for so those people are over helped even on small things reporting on what you have done like reporting on PMDS. They don’t do that and the next thing then I should come and score in fact we must score them in their presence but they can’t feel their PMDS.

**R-Mmm**

**H continues**......Another thing my experience in supervision, **(with a raised voice)** the calls… calls from the sub-district office can delay you in the morning when you arrive at work there are lot of calls who ever speaks is for the long time. He she will be demanding a lot of things if you say those things are not there she will force you to speak further, and bring those things and you cannot go and look for all what is wanted. When you arrive there, there will be phone calls manager phoning, human resource office phoning, programme coordinators phoning just like that you will stay there until 10. From 8 to ten you have done nothing you even fail to check if people have accepted delegated duties. Yaah because of lot of telephone calls which are delaying in fact they making you to forget most of the things.

**H continues**...... I am supervising aggressive workers especially after media cases they are troublesome even yesterday we have CHC reviews most of the time we disagree, arguing because people don’t want to do what they are expected to do. Arguing about simple thing TB screening was below the target, but we didn’t come up with a single point of why TB screening was low and i was expected to answer here in the afternoon sub-district review they are very troublesome.

**R-Mmm**

**H continues**........ Here the common practice is when somebody has taken leave without informing you have to grant that person a leave without pay. But it seems as if people are enjoying a leave without pay is enjoyable is doing them nothing.
H continues......Another thing that makes supervision difficult is like sister A says she is saying that supervision is from above. I agree, you will find that somebody is being delegated and you don’t know as the facility manager. You will realise when that somebody comes to you and say but I have been asked to do this and that without your knowledge as a supervisor. So it makes me to have some difficulty in terms of supervision. I think that is what I wanted to say we can’t sustain supervision eh.eh supervision. At times you supervise they agree and after few months they don’t regard policies and guidelines.

R-Mmm

H continues... I become so frightened of nurses not following guidelines, you cannot work without the guideline because they are the ones that they are guiding us...the department in order to attain the goals. I don’t know...we need help to sustain supervision in the facility.

R-Mmm Okay participant H okay participant A your card is up

A I just want to add. Some of the other challenge is that sometimes when we do the ideal clinic they come and say do you do the staff survey. The sub-district is not following the staff survey, so that they should know where are the challenges are. So that they help us and support where they see that we haven’t score well at question where people are saying is a problem. When they come they come for patient satisfaction survey but for us no one is caring or concerned.

R-Mmm

A continues......Then the other thing that makes supervision a challenge and people not to perform is the delay in translation of, of people’s ranks. Sometimes you will find that there are those counselors who are taken to go to school like nursing assistants, now they are qualified and they are still placed at the rank of cleaners, some are still in a rank of care givers. When you delegate her she will be pulling her legs.

R-Mmm

A continues......The HR is not doing justice to the newly qualified ENAs. And remember that they are very scarce because their training was cut off. We need them that person who is to be with you when she is dragging her legs and not supporting you is a challenge. Because she will be saying even if she has finished school she doesn’t know where she stands.

R-Okay, okay let me just make a follow up question to participant H. you mentioned that people are unable to fill up the PMDS form what do you mean.

H- With PMDS there are some of the KPAs there, so you have to respond to those KPAs especially where you are supposed to say something that you have done. So they can’t even write that because the clerk who was there used to write everything for them. So that’s why they cannot fill up the space. So I said they must fill up because they are the ones who are working so you that you just type what they have said about themselves.

R-And you also mentioned that eh eh that delegation is from above can you describe that for me

H-I will be working with sister G and you find that she is delegated to do something that i was even not told about. Then i will see her doing something else that i will be surprised and ask why you are doing these. For example when
they were electing information forum i did not delegate somebody from my facility to be part of the forum. I was just told that eh sister so and so will be in the forum or i will only hear that sister say iam going for the forum meeting. you see they will not inform me before that is what i wanted to explain.

R-Okay I understand. Participant E your card is up

E-I just wanted to add on what is said about filling of the PMDs forms. It seems as if we are in one sub-district and it seems as if we differ with other districts. At the hospital they will write everything for the subordinates. In our sub-district, they will say we write what you have done, somewhere they will say you…, like he said you are supposed to write everything that you have achieved. Then people here in our sub-district will write what was written last year. They will repeat what is missing like participant H saying data capturer will do it for everyone. You will just take information from last year and maybe change only the date.

