

2 PHC supervisor visit rate

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The PHC facility supervision visit rate is the number of fixed PHC facilities visited by a clinical supervisor at least once a month, as a percentage of the total number of fixed PHC facilities.

Supervision has been defined as “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, as well as general management to improve operations, clinical direction, review guidelines, and provide approaches to effective service delivery, including patient safety, treatment and health promotion”.^a

Supervision of primary health care (PHC) facilities such as clinics and health centres by higher level managers has been widely recommended.^b It is seen as a means of providing support to PHC staff in order to improve quality of service and programme performance. However, in practice, it typically appears to be confined to administration, checking (with or without checklists) and inspection of facilities without regard to facilitating improvements.^{b,c} Problem-solving, feedback, training and clinical supervision (to assess diagnostic and therapeutic competency) were less commonly practiced activities during PHC supervisory visits.^c

A systematic review by Cochrane Collaboration researchers on the effects of managerial supervision of health workers to improve the quality of primary health care in low- and middle-income countries found little to no evidence of benefit from supervisory visits.^a In their study, Enwereji et al. identified several systemic problems that hamper effective PHC supervision, such as lack of “planning, training, defined priorities, shortage of resources (man, materials and finance), episodic visits by supervisors, lack of adherence to work ethics, poor interpersonal relationships between supervisors and supervisees and others”.^c

The need to prioritise health worker motivation and performance in low-resource settings has been highlighted. However, the traditional approach to supervision, which has been authoritarian, top-down, emphasising the communication of directives and apportioning blame,^{c,d} has been criticised for its failure to investigate root causes and develop staff performance. This had led to the emergence of support for a new type of supervision, i.e. supportive (or facilitative) supervision.

Supportive supervision has been described as a form of supervision “that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimise the allocation of resources”.^d With this approach, the focus of supervision shifts from inspections and fault-finding to fostering discussion of problems and joint problem-solving; monitoring, provide immediate feedback and two-way communication between the supervisor and those being supervised.^{d,e,f} The emphasis is on assessing whether work processes are planned, designed and implemented in a manner that achieves quality health services.^e Staff are also empowered to participate in collective problem solving in order to continuously improve performance and health system outputs including meeting clients’ needs.

This type of supervision has been found to improve malaria case management in a study in Nigeria.^d Studies in Ghana found that supportive supervision increased productivity and delivery of PHC services, especially in rural settings.^{e,f} Supportive supervision was also found to be capable of enhancing the technical and clinical skills of supervisors as a way of mending deficient supervision processes that negatively affect primary health care services.^g

Given that the problems found in primary level facilities are multiple and range from lack of basic equipment to poor adherence to clinical guidelines, it is likely that the kind of supervision that is being measured in the District Health Information Software (DHIS) is one that emphasises compliance, authoritarianism and fault-finding rather than supervision which is supportive and focuses on solving problems.

The national PHC supervisor visit rate has increased marginally over the past five years from 69.3% in 2009/10 to 73.7% in 2013/14, with the highest rate of 76.0% achieved in 2012/13.

a Frimpong JA et al. Does supervision improve health worker productivity? *Tropical Medicine and International Health*. 2011; 16 (10):1225-1233.

b Bosch-Capblanch X, Liaqat S, Garner P. Managerial supervision to improve primary health care in low- and middle-income countries. *Cochrane Database of Systematic Reviews* 2011, Issue 9.

c Enwereji EE, Enwereji KO. Making Supervision Supportive and Sustainable in Primary Health Care Services in Abia State, Nigeria. *Middle East Journal of Family Medicine*. 2013;11 (1):19-25

d Bello D, et al. Supportive supervision: An effective intervention in achieving high quality malaria case management at primary health care level in Jos, Nigeria. *Annals of African Medicine*. 2013; 12 (4): 243.

e Aikins M, et al. Evaluation of facilitative supervision visits in primary health care service delivery in Northern Ghana. *BMC Health Services Research*. 2013; 13:358.

