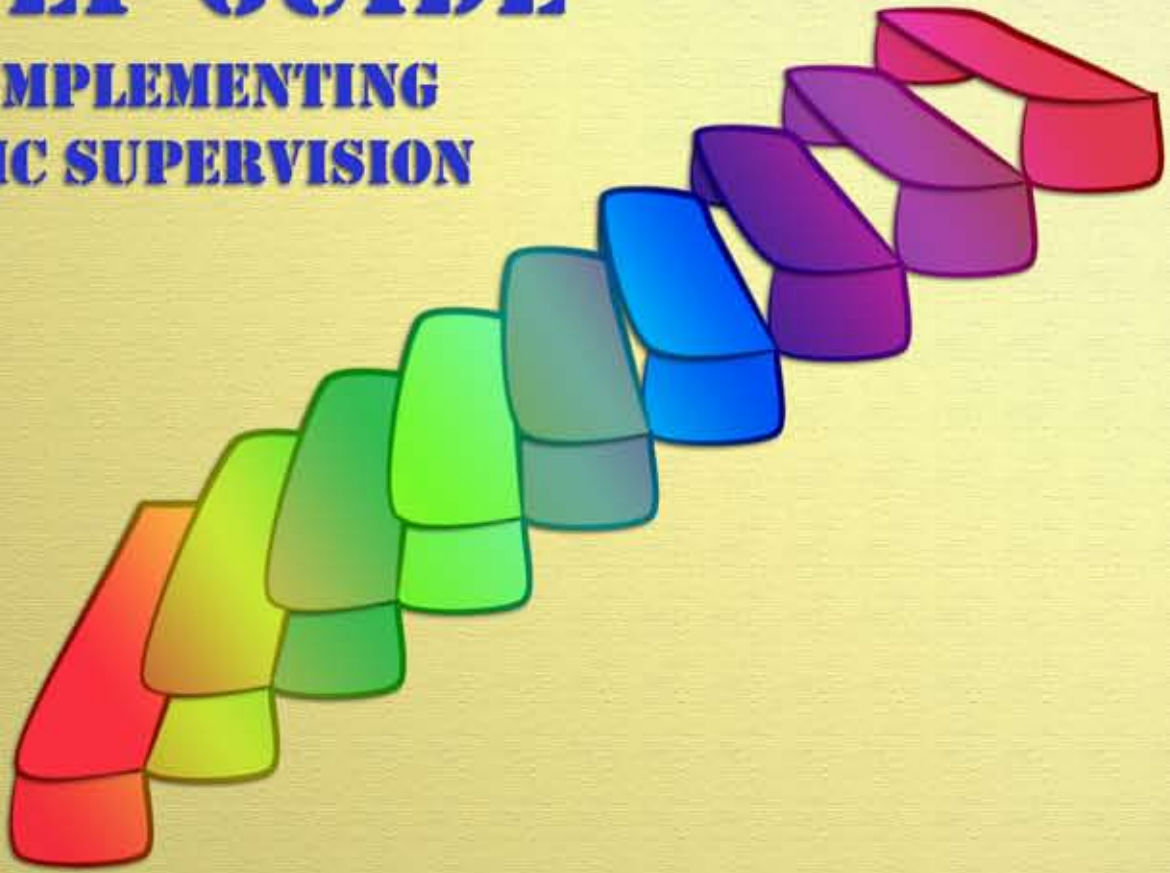
# 9 STEP GUIDE

## TO IMPLEMENTING CLINIC SUPERVISION



# The Nine Step Guide to Implementing Clinic Supervision

**Written by:** *Sarah Davids and Marian Loveday*

**Edited by:** *Fiorenza Monticelli*

April 2005

*Published by Health Systems Trust*

Health Systems Trust
401 Maritime House
Salmon Grove
Victoria Embankment
Durban 4001

Tel: 031 - 307 2954
Fax: 031 - 304 0775
Email: hst@hst.org.za
Web: http://www.hst.org.za

Suggested citation:

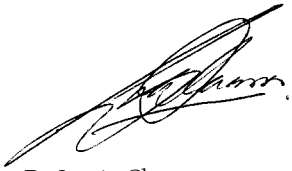
*Davids S, Loveday M. The nine step guide to implementing clinic supervision. Durban: Health Systems Trust; 2005.*

# Foreword

There is no doubt that one of the most effective ways of improving quality of health care at district level, is by means of clinic supervision. To that end, the Clinic Supervisor's Manual is being used to implement supervision throughout health districts in South Africa.

This booklet, *The Nine Step Guide to Clinic Supervision*, is a simple tool which guides the effective use of the Clinic Supervisor's Manual in addition to guiding the day to day activities involved in supervision towards successful and improved outcomes.

It is envisaged that clinic supervisors, programme managers, sub-district and district managers will benefit from reading and using *The Nine Step Guide to Clinic Supervision*. Especially for those with too little time and too much to do, this guide is a quick reference to the essential tools and activities involved in good quality supervision.



Dr Louis Claassens
Director: Quality Assurance
National Department of Health

*Designed and Printed by The Press Gang, Durban ~ Tel: (031) 502 4423 Email: info@pressgang.co.za*

# Table of Contents

## Acknowledgements

The contribution and commitment of public sector health workers to rise to new challenges deserves special mention. The ISDS team under the leadership of Dr Peter Barron have collectively shared their experiences to inform this guide. Special thanks also to Dr Faith Kumalo, Dr Noluthando Ford-Ngomane, and Thulile Zondi for capturing lessons to share.

