Education for Health, Vol. 17, No. 1, March 2004, 53–61

Taylor & Francis healthsciences

ENHANCING EDUCATION AND PRACTICE

Capacity Development Through Reflective Practice and Collaborative Research Among Clinic Supervisors in Rural South Africa – a Case Study

U. LEHMANN[1], W. BLOM[2], M. DLANJWA[3], L. FIKENI[3], N. HEWANA[2], N. MADLAVU[2], V. MAKAULA[4], M. PENNACCHINI[2], S. SEAL[2], T. SIVUKU[3] & K. SNYMAN[2]

[1]*School of Public Health, University of the Western Cape, Cape Town, South Africa,* [2]*Clinic Supervisor, Albany District, Eastern Cape Province, South Africa,* [3]*Clinic Supervisor, Umzimkulu District, Eastern Cape Province, South Africa and* [4]*Clinic Supervisor, Mount Frere District, Eastern Cape Province, South Africa*

ABSTRACT *This article provides an example of one form of action research, collaborative enquiry, in the health sector. It argues that collaborative inquiry is a powerful tool to develop reflective capacity among health workers and can facilitate the ownership of learning and the production of usable knowledge. It reports the results of a research project investigating the roles and functions of clinic supervisors in three districts in the Eastern Cape Province, South Africa.*

Background: *Clinics are the cornerstone of the new district-based health system. They are staffed primarily by nurses and are often the only contact point for large parts of the rural population. In conditions of remoteness and isolation, clinic staff depend upon personal interaction with clinic supervisors to enable them to function productively. Yet experience has shown that supervisors do not always fulfil this role. This project aimed at gaining insight into the status of clinic supervision, understanding the factors that hinder effective supervision and making recommendations for improvements.*

Methodology: *Using a participative approach of* Collaborative Inquiry*, a team of 10 clinic supervisors and the research co-ordinator collected data reflecting on their own practice over a period of 5 months. These data were then jointly analysed and written up.*

Conclusions: *The participating clinic supervisors went through several periods of uncertainty, when many of them asked themselves why they agreed to this project. However, the engagement with stakeholders and colleagues and the joint analysis of*

Author for correspondence: Dr. Uta Lehmann, School of Public Health, University of the Western Cape, Private Bag X 17, Bellville 7535, South Africa. Tel: +27 21 959 2633. Fax: +27 21 959 2872. E-mail: ulehmann@uwc.ac.za

Education for Health ISSN 1357–6283 print/ISSN 1469–5804 online © 2004 Taylor & Francis Ltd
http://www.tandf.co.uk/journals
DOI: 10.1080/13576280310001656141

research data soon proved to be a valuable source of insight. There was unanimity in the end that the research process had been very valuable and enabling.

KEYWORDS *Clinic supervision, reflective practice, collaborative inquiry, capacity development, South Africa.*

Introduction

It has been asserted recently that a continuing problem in health sciences research is ''the wide gap between academics, by whom most health research is carried out, and policy-makers, health managers and health workers who have to make use of the results'' (Varkevisser *et al*., 2001). This leads to two problems. First, research often does not cover crucial and priority topics in health systems and services. Second, health workers, who are at the core of health service provision, remain pawns in the research game, with no influence on research processes or results. The result is lack of ownership, indifference and often active resistance and undermining of research which is considered not useful, intrusive or even harmful by providers. Thus the crucial role that research could and should play in health service development and transformation is hampered. Participatory research has been identified as one potential strategy to overcome this problem. Nelson and Wright (1995) point out that the goal of participatory research is to increase participants' understanding of their situation. Their ability to use this information, in conjunction with their local knowledge of the viability of different political strategies, will help them to change.

The approach of participative research and collaborative inquiry was used to gain insights into the roles and functions of clinic supervisors in three rural districts in the Eastern Cape Province of South Africa.

Background

Health care provision at clinic level is central to health service transformation in South Africa. It affords many citizens, particularly in remote rural areas the first and often only access to health care facilities. While the introduction of a district health system and a PHC approach has been a national priority since 1994, different provinces have approached implementation in different ways, depending on their historical legacies.

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

Clinics are the cornerstone of the new district-based health system. Since 1994 numerous clinics have been built in the Eastern Cape, many of them in remote rural areas which previously did not have any access to health care facilities. Today, some 650 clinics provide the first level of care to a population of 6 million. They are expected to render a wide range of services under clearly stipulated conditions which include the availability of specialised professionals, regular medicine supplies and the availability of electricity, cold and warm water.