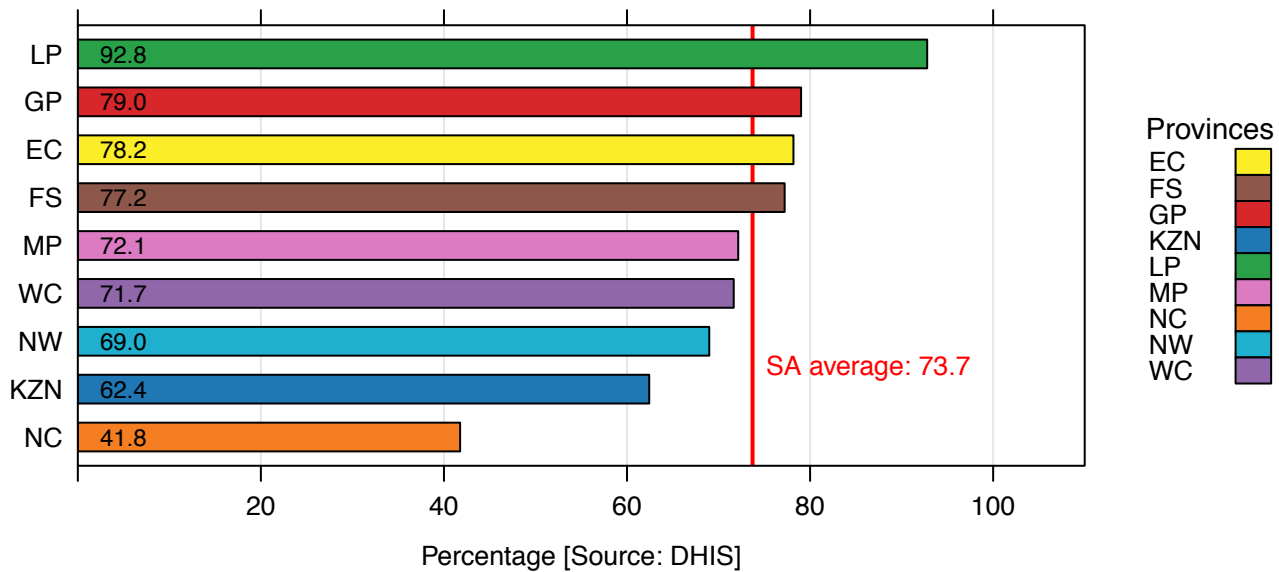
f Frimpong JA, et al. Does supervision improve health worker productivity? *Tropical Medicine and International Health*. 2011; 16 (10):1225-1233

g Enwereji EE, Enwereji KO. Making Supervision Supportive and Sustainable in Primary Health Care Services in Abia State, Nigeria. *Middle East Journal of Family Medicine*. 2013;11 (1):19-25

Section A: PHC supervisor visit rate

As shown in Figure 1, Limpopo (LP) had the highest PHC supervisor visit rate at 92.8%, with Northern Cape (NC) once again having the lowest rate at 41.8%, which was well below the national average of 73.7%.

Figure 1: PHC supervisor visit rate by province, 2013/14



On a year-to-year basis, the PHC supervisor rate for Eastern Cape (EC), KwaZulu-Natal (KZN), Mpumalanga (MP) and Western Cape (WC) remained relatively stable over the past five years. Supervision rates increased significantly over the same period in LP, North West (NW) and NC. Some provinces had similar supervision rates among their districts (LP, MP) whereas others had districts with widely varying supervision rates, e.g. KZN, Free State (FS).

As shown in Figure 2, the Central Karoo and Cape Winelands (both WC) and Capricorn (LP) districts achieved the highest three PHC supervisor visit rates at 100%, 98.4% and 95.6% respectively. The worst performing district continued to be Namakwa (NC) at 6.3%.

Among the NHI districts, Vhembe (LP) had the highest PHC supervisor visit rate (93.6%) followed by 89.3% in Thabo Mofutsanyana (FS) and 85.4% in Tshwane (GP). Pixley ka Seme (NC) had the lowest rate at 20.9%. Data quality issues were observed in the EC where incorrect values were recorded that did not comply with the definition of the indicator. Nonetheless, the province as a whole managed to achieve a PHC supervisor visit rate above the national average (see Figure 1).

Namakwa (NC) had the lowest supervisor visit rate, while another very sparsely populated rural district, the Central Karoo (WC), achieved the highest supervision rate in the country.