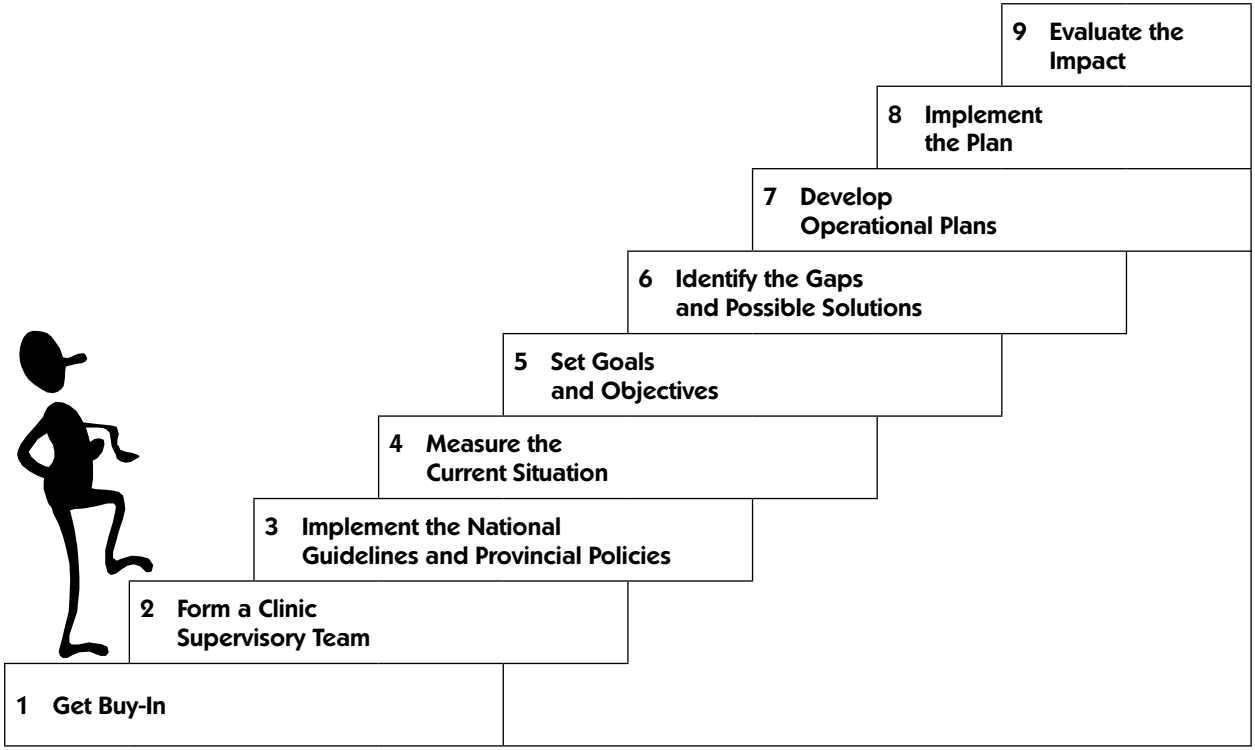
# Introduction

This booklet focuses on how to implement clinic supervision. Although it does not go into any great depth or detail, it aims to assist managers, programme coordinators, clinic supervisors and facility managers find their way in the day to day supervision of quality of care. The Nine Step Guide addresses implementation in an easy to follow method, using a number of tools and practical examples gathered from the districts where HST has worked over the last three years.

By following and implementing each of these nine steps, those involved in the process of supervision are sure to get closer to the common goal of increased quality of care within a relatively short period of time. The Appendices provide further advice on day to day matters such as tips for clinic supervisors and managers, quarterly review meetings and further reading.

We know that clinic supervision is one of the most effective ways of improving the quality of care at district level. For far too long however, it has been an activity that has fallen between directorates and has not been afforded the status and importance it deserves. It is hoped that this guide will contribute to supervision being an accepted, practical and workable activity that is essential in improving, and maintaining, good quality care at primary care level.

# Nine Key Steps in Implementing Clinic Supervision



# Tools recommended in this guide

The Clinic Supervisors' Manual (CSM) is useful for starting up and maintaining clinic supervisory practices in a district. Yet, it is very long and although it provides a good overview, it can be intimidating to use.

However, the tools recommended within the CSM, when used correctly, have been shown to improve management skills at a facility level. These are the **Red Flag** and **PHC/Regular reviews** which are used on a monthly basis. Other useful tools are the **In-Depth Reviews** for priority programmes such as TB and HIV, which can be used on a quarterly basis. For examples of this, see Appendix 5.

Some of the most rural and under resourced districts have considerably improved the quality of their PHC services, by using these tools regularly.

# Step 1: Buy-In

This is an important but often neglected first step. Buy-in means that all parties concerned, including the district manager, clinic supervisors, programme managers, the district information officer, clinic staff as well as key administrative officials, understand that regular supervisory visits improve the quality of care at a clinic level.

***Examples from the field that illustrate the importance of buy-in from different role players.***

### *1. Facility Managers, Umkhanyakude, KZN*

Although considerable time and effort was put into improving clinic supervision in Umkhanyakude district, the quality of PHC services did not improve. A workshop was conducted by the HST facilitator with facility managers to discuss and explore the importance of clinic supervision, the supportive role of supervisors and the role of facility managers. Soon after this, benefits of regular clinic supervision became obvious to all as the quality of PHC services improved. Supervisors and facility managers have since begun to work together to solve problems. In addition, facility managers now use the tools made available in the Clinic Supervisor's Manual as management tools to improve and maintain the quality of care at their facility.

### *2. The importance of Transport Officers in rural districts*

In many districts the unavailability of transport prevents clinic supervisors and programme managers from doing regular supervisory visits.

Clinic visits which are planned a month in advance are often cancelled at short notice due to there being no transport available. However, transport is always made available to attend meetings at the provincial capital. In fact, the vehicles originally allocated to supervision are usually those reallocated at the last minute to transport participants to meetings or workshops called at late notice by the provincial office. Supervisory activities are therefore not given priority nor supported by the transport services within the district. Transport officers must be "brought in" to the supervisory process from the beginning if they are to understand the importance of providing regular transport for supervisory visits.

### *3. Involving the Provincial Structures in Gauteng Province*

The Provincial Department of Health in Gauteng was included right from the start in the supervisory process. This resulted in a uniform implementation of clinic supervision. A provincial supervisory policy was approved in January 2004 and all districts have since implemented clinic supervision, using the key tools identified by the province. This is briefly how it was done:

The Clinic Supervisors' Manual was introduced in a series of workshops to provincial managers, district managers and local government representatives in Gauteng. At the first workshop, participants were given an overview of the CSM. District organograms and job descriptions were set up for the supervisors. They also conducted field visits to facilities to test the tools used in the manual. The need for a provincial policy on supervision, to ensure common supervisory practices in the province, was discussed and resulted in a draft policy being introduced which detailed:

- District organograms with clear lines of accountability for each clinic supervisor
- Job descriptions for clinic supervisors
- The number of facilities each clinic supervisor should be responsible for
- The need for each district to identify a "champion/driver" who would drive the implementation of clinic supervision
- Which tools to use and when:
  - The Red Flag on a monthly basis
  - The PHC Review on a monthly basis
  - One in-depth programme review, per quarter.

# Step 2: Forming a Clinic Supervisory Team

Step 1 explained the importance of involving various levels and role players in clinic supervision. The following step is to establish a supervisory team which could include representatives from the following groups:

- Health workers and managers from both Provincial and Local Government
- Clinic Supervisors
- Community Health Centres
- PHC Clinics
- Mobiles
- Programme Managers
- District Information Officer
- Quality Assurance (if available at a district level).

It is important to identify a team leader, who will be the driver of the process. Functions of the team leader include coordinating meetings, consolidating and presenting a quarterly report on key indicators and PHC activities within the district at the District Management Team meeting. In addition, the team leader would have to ensure problems encountered are highlighted, solutions are identified and that decisions taken are followed through.