Yet the actual situation in many clinics bears little resemblance with the stipulated standards. Anecdotal evidence describes services being rendered in collapsing rondavels (small, round, thatched mud huts) with no privacy for patients, no telephones, electricity, reliable water supplies and an increasing struggle to fill posts in rural clinics.

Under these conditions of remoteness and isolation, clinics in the public sector depend upon personal interaction with supervisory personnel visiting from a higher authority on a regular basis as the *Provincial Policy on Clinic Supervision* points out. Both the Provincial Policy and the National Norms and Standards furthermore stipulate that ''each clinic will be supervised by a single, multi-purpose nurse who will be the single liaison between that clinic and higher authority''. Tasked to be the go-between between clinics and management at a time of far-reaching change and innovation, clinic supervisors have been given a crucial role in ensuring the successful implementation of primary health care. And yet, in practice they often struggle to fulfill this role. Supervision happens unevenly. Visits often take place haphazardly and are not used most effectively to support service provision in the clinic.

It is against this background that the School of Public Health (SoPH) at the University of the Western Cape (UWC), in collaboration with three health districts in the Eastern Cape Province (Albany, Mount Frere and Umzimkulu), developed a research project aimed at gaining insight into the status quo of clinic supervision, understanding the factors that hinder effective clinic supervision and making recommendation for improvements. Using a participative research approach, the team of 10 clinic supervisors and the research co-ordinator collected data reflecting on their own practice over a period of 5 months. These data were then jointly analysed and written up.

Methodology

The study was conducted by 10 clinic supervisors in the Eastern Cape, facilitated and supported by a researcher from the University of the Western Cape, using qualitative methods of data collection and analysis.

Collaborative Inquiry and Reflective Practice

The study falls within the broad category of *participative action research* (PAR) or *collaborative inquiry* as introduced by Bray *et al*. (2000). It works with Schon's concept of the reflective practitioner, described by Carr and Kemmis (1986) as ''*simply a form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their practice*''. The concept was used in a very practical way, as an approach, which allows clinic supervisors the space to investigate and reflect on their own professional practice against the background of health service transformation.

Participative Action Research and *Collaborative Inquiry* are widely used in educational research but increasingly also in other professional contexts such as agriculture and industry (e.g. Farrington & Martin, 1990). In the health sciences, participative methods have been used widely in the area of community development. In health systems research, however, their entry has been slow, largely due to the dominance of medical models in the field. But even here researchers are beginning to realise the value of participation and self-reflection as tools to foster change and capacity development. One development is the methodological approach of *Health Workers for Change* (HWFC), which was recently comprehensively discussed in a special supplement of the journal *Health Policy and Planning* (Fonn & Xaba, 2001).

Participative action research and collaborative enquiry build on traditions of action research (Bowling, 1997), but have taken its principles further. *Participative Action Research* (PAR) asserts that ''the people who participate in the research process become full partners or co-researchers in running the research process itself'' (Bowling, 1997). The far-reaching implication is that ''the researcher must be willing to relinquish the unilateral control that the traditional researcher has traditionally maintained over the research process'' (Whyte, 1991). *Collaborative Inquiry* has taken this concept further by suggesting that those involved in the research process should form a ''group of peers''. ''Members may bring a diverse set of skills and experiences to the group, but these are not viewed as the basis for early differentiation... The initiator ... has to quickly concede authority as soon as possible during the inquiry'' (Bray *et al*., 2000).

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

The Research Process

The initial research proposal was drawn up by the School of Public Health. A number of research questions were developed, keeping in mind that these would be adapted and changed in the course of the research process.

The proposal was then sent to certain health districts in the Eastern Cape, asking for parties interested in the project to come forward. The choice of districts the proposal was sent to was purposeful, in that the targeted districts already had a working relationship with the SoPH, which facilitated collaboration. Three districts responded to the call for expression of interest and put forward the names of ten clinic supervisors.

At the initial workshop, the research team, consisting of the SoPH research co-ordinator and 10 clinic supervisors, was constituted. Participants were introduced to the research method, and the team reviewed the project objectives and research questions. It was agreed that all decisions on process and product of the project would be taken by consensus, a principle which was upheld throughout the project.