R-Mmm…

E continues...Like I said I think people need to be trained. HR should do an in-service training to teach people how this is supposed to be done maybe we will have a common understanding.

R-Mmm…Okay participant C do you want to say something

C-I just want to add on what she is saying she is right. Some of the things are just being happening and you wonder why. There was a time we were supposed to submit the PMDS report. Each clinic have to submit to the local area manager, surprisingly there will be this person one of the facility managers she submits her plans directly to the sub-district manager, and, and but we don’t have to question that.

R-Mmm…

C continues...This is the support that we need even mentally with PMDs when we submit you can be returned because it was not written well they say go back. But this facility manager with three nursing assistants they all submit the same copy and somebody just signs. All those documents they were brought directly to the higher person… the sub-district and they were accepted by the panel.

R-Mmm…

C continues....It makes somebody to feel that we are not supported because this person works in the different way and they cannot be returned.

R-Participant H did you want to say something

H-No iam okay

E.-Let me comment about, there are lot of complains from the clients. The clients are complaining about long waiting time. This is happening because of lack of staff so this thing is reported at the province, but i don’t know, we don’t get the support from the province because patients are reporting us directly to the province. I think somebody from above should come and ask why too many patients are complaining. This can help us because maybe we can express ourselves with regard to the situation we find ourselves in. I think they should come and see where we are working not to the management.
R-Mmm…

E continues... They should come to us, to see the situation that were are in maybe to see what we are going through because is too much (with frowning face)

R-Okay, okay participant E you mentioned some complaints can you tell me more with regard to those complaints.

E-You will begin like priorities to say such patients should not wait for more than two hours or whatever. So if you are the only person in the clinic how are you going to make this happen. The clients are reading, (showing by hands) it is there in the walls in the notice board, they are given an impression that lam going to leave the clinic within an hour because you are just alone maybe with an assistant nurse or just a staff nurse and they will not listen to you. Even if you say lam just alone maybe somebody is not on duty somebody is sick they don’t take it you said we will wait only for two hours.

R-Mmm…You mentioned something like eh they should not come to see the management what do you mean

E-They are not supposed to be questioned alone the nursing staff or the operational manager should be involved. So the clients will be reporting nurses to the provincial office. Instead of being called they will only talk to the top management in the sub-district.

R-Okay, okay, the complaints and you mentioned that there are lots of complaints

E-Most of the complaints from the community members are about long waiting time and people not satisfied about treatment given... (with a stammering voice)and, and the manager will be saying is because Iam not supervising that is why i am having a lot of complains about the service

R-What do you mean by the manager will be saying that you are not supervising when you are having complains from the community

E-I think they also need to help us in some cases, like we are having, we are having one of the retired nurses the person is not complying to the guidelines and it seems like she doesn’t want to refer or ask for second opinion. Even if you show him how to go about especially with prescribing treatment, and when you advise her and say if you have some difficulties with prescription just call us for assistance.

R-Mmm…

E continues,... So she will just work and we got complains community member saying I was there and I was given this. I was having a serious problem and I was just given panado and I was send back home. So it is very difficult and sometimes she will be very aggressive and not talk properly to the patients or attitude and we will have a complains of nurses attitude. So this managers they should help us (frowning phase)

R-Okay, okay o right okay. Can you describe the support because you also mentioned support?

E-(with a raised tone of voice) I just want to say how is the province helping us, are we supposed to call the media like the other nurses from the clinic did. Where are the nurses and they will be coming and just addressing managers and we the service providers being left out.

R-Okay. Participant H your hand is up
H-My experience after the media was called after that we managed to get two experienced nurses who retired, who resigned we don’t know how they were employed the other one is from Mahikeng the other one...but I was never informed I just saw them coming for work. I don’t know where the directive was from you know but the MEC came after the problem that occurred in Tlakgameng. You see (showing by hands) because of the problem we were able to get the staff...professional nurses. I was not informed about the employment I only saw them at work.

R-You only saw them at work I see

H-Mmmm..