A team approach provides a much needed support system for clinic supervisors. A lack of support impacts considerably on their ability to do supervision. The failure of the District Management Team to prioritise clinic supervision is primarily responsible for this lack of support. Supervisors are seldom supervised, seldom praised or thanked for their efforts and are invariably given negative feedback on their performance.

# Step 3: Implementing National Guidelines and Provincial Policies on Supervision

In this step we address:

1) Role confusion
2) The clinic supervisor's scope of work and lines of responsibility
3) The role of the supervisory team

The provincial policy formalises the supervisory system for the province. It should set the standard for the frequency of supervisory visits as well as the number of facilities each supervisor is expected to supervise. The provincial policy should also clarify the roles of programme coordinators and quality assurance staff in relation to supervision. In provinces where there is no provincial policy, the national guidelines should be used as a reference.

It is the responsibility of the supervisory team to ensure that these policies are implemented at district and sub-district levels. In order to do this, the team should ensure that supervisors:

- have job descriptions
- know to whom they are accountable
- know for which clinics they are responsible
- know how often they have to report to the district and the province
- know what must be reported on and in what format.

## 1) Role Confusion

In many instances confusion still exists between clinic supervisors and programme managers with regard to the supervisory role.

The role of district level programme managers varies across districts and between programmes. In some districts, clinic supervisors do the in-depth programme reviews for all programmes and are required to have detailed knowledge of all services delivered at a clinic level. In other districts, the programme managers visit clinics regularly and provide in-depth programme supervision and expertise on their specific programmes.

However, the main problem is that the lines of communication and accountability between district and provincial programme managers and PHC supervisors are not clearly defined.

Provincial and district programme managers need to address any confusion regarding the supervisory role of district programme managers. For instance, if programme managers visited clinics regularly once a quarter to do in-depth reviews, it would support the overworked and stretched clinic supervisors considerably.

***Example of role confusion and multiple roles at district level***

Health workers appointed as clinic supervisors generally have numerous other activities and responsibilities. In one district a clinic supervisor, in addition to being the designated clinic supervisor for eight clinics had the following responsibilities:

- Service delivery:
  - Running PHC services at clinics should staff not arrive for duty due to illness or other problems
- Financial:
  - Coordinating and preparing the sub-district PHC budget
  - Attending sub-district budget committee meetings
  - Attending district budget committee meetings
- Training:
  - Doing all PHC training required in the sub-district
- Management:
  - Functioning as the acting sub-district coordinator
  - Planning monthly clinic nurses meetings
  - Attending meetings on behalf of the district manager
- Inter-sectoral Communication:
  - Setting up forums in which to meet traditional leaders, traditional health practitioners and counsellors
  - Meeting regularly with these forums

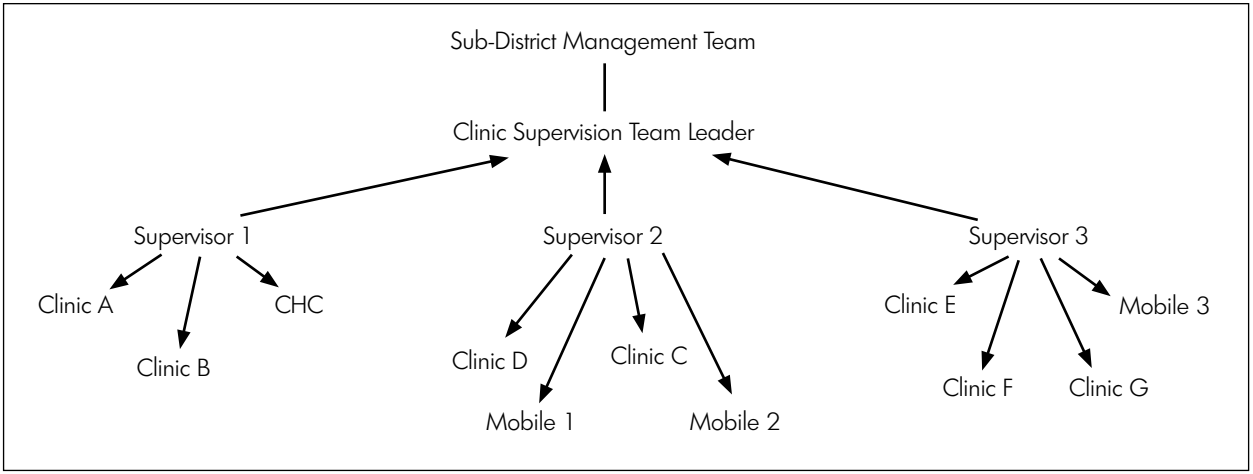
***The clinic supervisor's scope of work:***

- Line function responsibilities:
  - Attending to the numerous requests from the district and provincial office
  - Solving all PHC crises in the sub-district
- Programmes:
  - Supporting the implementation of all programmes at a district level
- Special events:
  - Coordinating awareness days
  - Hosting visitors

Although clinic supervisors have a number of different roles, the focus of their work should be on the clinics assigned to them. They have to visit these clinics regularly and assist in solving problems. At the end of each month, they should summarise their supervisory activities undertaken in the previous month. They need to document the visits undertaken, the problems identified and the activities undertaken to address these problems and present these at the supervisory team meeting.

## 2) Clinic Supervisor's Scope of Work and Lines of Responsibility

Flow diagram to illustrate a clinic supervisor's lines of responsibility:




To prevent role confusion and overwork it is therefore necessary to draw up a flow chart indicating which facilities each supervisor is responsible for. This can be done for both provincial and local government supervisors.

The monthly activities of the clinic supervisors will be guided predominantly by two tools in the CSM, the **Red Flag** and the **PHC Review**. Quarterly visits by the programme managers may be guided to a large extent by the in-depth tools in the CSM, for example the **In-Depth Review of HIV and AIDS Services**. In-depth reviews may be conducted by the programme manager alone or together with the clinic supervisor.

For example, in some districts the supervisor conducts the **Red Flag** and **PHC Review** whilst the programme manager conducts the relevant **In-Depth Programme Review**. However, communication between the two is key and if the programme manager visits a clinic on his/her own, the clinic supervisor must be informed of the visit beforehand. The findings of the visit must also be shared with the clinic supervisor. (See also Appendix 2: Suggestions for conducting In-Depth Reviews.)

## 3) The Role of the Supervisory Team

In implementing the supervisory policy the supervisory team has to ensure that:

- Facilities and programmes run smoothly
- Staff are supported and developed
- Policies and procedures are followed
- Problems are identified and solved
- Quality of care improves
- The motivation and morale of clinic staff improves.