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

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

At a second workshop, team members began the data collection process. The first step was completing a basic information questionnaire compiled by the co-ordinator, which covered questions of personal professional background (years of service, etc.) as well as working environment (numbers of clinics under supervision, distances travelled, etc.). This was followed by a mapping exercise. Team members drew their districts on newsprint to familiarise themselves and each other with the number of clinics supervised, distances covered, terrain, road conditions. Lastly, all team members interviewed each other, based on interview guides that had been developed collaboratively by the group. This was an instrument introduced experimentally, and very successfully, by the research co-ordinator to foster team members' familiarisation with each other and their professional context and to nurture the concept of collaborative inquiry and ownership of the research process. Team members also reflected on the first few weeks of keeping a diary which all found very time-consuming and sometimes tedious, but also enlightening.

The second workshop was followed by a series of interviews and four workshops with clinic staff and community members in the selected districts. The workshops were well attended and followed the same pattern, although slight adjustments were made after the first workshop.

Team members from the respective districts organised and attended the workshops. However, to encourage free and unconstrained discussion, they did not take part in the small group discussions when staff and community health committee members discussed their experiences and existing skills of clinic supervisors. The workshops were conducted in Xhosa and English, and translation was provided where required. The feedback sessions of all workshops were taped, written up, and the tapes were transcribed. The workshops were introduced and led by the research co-ordinator as the ‘‘outsider’’ to the district and its health services. During small-group discussions each group elected a leader and rapporteur who presented the group’s results to the plenary session. Furthermore, the research co-ordinator interviewed the district managers in all districts and the director in charge of PHC in the provincial health department.

In the following step, all data were jointly analysed in a 2-day workshop (on the topic of joint data analysis see Oelsen *et al*., 1994). After revisiting the research questions, the team established a list of themes and analytic categories, which were then used to analyse the data. Team members worked individually to look at their ‘‘own’’ data (interviews and diaries) and in groups to look at clusters of data. They then discussed the emerging themes, turning them into research results.

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

Findings

The findings of this project are presented on two levels: the emphasis of this section is on reflections about the research process, the key focus of this paper, followed by a brief summary of the ‘‘substantive’’ findings emanating from the project.

The Research Process

The research process was not any easy one, placing substantial demands on all team members. The joint workshops of the research team proved time-consuming and logistically demanding, as team members had to travel between 2 and 6 hours to get to the different, mutually agreed upon workshop venues. The organisation and implementation of the four workshops with service providers and communities took up substantial additional time. Keeping a diary of daily activities, which all team members had committed to at the beginning of the research process, proved most taxing. It was evident that several team members seriously doubted the value of this time- and energy-consuming exercise by the time the team met for the second workshop.

Apart from demands on time and energy, the other challenge was the need to negotiate and come to consensus on all aspects of the research process and product. While the research co-ordinator provided input on background and methods, all research questions, data collection and analysis instruments, structure and content of the report, as well as logistics, were extensively negotiated and agreed upon by the entire team. As could be expected in such a comparably large group working together closely, not all group members were initially happy to participate in these negotiations and discussions to the same extent. However, as the participants, all mature women over the age of 40, became more comfortable with each other, the topic and the process, the level of participation became increasingly even and active.

While the process was demanding, it also proved enormously enriching to all participants. First, the intense engagement with colleagues from different districts over a prolonged period broadened participants' horizons with regard to the different professional contexts. All gained valuable insights into the scope and challenges of the different activities of clinic supervisors.

Second, the structured engagement with stakeholders and colleagues outside the rush of meetings allowed for self-reflection and a critical look at practices which routine daily schedules do not allow.

Thirdly, the team learnt a range of research skills, from the formulation of research questions to the development of interview guides and, very importantly, the analysis of data. A 2-day data analysis workshop proved to be the highlight of the project. Whereas team members had kept particularly the diaries with a certain degree of suspicion as to whether they were worth the effort, it was the engagement with these "raw" data, which brought the project to life for all. Team members spent considerable time analysing their own diaries, categorising their activities and time spent on each of them. Individual findings were then discussed and categorised in the group. This exercise generated one of the key findings of the project, i.e. that most clinic supervisors spent an extraordinary amount of time on administrative duties and in meetings and relatively little time in supervisory activities. By way of data triangulation these findings were subsequently further analysed.