Both Namakwa and ZF Mgcawu in NC received the majority of their 1.8 and 2.8 PHC supervisory visits, respectively, in the last quarter of the year. This raises issues of governance and accountability and should be investigated.

NHI districts have been receiving more health systems strengthening interventions and yet some are still performing poorly. This needs to be investigated as resources and time have been invested in these districts.

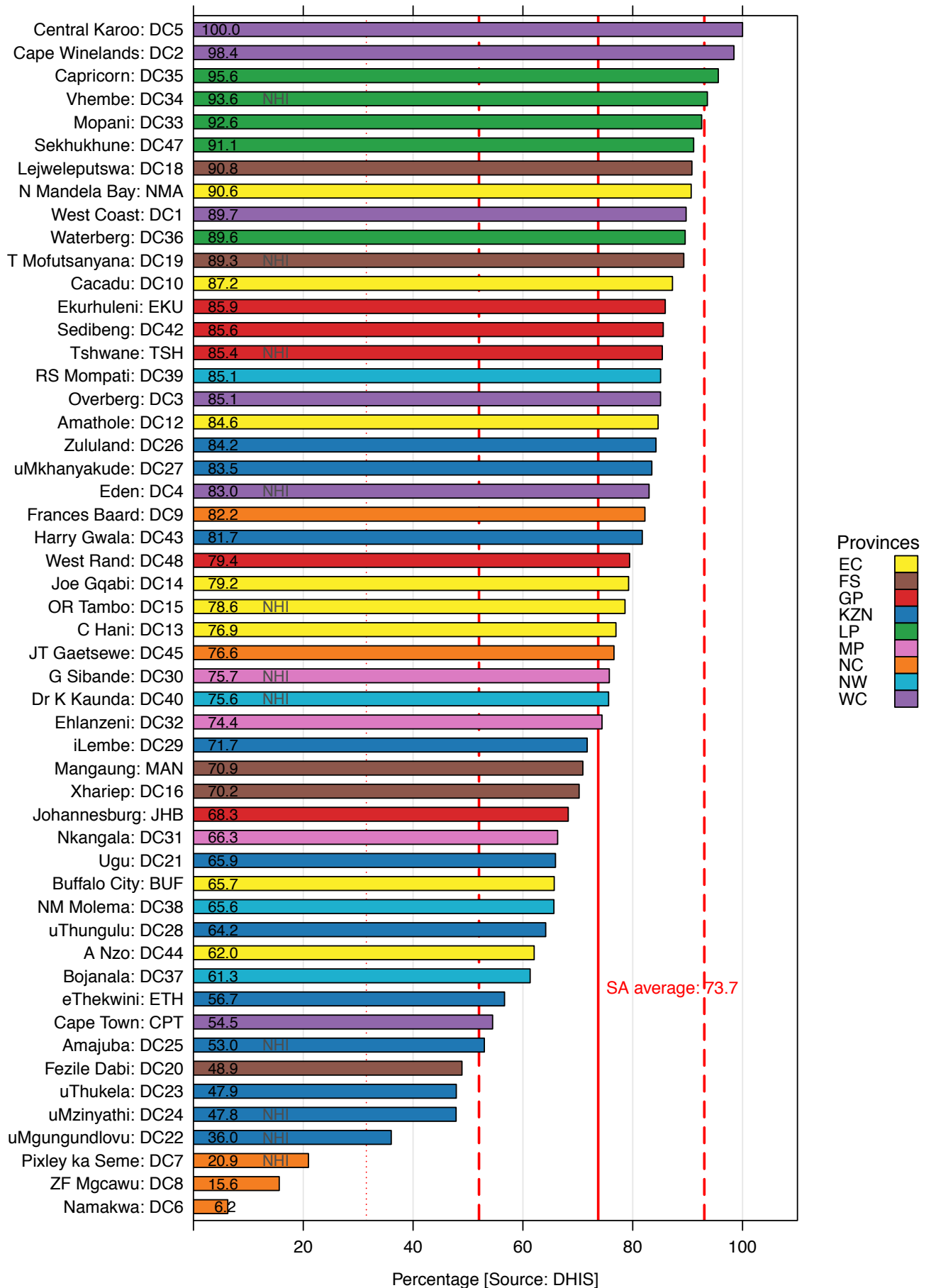
Recommended areas of research include:

- ◆ Evaluation of the patterns of supervision within and across districts
- ◆ Comparing worst and best performing districts (especially those with similar profiles) and understanding the facilitators and barriers to achieving good PHC supervisor rates
- ◆ Evaluation of the effectiveness of the current PHC supervision model because of its importance for improving PHC service delivery and quality of care

It is encouraging that most districts were able to achieve PHC supervision rates above the national average. However, an in-depth assessment should be conducted to understand the factors that lead to districts achieving a less-than-satisfactory supervision rate, particularly in the NHI districts.

The PHC supervision visits should be linked to performance in terms of service delivery and quality of care. Currently, the reporting system only requires an indication of whether a visit took place or not. However, the outcome of the visits in terms of quality assurance and quality improvement efforts is unknown, which reduces the value of this indicator in its use for decision-making.

Figure 2: PHC supervisor visit rate by district, 2013/14



Map 1: PHC supervisor visit rate by district, 2013/14

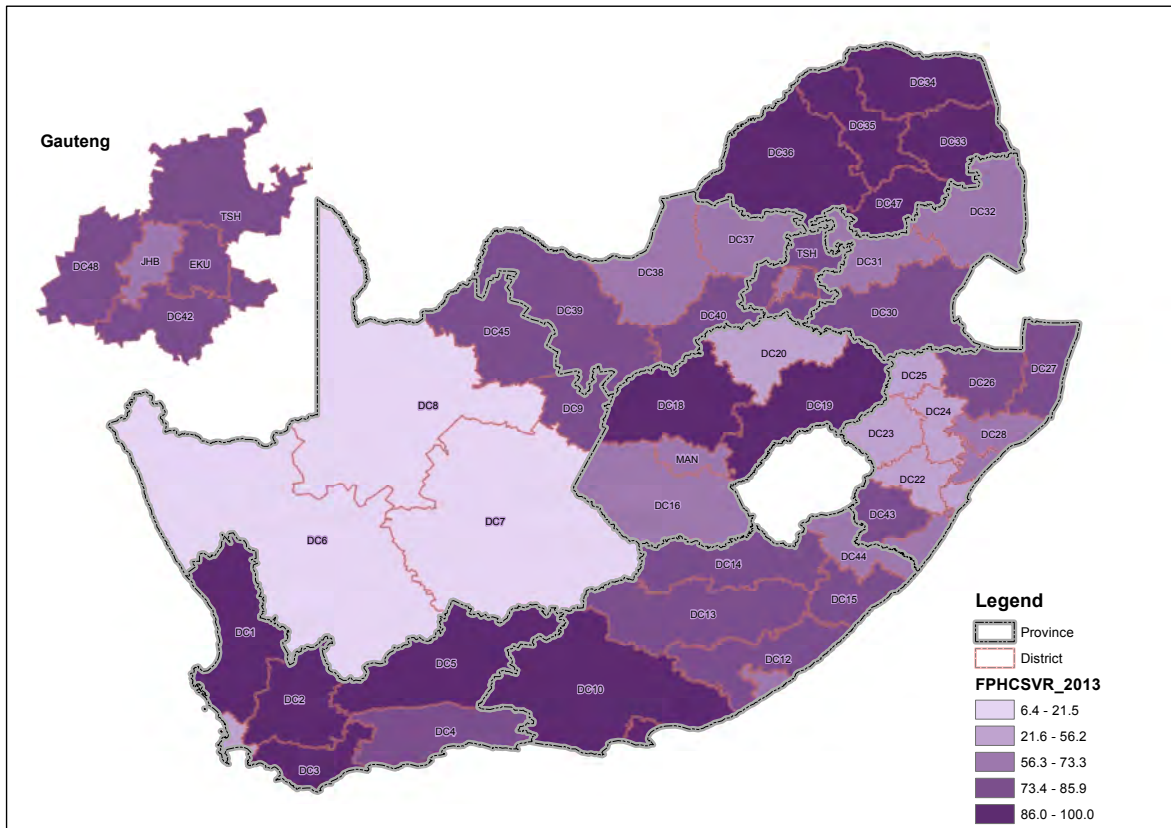


Figure 3: Annual trends: PHC supervisor visit rate

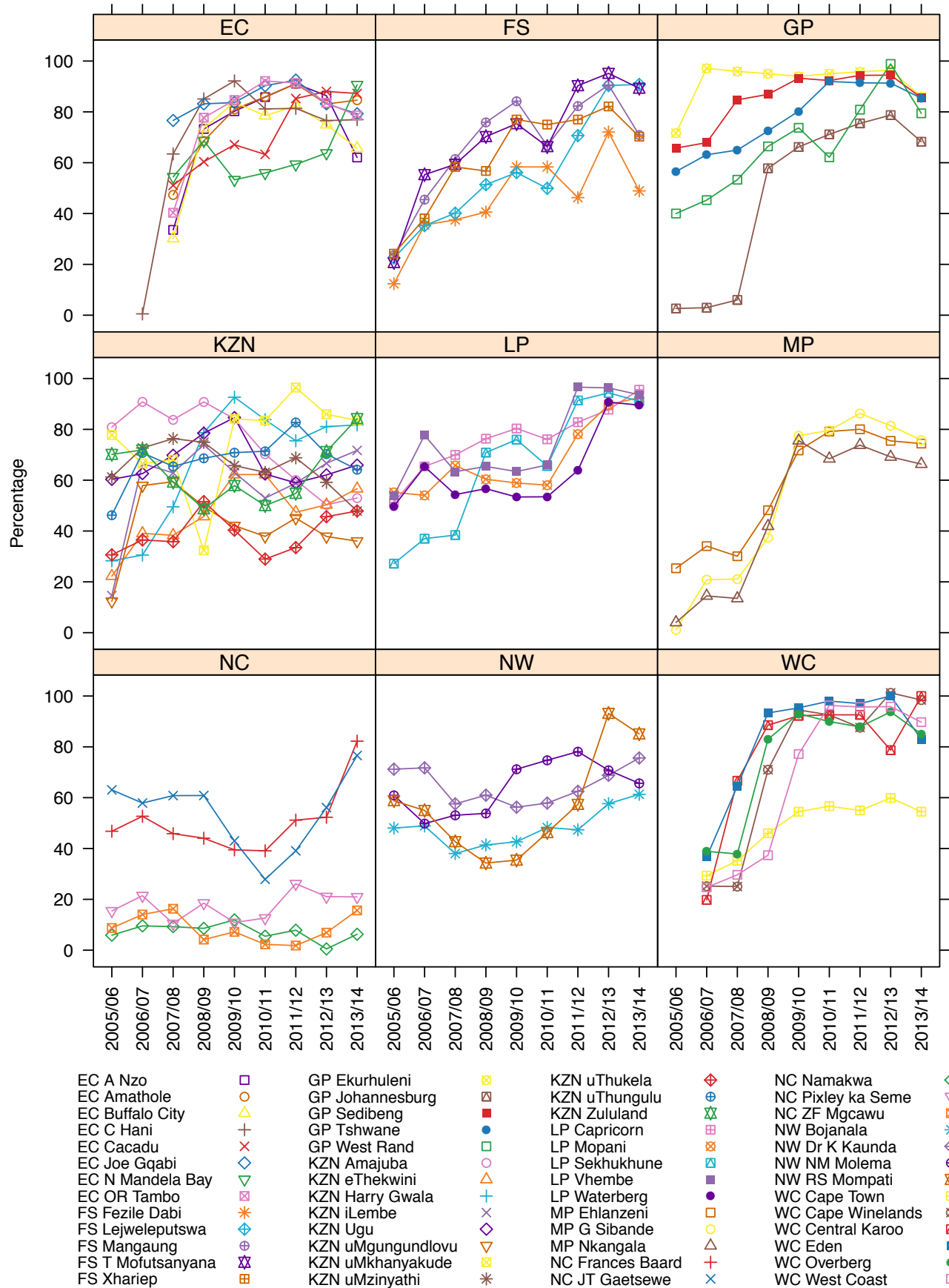


Figure 4: PHC supervisor visit rate by SEQ