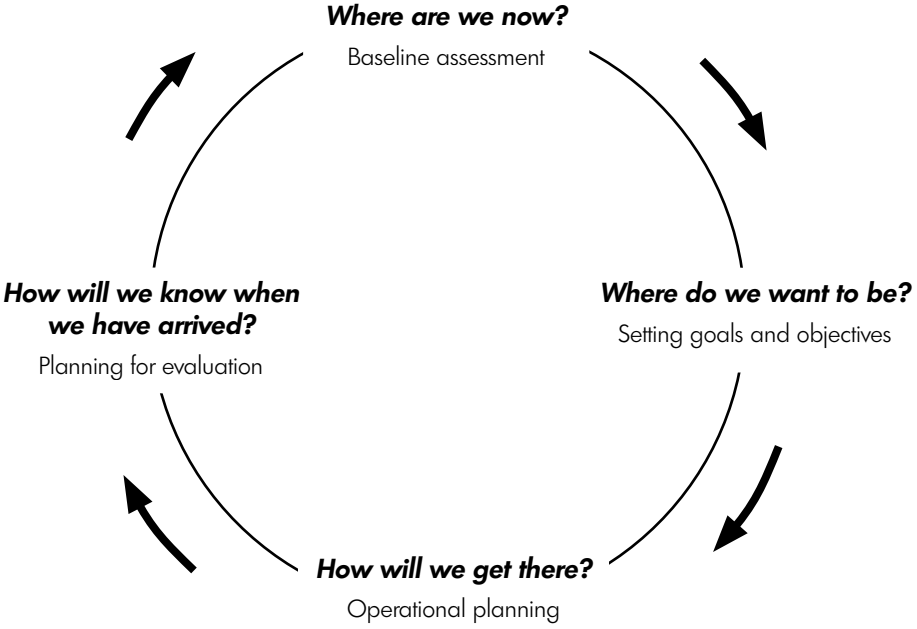
In most provinces, district health managers are expected to produce quarterly reports on reviews done. (See Appendix 3 Quarterly review meetings: Suggested process.) Provincial programme coordinators and representatives of the quality assurance units should *attend these quarterly review meetings* as provincial support is important for a number of reasons:

At a provincial level:

- The province is seen to prioritise and support supervisory activities in the districts
- The province is seen to support district level activities
- The province can assist in exploring strategies to address problems
- The province can guide district activities in line with provincial targets and policies
- The province is able to monitor and evaluate progress at a district level.

# Step 4: Measuring the Current Situation - Doing a Baseline Assessment

***The Planning Cycle***



## The baseline assessment

A baseline assessment is a look at "where are we now?" It helps to describe what the situation is and how the district primary health care services are performing against provincial, national, and even international standards. A baseline assessment provides measurements of what the starting point is, so that after implementation it is possible to determine whether there has been any change.

A baseline assessment will assist to:

- Measure the health status of a district
- Measure the quality of health services
- Measure factors that determine the quality of services rendered
- Identify key issues/priorities that need to be addressed to improve health in the district.

When choosing what to measure in your baseline assessment, first determine what is important.

The document "The Primary Health Care Package for South Africa - A Set of Norms and Standards"[1] provides norms and standards for primary health care facilities in South Africa. These are also included in Section 9 of the Clinic Supervisors Manual. The PHC package together with the targets set by the national and provincial Departments of Health provide a guide to determine what is important to look at in a baseline assessment.

1 Available from the National Department of Health, Quality Assurance Unit.

The baseline assessment should be action-oriented. Once identifying the major problem areas, it should help to direct the actions required.

When planning what to measure in the baseline assessment, also give consideration to what is feasible to collect with the resources available. It should be possible to obtain most of the information from the routine District Health Information System.

## Using indicators when conducting Baseline Assessments

Indicators are a useful way to obtain measurements that will give an indication of the health of people living within a district and of the quality of care services delivered within the district.

### Types of indicators include:

**Input indicators:** Measure the availability and accessibility of resources needed to carry out activities e.g. number of posts filled and number of posts vacant, percentage of PHC clinics with running water.

**Process indicators:** Measure the activities that lead to the provision of a service e.g. number of training sessions conducted; availability of drugs or nutrition supplements.

**Output indicators:** Measure the services provided e.g. percentage of clinics visited monthly by a clinic supervisor, percentage of sexually transmitted infections (STIs) treated according to the national protocol, number of clients served.

**Outcome indicators:** Measure changes that result from the outputs (usually relatively short term) such as changes in knowledge, attitudes and behaviour of clients e.g. percentage of women who attend their 1st ANC visit before 20 weeks, adherence to treatment.

## Using the Red Flag and Regular Review List in the Baseline Assessment

The first time these two tools are used, serves as a baseline assessment. **The Red Flag** and **Regular Review List**, together with guidelines to their use, can be found in Section 3 of The Clinic Supervisors Manual. They focus on key administrative and quality of care issues which have to be in place for the delivery of effective PHC services.

Many districts have used the **Red Flag** and **Regular Review Lists** to assist not only in doing the baseline assessment, but in all stages of the planning cycle. The goals and objectives of the district are highlighted in the lists. For example, supervisors are asked to detail if there were any drug stock outs. The *goal* of the district is identified as "No Drug Stock Outs". The *plan of action* is to address the problem of drug stock outs. A month later, *progress is reviewed*.

# Step 5: Setting Goals and Objectives

Having completed the baseline assessment, the district supervisory team has to set its goals and objectives. Some of these may be contained in the Red Flag and Regular Review for example:

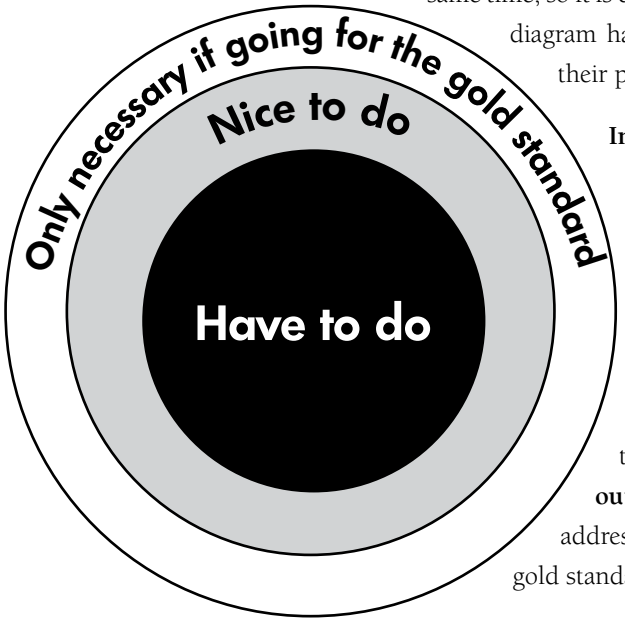
- No drug stock outs
- All refrigerators working and monitored twice a day.