R-Okay

A-So the challenge is do we need to get that level so does it mean that the patient should complain or some people should go to that level of calling the media before they can increase the staff because there is a challenge.

R-Mmm

A continues.... Most of the patient they complain of the waiting time and then it comes back to us also most of the sisters including us there is no one who will go off at exactly four o’clock, or she goes to tea at the right time we just to do everything for the community. You put all your energy there but still there is always that shortage and it hurts because even if you are trying to sacrifice for tea time and knocking off no one from the management even your LAM will come and appreciate on what you are doing.

R-Mmm

A continues..... They are not employing like know we have been having the COMM. SERVE, we had high spirits that these comm. Serve will be absorbed in the system maybe to alleviate this shortage. But it is still not clear whether are they going to be employed in the North-West Province. So most likely this comm. Serve they will sit for interviews in other areas because within the shortest time they are going to go away. And this are the people that we have been mentoring so it comes a challenge it demoralizes us and the managers always say you are not supervising if you are having complains from the community about nurses attitudes, long waiting.

R-Mmm

A continues.....If we get support from the province and those people come down especially during pick hour around ten two o clock, maybe they will think differently and do something because some of the post have been frozen and we are not having enough staff, they could not advertise the post. I also say we need support from the provincial office we need their reassurance.

R-Mmm (quietness observed)

R-I think we should go to the next question, and before moving to the next question remember that everything is captured in the audio but I need to briefly make a summary with regard to what you have said.

You mentioned poor supervisory visits, lack of uniformity with regard to PMDS. You also expressed some favoritisms with regard to PMDS incentives, there is lack of communication between the supervisors, clinic staff, hospital doctors, lack of resources, you talked about shortage, lack of appreciation from top management, lack of
orientation, demoralized staff, difficult staff to supervise, favoritisms makes supervision very difficult, lack of discipline, difficult staff moved from one place to another, difficult delegation. Now lets move to the second question

**How can supportive supervision be facilitated effectively in the primary health care facilities**

**H**-I think in the clinic where I am working the best thing is to transfer the present staff and bring the other one because the present staff members are so difficult to manage in actual fact as I speak they manage themselves. there is a serious problem they don’t listen I am just there to go to work but they don’t listen on what I am saying but maybe things can be better if PMDS can be allocated accordingly **R**-Meaning you are recommending reshuffling

**H**-reshuffling re-shuffling not reshuffling of professional nurses because there is lawlessness. They are thirteen in number including myself

**R**-Can you describe that lawlessness that you are talking about?

**H**-The lawlessness in terms of following the policies you know what they fear is they fear to leave the patients alone before even in my presence they will say lets do this first because with this we will be called so that’s why they are still working. That’s why they see to it that when there is shortage they call one from their home eeh from their own thinking but in terms of following policies if you can say we are told to do this like this referring them to policy.

**R**-Mmm

**H continues....**For instance there is an ambulance that is there sitting there for incase there is an emergency and there is only one driver. They are saying the ambulance must come with an escort and the managers have explained the problem...then I told them that no don’t worry if there is a need for escort, one of them will escort one of them will escort.

**R**-Mmm

**H continues (With a frowning face and raised voice)** They are always questioning even if you come up with a good plan they refuse I wanted to divide the work they refused and it was going to be good. The supervision was going to be easy what they said and you know what they said what it seems especially with this one I am talking about it seems as if she is having a serious problem with the management.

**R**-Mmm

**H continues....**Even if I come with something she will say no this is a management is not from us is from the management. This management has put us into trouble and they don’t want to take us out of trouble. That’s what she use to say(Looks sad).

**R**-Can you tell me more with regard to refusal to escort the patient

**H**-It has not happened now, the ambulance is placed at the CHC it has started this season because of a lot of rain but my experience is that the supervisor of the ambulance came to me and said: I have sent a person, the driver of the ambulance but there is no escort so I heard him saying nurses said they are not going to escort the patient. They want him to provide an escort I said: (voiced a raised and showing by hands) no don’t worry if there is an emergency
they will escort just like during Christmas somebody was stabbed they escorted that person in a car. So...so they are
difficult they can really make you think a lot with regard to that.

R-Mmm

H continues...That’s why I decided to work during the holidays because I was not going to sleep they were going
to phone you see. So it was better because I was with them.