There was enthusiastic agreement among team members that they walked away from the project armed with valuable new skills, new insights into their own practice and a better understanding of the factors impacting on their work. In fact, a request was made that further research be conducted using this approach, but involving staff from the earliest stages of the conceptualisation of the research project, so that staff could initiate and conduct research independently in future. This request still has to be followed up.

The State of Clinic Supervision in the Eastern Cape

The research team, in triangulating all data, identified a number of key results which can be summarised as follows: all stakeholders agreed that the most

important contribution to making clinic supervision more effective would be to provide regular and ongoing contact between supervisors and clinics. While this has been recognised and stipulated in the Provincial Policy, the reality in those districts discussed in this study is quite different. Due to a variety of reasons which range from uneven distribution of supervisors to unresolved governance issues, understaffing, lack of infrastructural support and time spent in meetings and workshops, clinic supervisors could not perform their duties as expected. Resolving these issues and rendering ongoing support and training to clinic supervisors were considered crucial to make supervision of rural clinics more productive and effective.

Conclusion

Martinez and Martineau (1998) have pointed out that ''human resources are often the greatest threat to the success of reforms'' because a lack of development and training leads to low levels of staff morale, low productivity, high turnover and a drain of human resources into the private sector and other countries. The study found that among clinic staff and supervisors who participated in this project, this was not the case. All were deeply committed to health sector transformation and community service. But all of them had stories to tell of colleagues who had left the service, of high absenteeism rates and low morale. And all acknowledged that the slow and uneven process of transformation, which leads to long periods of insecurity and which is taking place without adequate support for staff, is taking its toll. The key recommendations therefore addressed themselves to issues of stability: the resolution of governance issues, achieving uniformity in conditions of service, and the establishment of structured induction, support and appraisal mechanisms. The research team and its key informants were unanimous that addressing these issues would lay the basis and would be a prerequisite for more effective, more fruitful clinic supervision.

The research process proved to be difficult but fruitful. The participating clinic supervisors went through several periods of uncertainty, when many of them asked themselves why they agreed to this project, which involved substantial travelling and work in addition to their normal workloads. However, the structured engagement with stakeholders and colleagues outside the rush of meetings soon proved to be a valuable source of insight for all. Even more important for the team was the joint analysis of data and particularly the diaries, which provided a unique opportunity to reflect on one's own day-to-day activities. There was unanimity in the end that the research process had been very valuable for all participants and that collaborative inquiry is indeed a powerful and enabling tool for research with and among health workers.

Note

1 This paper is based on a project report: Lehmann, U. et al (2002). *Investigating the Roles and Functions of Clinic Supervisors in Three Districts in the Eastern Cape Province*. HST Technical Report. Durban: Health Systems Trust.

Acknowledgments

The authors gratefully acknowledge the support from the South African *Health Systems Trust*, which made this project possible.

References

BOWLING, A. (1997). *Research Methods in Health. Investigating Health and Health Services*. Buckingham: Open University Press.

BRAY, J.N., LEE, J., SMITH, L.L. & YORKS, L. (2000). *Collaborative Inquiry in Practice*. Thousand Oaks, CA: Sage Publications.

CARR, W. & KEMMIS, S. (1986). *Becoming Critical: Education, Knowledge and Action Research*. London: Falmer Press.

FARRINGTON, J. & MARTIN, A. (1990). *Farmer Participation in Agricultural Research: A Review of Concepts and Practices*. London: Overseas Development Institute.

FONN, S. & XABA, M. (2001). Health workers for change: developing the initiative. *Health Policy and Planning*, *16* (Suppl. 1), 13–18.

MARTINEZ, J. & MARTINEAU, T. (1998). Rethinking human resources: an agenda for the millennium. *Health Policy and Planning*, *13*(4), 345–358.

NELSON, N. & WRIGHT, S. (1995). *Power and Participatory Development. Theory and Practice*. London: ITDG Publishing.

OELSEN, V., DROES, N., HATTON, D., CHICO, N. & SCHATZMAN, L. (1994). Analyzing together: Recollection of a team approach. In A. Bryman & R.G. Burgess (Eds), *Analyzing Qualitative Data*. London: Routledge.

VARKEVISSER, D., MWALUKO, G.M.P. & LE GRAND, A. (2001). Research in action: The training approach of the Joint Health Systems Research Project for the Southern African region. *Health Policy and Planning*, *16*(3), 281–291.

WHYTE, W.F. (1991). *Participatory Action Research*. Newbury Park: Sage Publications.