Other goals and objectives will be guided by national priority programmes and goals set by the national and provincial departments of Health, for example:

- Turn around time for laboratory specimens < 48 hours
- Smear conversion rate > 85%
- VCT to be available at 100% of facilities
- All cases of diarrhoea treated according to the standard treatment guidelines.

## Prioritising Problems

Not all problems can be addressed and not all programmes can be improved at the same time, so it is essential to prioritise when setting goals and objectives. This diagram has been used successfully to assist districts in prioritising their problems.




**In the centre**, the bull's eye, are the key "have to do" issues that each district must do in order to achieve its core function of delivering PHC services, eg. the delivery of VCT at all facilities in the sub-district. These are mostly determined by the priorities set at a national and provincial level as well as those identified by the district. **The second ring** contains issues which would be "nice to do" once the central issues are functioning effectively. For example, the monitoring of all absenteeism rates in the district. **The outside ring** represents those issues which should only be addressed in a well functioning district which is going for the gold standard; for example, setting up a monthly district newsletter.

Clinic supervision is considered important by national, provincial and district health departments. However it is seldom prioritised by these three levels of government. There is no national policy on clinic supervision, few provinces have provincial policies and even fewer districts have incorporated supervision into their plans for improving the quality of Primary Health Care services.

## The Time Management Quadrant

The time management quadrant can be used as an illustration of the prioritisation of activities at a district level. In this quadrant the urgency and importance of activities are compared to one another (see time management quadrant below).

Clinic supervision is considered by managers at provincial and district level to be important, and therefore falls into quadrant 2 (important) in the time management quadrant. However, in reality in most districts, it is not seen as urgent and is therefore not prioritised. Other activities are defined as urgent and are prioritised, regardless of their importance in relation to the core business of the district, which is the implementation of PHC services. The result is that clinic supervision can at times not take place for months on end whilst these more 'urgent' activities are attended to.

***The Time Management Quadrant***

| | **Urgent** | **Not Urgent** |
|---|---|---|
| **Important** | Quadrant 1<br><br>Urgent and Important | Quadrant 2<br><br>Important |
| **Not Important** | Quadrant 3<br><br>Urgent | Quadrant 4<br><br>Not Important and not Urgent |

**Examples**

**Urgent and Important**
Keeping to the planned schedule of supervisory visits.

**Urgent**
A request from province for the number of disabled people employed in the district by tomorrow 16h00.

**Important**
Attending to issues raised at previous clinic visits (such as shortage of nevirapine tablets).

**Not urgent and not Important**
Attending a candle lighting ceremony at the provincial office on the day of a scheduled clinic visit.

# Step 6: Identifying the Gaps and Possible Solutions

At this stage of the planning cycle it is necessary to explore the gap between each goal set and the baseline assessment made. Having identified possible reasons for the gap, possible solutions to the problems need to be worked out. This can be done by brainstorming. Clinic supervisors and facility managers can brainstorm together to try to identify possible reasons for certain problems, how they should be resolved, and whose responsibility it is to resolve them.

***Examples from the field demonstrating problem identification and finding solutions***

***STI Management in a Remote Rural Clinic***

At a small clinic in a remote area of the country it became apparent in the baseline assessment that speculum examinations were seldom done on women presenting with STIs. Discussions with the staff at the clinic revealed a number of reasons for this:

- shortage of specula
- no electricity for examination lights
- no torches
- health care workers are unaware of the importance of speculum examinations in ensuring a correct diagnosis
- health workers lack confidence in using specula
- health workers feel they are too busy to do such a time consuming procedure.

***Discussion:***

Each of the reasons for these problems require a different solution. If the correct reason is not identified, the proposed solution may be inappropriate. For example, ensuring there is enough equipment may not lead to any improvement if clinicians are not confident in the use of specula. On the other hand, providing training in speculum examinations may be a waste of time and money if the actual reason for not doing speculum examinations is that there are no specula at the clinic.

***Partner Notification of STIs in KwaZulu-Natal***

The national HIV and AIDS directorate defined "STI Contact Tracing Rate" as an indicator that measures the proportion of partners who go to the clinic because they have been given a slip by their partners asking them to do so. A number of clinics in KwaZulu-Natal were concerned about the poor return on partner notification cards. At a Clinic Sisters' meeting, possible solutions to the problem were brainstormed. These included:

1) Approaching local radio stations and newspapers to increase awareness in the community of the importance of partners being treated
2) Exploring ways of helping clients to discuss the need for treatment with their partners
3) Providing leaflets in the clinic that explain the importance of the treatment of partners
4) Extending clinic hours to enable partners to visit the clinic after work
5) Creating a 'fast lane' so that partners can be seen quickly.

Solutions 3, 4 and 5 were implemented and within 3 months the STI contact tracing rate had increased by 4%.

# Step 7: Developing Operational Plans

In the previous step possible solutions to problems were identified. Weighing up solutions by using the SMART method has been found to be an effective method for finding the right solutions.

***SMART Method:***

Operational Plans must be SMART:

| | | | |
|---|---|---|---|
| ***S*** | – | Specific | – What action will be done? By whom? |
| ***M*** | – | Measurable | – How will we know when it has been done? |
| ***A*** | – | Attainable | – Is that something we will be likely to achieve? |
| ***R*** | – | Realistic | – What is feasible? This overlaps with attainable, but includes identifying the resources that will be needed. Are the necessary materials, finances and personnel available? Local conditions will influence what is attainable and/or realistic. |
| ***T*** | – | Timeframe | – By when will this be done i.e. action completed? Do some of the plans need interim time frames? |

The table on page 24 provides an example of an action plan for solving problems using the SMART method.

***The Action Plan for Chronic Care in a Sub-District in Gauteng***

| ***Problem*** | ***Possible cause*** | ***Action*** | ***By whom*** | ***Time frame (By When)*** |
|---|---|---|---|---|
| No records kept at facilities for those clients who carry their own cards | Oversight | To have a summary on client management in the facility. | Facility managers<br>Admin clerks | By 31/05/04 |
| No system to follow up defaulters | Ineffective record keeping system.<br>Shortage of staff. | To improve the present record keeping system.<br>To initiate chronic care support and to utilise this support for follow-ups. | Facility managers<br><br>Admin clerks | By 31/05/04<br><br>By 31/10/04 |
| No health promotion activities in the community | Health promotion activities not well coordinated.<br><br>Shortage of health promoters. | Health promoters to submit their weekly, monthly plans to facility managers.<br><br>To write a motivation letter to the District Manager requesting three additional health promoters (what is feasible is also about what you have control over; appointing more staff is not appropriate at facility level). | Health promoters and facility managers<br><br>Facility Manager | By 31/10/04<br><br>By 31/05/04 |

| *Problem* | *Possible cause* | *Action* | *By whom* | *Time frame (By When)* |
|---|---|---|---|---|
| Equipment - shortages. | Delays on repairs.<br>Equipment never enough.<br>Clinicians not taking good care of the available equipment. | Frequent follow-ups to be done on breakages.<br>Equipment to be audited, budgeted for & purchased.<br><br>Discuss care of equipment at staff meetings. | Facility Managers and clinic supervisors<br><br>Clinic supervisors and facility managers | Monthly<br><br>By Sept. 04<br><br>Immediately & Monthly |