R-Mmm You also mentioned that they are afraid to implement policies what do you mean

H-If there is a policy they will question it even for simple things and you will hear them saying let those who get
PMDS do that (frowning face), they question things that they know because if they don’t follow policy they don’t
screen patients they don’t write on, on patients files for CCMD and obviously the CCMD policy says you must just
give patient treatment and patient should go home. But the thing is you must write on the file of a patient so that this
can improve the patients waiting time. So they are very difficult in following the policies (low voice). I don’t know.

R-So you think that reshuffling of PN can work

H-Yaah, if I have experienced that because at clinic A I was working with only with retired nurse and a comm. Serve
and then I used to train them the way I like and it was working for me. That’s why I am saying if they can reshuffle
and give the clinic junior nurses maybe I can get among these people I can be able to supervise them to become a
better workers. From the experience of what I did at clinic A

R-You mentioned they be having a serious problem with the management what do you mean

H-I was saying serious problem with the management of the institution itself not the sub-district the problem with
the management of the clinic. The problem with the sub-district is that of delegating the staff without informing me.
That is the only problem that I have but I used to refuse and ask them not to do that but know a days I have just given
up because is continuous.

R-Okay, okay then I understand

G-Thank you the madam chair. I will say that they should supply us with instruments so that we can reach the goal
of the ideal clinic. To know how to talk to subordinates knowing that she is the one who allocated you in that clinic
or in that post. And to, to allocate more professional nurses so that we should not work with only one comm. Serve.
Atleast two or three was including facility manager.

R-Mmm

G continues-The programme managers and LAMs to support us, they should come for supervision. They should
train us before placing us on facility managers’ position. This will help the person to render the service maybe as
they expect

R-I seem not to understand when you say they should know how to talk with subordinates. What do you mean?

G-(With a low stammering voice) Sometimes the person can talk roughly with you and maybe you want to do
something she just say owaii she belittle you so they should know how to talk to their subordinates
R-Okay, okay what do you mean by she belittle you

G-(silent)

R-Can you tell me more with regard to that

G-I visited another facility in our local area just for me to bench mark. I wanted to see, copy the relevant documents to be put on the file for ideal clinic, how to arrange that file. So the sub-district manager called the facility manager I visited. So, still there the manager asked the facility manager who is there in your office. Then the facility manager said I am with sister G from T clinic. I was listening and she asked, what is she doing there and the facility manager said no she just want to copy something from our facility so that she can improve on what she is doing at her facility. And the whole sub-district manager belittled me in front of my colleague and said owai..and I was so..so hurt (voice low and showing by placing hand on chest) (All laughing).

R-I can see that all of you are smiling and giggling why are you giggling

A-Is something that you should just have to accept my sister because it happens just like that , and you just have to accept and move on.

H-(With a raised voice and frowning face) That’s why I said I used to argue with her (silent for a while) our sub-district manager is so argumentative she cannot be defeated when coming to arguments. So in order to.. to be eh not hurt emotionally and psychologically you have to accept what she is saying. Even if you know that she is not telling the truth. and she can hurt and belittle you I know her very well

R-Okay, okay, so is the sub-district manager she can belittle you

H-Yahh she is not argumentative only but too directive (frowning face)

R-Too directive

H-She is so authoritative is not easy that you say something you can’t do it. No you must do it is the sub-district manager

R-I heard participant A saying you just have to accept her like that can you tell me more

A-The thing is , when you are employed what, you must know what you want, and all of us we have reasons for working for the department of health. We have other social background problems, we have problems at work, and we stay at work for longer hours so if we take in what comes every day because here there is inconsistency of orders.

R-Mmm

Participant A continues...Every day and where there is sometimes when the instruction say do A. You put down the receiver and try to do A. At 2 o’clock they say I said you must... I dint say A I said B, that… that is that change so you say is it happening to me alone. so sometimes you let go and say I have come here to work, and put aside and try to focus on something because sometime you can lose direction just as I have said from the beginning there you can be like under the table.

R-Mmm
A continues.... You don’t know whether you are going to supervise that person seen and heard the way you have been addressed and you are supposed to be a supervisor. So such things happen you will cry emotionally and there and then you say, let go let me do the right thing. I am just saying to my colleague that at the end of the day you must put aside all those negative comments and go on.