## Challenges experienced in sorting out problems

Clinic Supervisors are expected to ensure that PHC services are delivered effectively and efficiently at a clinic level. Many of the problems experienced at a clinic level are as a result of poorly functioning support systems. For example, drug stock outs are often caused by no transport to deliver drugs. Supervision is advocated as a means of dealing with systemic needs and problems. However, no authority is delegated to the clinic supervisors to deal with other members of the District Management Team (DMT) whose poor management is affecting the functioning of the clinics. Clinic supervisors do not have the authority to address and act on the problems causing poor service delivery. In addition, supervisors may be reluctant to undertake supervisory visits as the problems identified during previous visits have not been addressed. Discussing these issues at the DMT meetings is a way of getting the team to address the identified gaps collectively in support of the supervisor.

# Step 8: Implementing the Plan

At a district level many good plans are made in response to provincial requests, but far too many of these are filed and never implemented. A plan is only as good as the extent to which it is carried out.

Implementation of a plan will always require support. Ongoing support of all the role players concerned, is an important part of any intervention aimed at improving quality of care. This includes emotional support and encouragement as illustrated in the example below from the Eastern Cape.

***A Small Rural Clinic in the Eastern Cape***

A TB coordinator visited a small clinic in Umzimkhulu sub-district to train two nursing sisters on the National TB Control Programme. It was winter and the sister in charge was very uncomfortable and cold. The clinic used a paraffin heater because it had no electricity. Although the sister had ordered paraffin from the district office more than six months previously, it was not supplied. It was no wonder she was not interested in hearing the details of the National TB Control Programme.

Some time later, the District Manager realised that the measure of her success as a district manager was closely related to the happiness of the clinic staff as well as the quality of PHC services that are rendered at a clinic level. She made sure that the clinic sister had paraffin for her heater, and now this clinic is one of the best clinics in the district in terms of implementation of the National TB Control Programme.

This example of targeted supervision in Tshwane, shows that regular monitoring by supervisors at the clinics is a form of support which is essential for improved service delivery.

***Targeted Supervision in Centurion, a sub-district of Tshwane, Gauteng***

The quality of STI management in Centurion was first assessed in November 2001 using the District STI Quality of Care (DISCA), one of the in-depth tools from the Clinic Supervisors Manual (Section 10). This baseline assessment found that the PHC clinics in Centurion had sufficient resources. This included equipment, drugs, protocols, stationary and condoms. However, in spite of sufficient resources, up to 19% of STIs were treated incorrectly. This was evidence that clinicians did not always refer to the protocols.

At this time, the Clinic Supervisors Manual was being introduced in the district. Clinic supervisors were required to visit each facility at least once a month. Because the treatment of STIs had been identified as a problem, each supervisor was also expected to review the records of at least one STI case per month. The use of specula by clinicians was also promoted and monitored by each facility manager and by the clinic supervisors (by regularly checking on the number of used specula). Clinicians became aware that their management of STI cases was being monitored.

The quality of STI management in Centurion was assessed again six months later and incorrect treatment had decreased from 19% to 15%. A further six months later it had decreased to 9%. No additional STI training had been undertaken between these assessments.

# Step 9: Evaluating the Impact

Once the plan has been implemented, it is necessary to evaluate how well this has been done and if it has had a positive impact.

### a. Evaluating how well the plan has been implemented

In order to monitor progress, the indicators that were identified in the planning phase should be used (as in step 4). These will give a measure of progress towards the goal.

We need to ask:

- Have we closed the gap between where we want to be (our goal) and where we were (baseline assessment)?
- Was our action plan appropriate?
- What is the reason for the lack of success in some areas?
- Do any of the proposed activities need modifying?
- What steps need to be taken to sustain and further improve quality of care?

### b. Monitoring the impact

Monitoring the impact should take place on a monthly or quarterly basis. It provides an opportunity to analyse progress, plan additional activities towards achieving the goal and to reprioritise. It also ensures that the team remains focused on the key result areas identified by the district. Some examples of how this can be done follow on the next few pages.

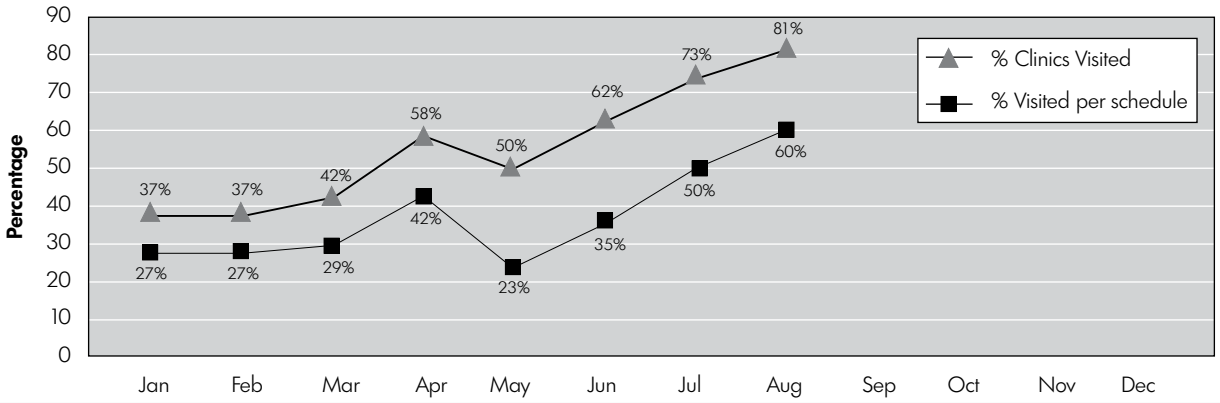
***Monitoring and Evaluation in Ukhahlamba District using indicators***

Ukhahlamba district has a clearly identified set of key result areas which are monitored monthly. The graph below shows the district's performance with regard to two indicators that monitor clinic supervision. They are:

- ✦ The percentage of clinics visited monthly by the clinic supervisors
- ✦ The percentage of clinics visited according to the monthly schedule

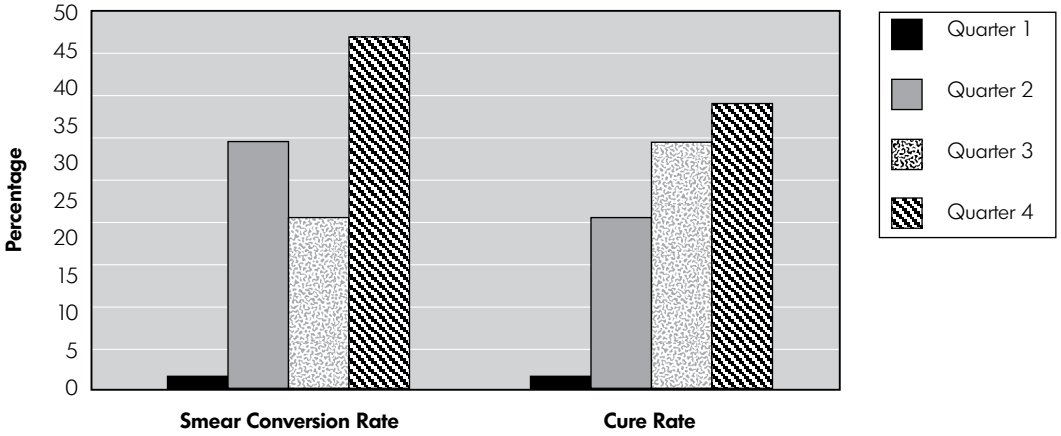
The graphs that follow show an increase in percentage (%) of clinics visited from 37% in January to 81% in September with the only decrease occurring in May. The percentage of clinics visited according to schedule also increased over the nine months from 27% to 60%.

***Supervision Visits***



Two of the indicators chosen by the Umzimkhulu sub-district to monitor TB were the smear conversion rate and cure rate. Increasing the awareness of clinic staff to TB will lead to an increased number of patients being suspected of having TB. The smear conversion rate measures the percentage of new smear positive pulmonary TB cases who are smear negative after two months of treatment and therefore no longer infectious. It is an important indicator as it measures how effective the initial treatment is in stopping the transmission of TB. The cure rate is the proportion of new smear positive TB patients who are smear negative at the end of six months treatment. The graph below compares the increase in smear conversion and cure rates over a year. As can be seen, both increased over the course of the year.

***Smear Conversion and Cure Rates***



# Conclusion

Using the Nine Step Plan as a guide to effective clinic supervision gives a clear and methodical approach to tackling a complex issue. It provides an outline of the path that can be followed to implement clinic supervision. Whilst it does not provide great detail or depth, it provides guidance on what tools to use and which skills are required, in order to find one's way. The results of using the 9 steps in this guide will improve quality of care and contribute to clinic supervision being seen as both manageable and a priority by clinic supervisors, programme managers, sub-district and district managers alike.

# Appendix 1:

## Clinic Supervisory Visits - Tips for Clinic Supervisors and Programme Managers

- Contact clinic staff in advance to arrange a visit at a time that is convenient for the facility. A supervisory visit is a planned facility visit. Explain that you will require the previous month's data and patient records/ files/ register. If this information is made readily available by clinic staff, it will facilitate the supervisory process.
- If possible call all the staff together to explain the purpose of the visit. This is particularly important when conducting in-depth reviews.
- Commend the staff for good quality care and initiative.
- Use the visit as a teaching opportunity. Clinicians should not feel that supervisors intend only to find fault. Many of the problems identified can be dealt with right there and then.
- Remember that availability of resources does not automatically mean that they are used.
- Encourage staff to come up with their own suggestions of how quality of care could be improved.
- Ensure that you give timeous feedback to the clinic on the findings of the evaluation (passed on to all clinicians in the clinic).
- Expect to spend between 45 and 90 minutes to complete an assessment per facility, depending on the availability of the data and your experience with the tool.

- When subsequent evaluations are done, review problems highlighted in the previous visit and make plans to address these. Were key activities undertaken? Point out the areas of progress and discuss the possible reasons for poor progress.
- Leave a copy of the completed form at the facility before you leave. Include a clear action plan with responsibilities for any identified gaps.
- Bring one piece of "new" information to share with the facility during the supervisory visit. It can be an update of a new policy/guideline or an update on case management (such as on prophylactic co-trimoxazole in HIV positive patients with TB). Section 11 of the CSM has a number of clinical tips that can be used for this purpose. Take enough copies for the facility to use. The facility staff will soon start to expect and look forward to learning something new from your visits!

# Appendix 2:

## Quarterly Review Meetings

This is a planned or scheduled meeting for the district. The district "driver" of supervision is responsible for coordinating and chairing the meeting and ensuring activities highlighted at the previous meeting have been addressed.

Each sub-district presents key issues highlighted by the Red Flag, Regular Review and In-depth Tools. Time is taken to describe the actions undertaken, the successes as well as the outstanding issues which were not addressed and those which may need the assistance of the District Management Team. The presentation should also focus on the progress made towards achieving the goals set for the district and the provincial programmes. It should identify intended progress in the next quarter. The presentation can be compiled into a written report and submitted to the DMT.

### Suggested Process

- The Chairperson is the champion/driver of the process at a district level. Ideally they should be a member of the District Management Team.
- The meetings can rotate quarterly from sub-district to sub-district. Minutes should be taken by the host sub-district.
- Each sub-district has to prepare written reports as described above which are handed in on computer disc if there are no e-mail facilities.
- Each sub-district should give a presentation based on the report. If available this should be done using Power Point.

What to present:

- Sub-district population. Number and type of facilities. Number of supervisors.
- For Red Flag and Regular review: (10 minutes)
  - What were the outstanding issues highlighted in the Red Flag and Regular Review. What was done to address these gaps and what outstanding issues need to be followed up by the district management or supervisors. Were any trends identified?
  - What facilities did not have reviews conducted and why
- In-depth reviews: (10 minutes)
- Presentation per sub-district (10 minutes)
  - Feedback or update from programme manager on progress made
  - What were the problem areas identified when conducting the In-depth Reviews. What action plans were drawn up to address these and have these been carried out?
  - Which facilities were not reviewed and why?
  - New information/clinical tips/capacity building activity for the group
  - In summary the Programme manager can compare the findings with goals, targets and indicators for the district.

*Tip! Copies of all in-depth review tools should be given to the programme manager. S/he can summarise these on an excel spreadsheet and keep as baseline. Invite provincial programme manager to this meeting to improve working relationships and provide an understanding of issues at a district level.*

# Appendix 3:

## Supervisory Skills

Clinic supervisors are often away from their districts, attending training on health service issues. However it has been found that little training is provided to develop key skills such as:

- Leadership skills needed to inspire and motivate clinic staff
- Management skills to assist clinics in setting realistic goals and solving problems
- Skills in using health information to assist with PHC management
- Planning skills to assist with prioritisation, time management or to plan a supervisory visit
- Report writing skills
- Interpersonal skills
- Motivational skills
- Problem-solving skills

## Supervisor skills: Suggested focus areas

**Planning skills**

- Summarising, collating and writing up results or findings for group of facilities that the supervisor is responsible for (Refer to section 2 of the Manual)
- Prioritising key areas needing attention
- Developing and practising problem solving
- Developing an action plan (use standard format)
- Monitoring the implementation of an action plan.