R-I have seen participant E also giggling when participant G saying she was belittled.

G-I once told my local area manager I asked her how is this person of yours and she said he just take her as she is and don’t stress yourself. So I used to hide if I want to go to her I will go to someone and say I am looking for this and this and she will say go to sister E I will say no please go.

R-Mmm

H-You know what makes things difficult because sometimes she will say she has given you an instruction to do this. Only to find that she has never (showing by shaking head) she has never so I used to say no and she will force me to say yes. So nowadays I don’t say no I say I didn’t hear you is then you can win her.

R-Mmm

H continues.... I mean that is the maneuver that I have developed because she will say I told you I don’t say no, I say I didn’t hear you. Is then that you can win that is the maneuver that I have developed because she will say I told you but I will say you didn’t tell me and she will force me to say yes. I told you to do that, so I changed the way I respond to her and say I dint hear you. So it became better just to stop fighting because she will say you are not compliant you (with frowning face) you become frightened when the overall manager says you are not compliant is a very big word to hear coming from a big manager.

R-Yes I understand

A-We have to improve on trust of one another because it the trust especially with our seniors because sometimes is not there. So I we need to improve that whatever is done and whatever is given to us. We should have confidence in each other so that the work can go.

R-Mmm

A continues.... Another thing is as I said we should have consistency in giving instructions and also the trust that I am saying here is that if you delegated me to act on your behalf you must allow me to do that work and allow me to give you feedback.

R-Mmm

A continues..... Don’t come when I am not there and even when I am there and change things and you will hear from your juniors no she was here and she changed this to that. To stick on your role like if somebody is acting on your role let that person do things and let the supervisor come for help when necessary.

R-Mmm

A continues.... Because maybe you are not there and the supervisor who said you must act on her position will come on your absence. Now you will get the report that so and so was in the clinic and said you must do that. You must
move this chair to this place so it becomes confusion and you find yourself with a lot of questions being, and being confused.

R-Mmm

A continues...The other one is give clear information like mr H said that clear instructions sometimes if it does not come from the high level you don’t know which instructions you should follow.

R-Mmm

A continues...We have to go back to the basics of as I am saying respect of one another confidentiality of what belongs to each category. Like as we are here it has been said that everything should remain confidential we respect that. if I am on that level but if the from the highest level matters are passed on to the, the lowest it becomes a problem and some of those are confidential.

R-Mmm

A continues... I think the supervisor should practice openness on us. For example my supervisor is not open to me to say did you hear me when I say this. This means that you are not open enough, I don’t have that braveness to discuss the issue on the table with my supervisor. We leave the issues like that and hence we get instructions from the highest level.

R-Mmm okay

A continues...Now when you are not sure whether you got the instructions right because of lack of openness the person will just come and instruct you and go. They are not open enough to discuss issues she just instruct and leave.

R-Mmm… mmm

A continues … The other serious thing that we must avoid is to discuss the senior person with the junior person because it is a problem. It is like me an OPM hanging my private wearing on the line where is not supposed to be seen.

R-Mmm… mmm

A continues... I will be trying may be I am calling a staff meeting today but everybody knows what has happened. So it doesn’t take one well but if we can stop discussing a senior person with the junior person, if we keep that in mind it will improve our supervision.

R-Okay, participant E wants to say something

E-Yes I did say something about HR. now supervision can be effective if HR personnel can be involved. They should atleast once or twice a year just come and talk about unnecessary leave how do they affect the work profile of a person maybe the sick leave and maybe unnecessary leave may reduce.

R-Mmm… mmm
H-Another thing there are programmes that are here in the sub-district, now with my experience programmes that are in the sub-district like labour relations programme are the ones that have to ensure that the sanctions that we have applied in the institutions are carried out. Because you will as an operational manager you will be writing a warning letter, and you will be the one who should decide whether this warning letter need eh eh a hearing or what.

R-Mmm… mmm

H continues…I have never heard that there is a hearing and people are making a lot of misconduct. But I have never heard that misconduct are taken for hearing except for the one that instituted by the MEC. The labor things make our supervision very difficult.