**Communication skills**

- Presentation and public speaking skills
- Use of posters or newsprint where there is inadequate electrification
- Use of overhead projector
- Computer literacy:
  - MS Word
  - Power Point
  - Excel

**Information skills**

- Know what are goals, targets and indicators
- How to check data quality
- How to use information for management

**Contextual information**

- Understanding the District Health Plan/sub-district operational plan
- Understanding where or how to access DHIS software
- Up-to-date on relevant policies (National policy on quality assurance and the national policy on TB-HIV integration.)

# Appendix 4:

## Resources Used and Further Reading

Clinic Supervisors' Manual. Pretoria, Department of Health; 2003.
URL: http://www.doh.gov.za/docs/index.htm (click on factsheets/guidelines)

Marquez L, Kean L. Making Supervision supportive and Sustainable: New Approaches to Old Problems. Washington DC, 2002. MAQ Paper vol. 30, no.4.

Van Rensburg D, Viljoen R, Heunis C, Janse van Rensburg E, Fourie A. Primary Health Care Facilities Survey. In: Ntuli A, Crisp N, Clarke E, Barron P, editors. South African Health Review, 2000. Durban: Health Systems Trust; 2000.

Simmons R. Supervision: the management of frontline performance. In: Lapham RJ, Simmons GB, editors. Organising for effective family planning programmes. 1987. Washington DC, National Academy Press: 233 - 261

Kim YMP et al. The Quality of Supervisor-Provider Interactions in Zimbabwe. Operations Research Results. 2000. 1(5): 1 - 16.

Heiby J. Quality Assurance and Supervision Systems (editorial). QA Brief. 1998. 7(1): 1 - 3.

Scanlon C, Weir WS. Learning from practice? Mental Health nurses' perceptions and experiences of clinic supervision. Journal of Advanced Nursing. 1997 26; 295 - 303.

Flahault D, Piot M, Franklin A. The Supervision of Health Personnel at a District Level. Geneva, World Health Organization. 1988.

Kwik-Skwiz # 15. Supporting staff through effective supervision: How to assess, plan and implement more effective clinic supervision. Durban: Health Systems Trust; 1999.

Lehmann U. Investigating the roles and functions of clinic supervisors in three districts in the Eastern Cape Province. Durban: Health Systems Trust; July 2001.

Much of the information in Step 4 was developed by Anna Voce and Prof. Hugh Philpott. It was initially developed for Reproductive Health Teams in Limpopo Province.

Appendix 4

## Further Reading

Heywood A, Rhode J. (undated). Using Information for Action. A manual for health workers at facility level. The Equity Project; University of the Western Cape. www.equityproject.co.za

The Primary Health Care Package for South Africa – A set of norms and standards. Pretoria: Department of Health; September 2001.

A Comprehensive Primary Health Care Service Package for South Africa. Pretoria: Department of Health; September 2001.

Barron P, Monticelli F, Leon N. Lessons Learnt in the Implementation of Primary Health Care, Chapters 2 and 3. Durban: Health Systems Trust; December 2003. ISBN: 1-919743-76-6

WHO (1993) Training Manual on Management of Human Resources for Health: Section 1, Part A. Geneva, World Health Organization.

Moys A. Evaluating Quality of STI Management at a Regional Level using the District Quality of Care Assessment (DISCA). Durban: Health Systems Trust; August 2002.

*All publications by Health Systems Trust available from:*

*Health Systems Trust, 401 Maritime House, Salmon Grove, Durban 4000.*

*Tel 031 307-2954 Fax 031 304-0775 and on the HST website at www.hst.org.za*

# Appendix 5:

**RED FLAG LIST** (Also available in the Clinic Supervisors' Manual)

| **CLINIC NAME** | |
|---|---|

***DRUG STOCK OUTS***

| | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** | **Nov** | **Dec** |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| FP | | | | | | | | | | | | |
| STD | | | | | | | | | | | | |
| TB | | | | | | | | | | | | |
| ANC | | | | | | | | | | | | |
| EPI | | | | | | | | | | | | |
| Chronic | | | | | | | | | | | | |
| HIV | | | | | | | | | | | | |

***REFRIGERATOR NOT FUNCTIONING***

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Mechanical | | | | | | | | | | | | |
| Electricity | | | | | | | | | | | | |
| Gas | | | | | | | | | | | | |

***STAFF NOT ON DUTY (LEAVE, TRAINING, ABSENT WITHOUT LEAVE)***

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Professional | | | | | | | | | | | | |
| Non-Professional | | | | | | | | | | | | |

***BROKEN EQUIPMENT***

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Baumenometer | | | | | | | | | | | | |
| Scale | | | | | | | | | | | | |

Appendix 5

***RED FLAG ACTIONS****

| | | |
|---|---|---|
| January | February | March |
| April | May | June |
| July | August | September |
| October | November | December |

*The supervisor and clinic manager will decide how to deal with the red flag item needing attention

# Appendix 6:

**REGULAR REVIEW LIST** (Also available in the Clinic Supervisors' Manual)

| | |
|---|---|
| **CLINIC NAME** | |
| **SUPERVISOR NAME** | |

| ROUTINE REVIEW | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|
| Staff Management | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Clinic Management | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

# Appendix 6

| ROUTINE REVIEW | Jan | Feb | Mar | Apr | May | Jun |
|---|---|---|---|---|---|---|
| Information Review | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Referral Review | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

| **Clinical care** | | | | | | |
|---|---|---|---|---|---|---|
| STGs followed | | | | | | |
| 1 Dnosis/Correct Manag | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 2 Dnosis/Correct Manag | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 3 Dnosis/Correct Manag | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 4 Dnosis/Correct Manag | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| 5 Dnosis/Correct Manag | Y/N | Y/N | Y/N | Y/N | Y/N | Y/N |
| Public Health Impact | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Clinic committee | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Clinic visits | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| Supervisory visit actions completed | Y/N/P | Y/N/P | Y/N/P | Y/N/P | Y/N/P | Y/N/P |

P = Partially

Dear Reader,

If you have found this publication useful in your day to day work, or have any comments please contact us:

Email: editor@hst.org.za or webmaster@hst.org.za

or

Phone: (031) 307-2954

or

Fax: (031) 304-0775

or

Write to us at
HST
P.O Box 808
Durban
4000

***We value your views***

For more information about HST visit
http://www.hst.org.za
email us at
webmaster@hst.org.za