R-Mhnn

H continues...And even this naughty one, the one that I have spoken about her earlier she knows a lot ,when I come with a sanction she will say “I sign this because there will be no one taken for a hearing” and she will say let me sign MNR. So if they want us to deal with labor matters at the clinic they could have brought labour relations officer just like an environmental health officers they have decentralized them. So this one the environmental health officers have been decentralized. Labour relations officer deals with labor issues we need him to help us, assist us to institute sanctions. If you have written something about a person I think we must just go and tell the labour relations officer, he is the lawyer of the sub-district but here is not happening.

R-Mhnn

A-Labor relations personnel’s visit should be strengthened so that he should address staff about labor and HR issues because these are the core issues in supervision. These are the things that really, really help to control the staff because if there is really, really labor relations officer who will strengthen the issues of the code of conduct because really people also need training to be reminded ,we will not go to square zero in supervision and control of staff as other facilities are going backwards.

R-Mhh

A continues....When we are not visited and when staff is not trained about labor relations issues and supervisors comes only when there is crisis…then It is a challenge. Some of these things need to be addressed immediately. The problem regarding labor should not take long, the labor relations officer should help us to take action. The labor relations officer should also make a follow up for a particular person who did a misconduct to find out how is the staff, and as soon as possible and he should give a way forward so that maybe be the case be moved for EAP, or..otherwise we will not be moving anyway if things are left in this way.

R-Mhhm

H-I will say HR section causes supervisory problems, they are not paying people on time. I have a problem with nurses when coming to night duty, I have to allocate people for night duty and they will say they don’t want to work night duty because they have not received their night duty allowance for six months. So I decided to go to HR and I asked them to check so they did that. So they managed to give payments for those months. So nurses were not paid for night duty until I came and then they promised to pay them. You will find that people who are due for night duty not willing to go for that only to find that there is a problem with payments.
R-Mhhm…

**H continues....**Although the other one was totally refusing directives that warrant discipline but its genuine some have not received their night duty allowance. Even the payment of PMDS is sometimes affected because you will find that they don’t pay during the pay period they pay the following year. So every time they pay late. I think if they can process night duty allowance on time our delegation of people for night duty could be easy.

C-With HR its so happened that the absenteeism in the clinic was just sky rocketing. People were signing sick leave and it was difficult to control them, until I asked and asked the HR person and only to realize that the leave days were not captured. You will be asking, how many days does this person have they will say 30 days 30 days and this person you know that he is been taking leave previously and this person will fill leave and say my days will expire. What do you have to do you will release him because HR is not capturing those leave on time.

The HR people should improve the capturing of leave because as we speak the leave days were not captured since October last year. Even the sick leave some people will be filling sick leave for so may times but in the computer its like she has never taken sick leave so it becomes a problem but if they could strengthen HR issues the control and supervision of staff will improve.

**R** -Is there any information on how can supportive supervision be facilitated

**All-Silent**

**R-Does it mean that you have said it all. Ok let me now summarise what you have said**

You mentioned that staff should be increased, you need supervision and support from the programme managers and LAMs, trust, confidentiality, respect, openness, reshuffling, strengthening of labor and HR issues.

**A-Training** let people go for training, for workshops we must not have maybe one category going for training for this workshop, let’s have transparency on taking people for training. If this person was to go for training let’s not jump him and take another one because training can boost morale of staff let them go accordingly.

**All-Silent**

**R-Does it mean that we have come to the end of the interview? Okay let me take this opportunity just to say thank you for participation in the discussion. And I am saying everything that has been written and recorded will remain confidential and let me again emphasis that we are also expected to make sure that we maintain confidentiality among ourselves as professionals. Remember I will be expected to come back for validation of the programme before the actual publication of the results. Thank you once more.**

**All-thank you mam**
# ANNEXURE R

A Proposed Induction Programme for Newly-Appointed OPMs

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ANNEXURE S

Confirmation by Language Editor and Typesetter

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23 May 2018

To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the PhD thesis by Maserapele Gladys Seraphewane, titled: “A Supportive Supervision Programme for Operational Managers in the Primary Health Care Facilities of North-West Province.” The manuscript was also professionally typeset by me.

Sincerely Yours

[Signature]

Cert. Freelance Journalist, Dip. Creative Writing, MSc (Medicine), PhD