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Planning, Developing & Supporting the Health Workforce

Supporting Health Worker Performance with Effective Supervision

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Introduction

Access to quality health services depends on the performance of skilled personnel (Dussault and Franceschini, 2006). Consequently, improving health services requires continuous support for health workers to allow those in the frontline of service delivery to perform as expected. In the context of strengthening human resources for health (HRH), making supervision systems more effective also holds potential for increasing health worker productivity and improving retention (Yumkella, 2005). Supervision is one of the most relevant tasks in health systems management (Iles, 1997)—yet health managers commonly neglect supervision, and many supervisors lack the knowledge, skills and tools for effective supervision.

There is evidence that supervision can be improved. A field experience in Kenya showed that properly trained and supported external and on-site supervisors were able to support local health teams' performance in district hospitals and health centers (Lynam and Takuom, 2005). Field experiences in business and development suggest that appropriate supervision empowers local teams to identify and face their own challenges in a continuous improvement loop (Thomsen, 2005; Galer, 2005). A literature review found that supervision produced positive effects on staff performance, especially when self-assessment was in place (Rowe et al., 2005). When supervision supported performance improvement, the results were also positive (Lynam and Takuom, 2005). Supportive supervision and self-assessment can reinforce communication and counseling, reflection and learning—especially among inexperienced health workers, helping them to improve their communication skills (Kim et al., 2002).

During a workshop on supervision practices organized by the Capacity Project in October 2005, participants generally agreed that the traditional visiting supervisor model does not work. In response, the Project worked with governments and partners in Uganda and Central America to test more systemic approaches for strengthening supervision systems in the health sector using a performance support (PS) approach. This brief includes the results of the Project's PS interventions, and discusses factors that contributed to those results. The brief shares the common intervention model, analyzes the variations in content, context and methods of the interventions and discusses how similarities and differences played a role in the results. Finally, the brief includes recommendations for implementing and scaling up PS interventions.

Traditional Supervision Systems

The visiting supervisor model requires that resources are in place for visiting health facilities regularly. Since resources are often limited, however, usually only the more accessible health facilities receive supervision visits, and only a few times per year. Furthermore, visiting supervision is often ineffective not only as a result of the limited number of visits, but because it uses a top-down, control-oriented approach that mostly focuses on collecting epidemiological and administrative data without addressing local staff's performance needs. Under these conditions supervision visits can be worse than no visits at all (Luoma, 2005).

In addition, many health workers fear supervision, mainly due to perceived or real misuse of authority by supervisors. In Uganda, one out of four interviewed health workers reported physical, verbal or emotional abuse from their supervisors (McQuide et al., 2008).

In contrast, the successful experiences of improving supervision cited above have the empowerment of frontline health workers as their common feature. Dealing with supervision issues goes far beyond increasing the number of supervisors or improving their supervision skills. To succeed, health managers should change the role of supervision from a control-oriented activity with punitive consequences to a supporting role that helps local teams improve performance and service delivery.

The Capacity Project's Approach for Improving Supervision

The Project designed and tested the PS approach, which, like performance improvement, ensures that three basic human resources management rules are in place:

- Staff know and understand what performance the organization expects from them
- Staff have the competencies, tools and equipment necessary to perform as expected
- Staff receive continuous positive feedback about their performance (Iles, 1997).

Under the PS approach, district officers or Ministry of Health managers and regional management teams support local performance improvement processes to close the gap between expected and actual performance. Performance improvement has proven to be effective as a stand-alone intervention at individual facilities (Bossemeyer and Necochea, 2005; IntraHealth International, 2005). The goal of PS is to implement performance improvement and supportive supervision in a complementary and sustainable way, and one that can be scaled up.

The Project's approach includes the following five steps for implementing PS interventions:

1. **Foster agreements and commitments among stakeholders.** During this stage, external facilitators skilled in PS help the organization's leaders to understand the approach. The goal is to commit them to invest resources to implement PS learning experiences and eventually to scale

Performance Improvement and Performance Support

Performance improvement (PI) often refers to an internal process in a given health facility to bridge gaps between expected and actual performance. Performance support (PS) is a broader concept; it consists of aligning district/provincial/regional/national management to support several simultaneous PI processes. Therefore, PI is a component of PS in this context.

PI typically focuses on strengthening existing good practices and implementing needed practices that are not in place. Examples include actions to encourage hand-washing protocols that are already in place, and actions to improve information given to clients on side-effects of contraceptive pills.

PS is a function of district/regional/national management. It focuses on common issues affecting several local teams or addressing issues where the local team has weak or no control—for example, district-wide training activities for improving neonatal resuscitation and improving a district logistics system that is preventing health facilities from having required drugs.

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Region or Country	Scope	Purpose
Central America	*36 hospitals in six countries: Belize, Costa Rica, El Salvador, Guatemala, Nicaragua, Panama*	*Improve performance and quality of decentralized HIV services*
Uganda (Ministry of Health)	*104 health facilities in nine districts: Amuru, Amolatar, Apac, Dokolo, Gulu, Kitgum, Lira, Oyam, Pader*	*Improve performance and quality of prevention of mother-to-child transmission services*
Uganda (Uganda Protestant Medical Bureau)	*Nationwide*	*Improve performance of health management information system*

Table 1: Capacity Project Performance Support Testing Locations and Purpose

"This is the first time in my career that I knew very clearly what the staff in the visited health center needed; it has been the first time that I was able to support them. The performance assessment tool allowed me to see beyond the appearance. PS is the key for making supervision supportive."

—District health officer, Uganda

up. Leaders should define how to recognize advances in performance improvement in order to garner staff commitment and enthusiasm.

2. **Determine the expected performance of local health teams.** Technical and management leaders, assisted by external facilitators, select good practices from national and international clinical guidelines, management procedures, expert advice, client preferences and provider expertise. Proven/promising practices are organized as performance standards, which state clearly what the local health team must do. Standards are broken down into verification criteria that specify how local staff should implement good practices.
3. **Assist local health teams to carry out performance improvement.** Authorities at the highest level of the organization ensure proper regulations, a positive environment and financial resources that support local teams to carry out their performance improvement action plans. District-level managers and supervisors should be ready to respond to local teams' needs, promote coordination and provide technical support.
4. **Manage change and PS efforts.** Performance improvement has been difficult to sustain (Marquez and Kean, 2002). To address this issue, PS creates a bottom-up movement strengthening the capacity of the local health team to bridge identified performance gaps through its own action plans. A complementary top-down movement from the district and national levels orchestrates and networks local efforts through effective supervision, facilitating continuous learning.
5. **Celebrate progress.** A combination of positive feedback, social and material recognition should be used by supervisors to recognize advances, which will motivate local staff to continue progress toward performance improvement goals (Bossemeyer and Necochea, 2005).

The Uganda Experience

Ministry of Health

USAID/Uganda asked the Capacity Project to take part in the initiative to improve prevention of mother-to-child transmission (PMTCT) of HIV services in nine northern districts. The Project facilitated assembling a task force of central-level officers, with participation of the reproductive health and HIV programs and infection control officers, under the leadership of the Human Resources Development unit. Officers from the Northern Uganda Malaria, AIDS and Tuberculosis (NUMAT) Program and a Project consultant also participated on this team. This task force led the implementation of PS in the nine districts. After determining expected performance, the task force used a cascade strategy to train district health management teams, which in turn should train local staff and implement performance improvement processes at the local level.

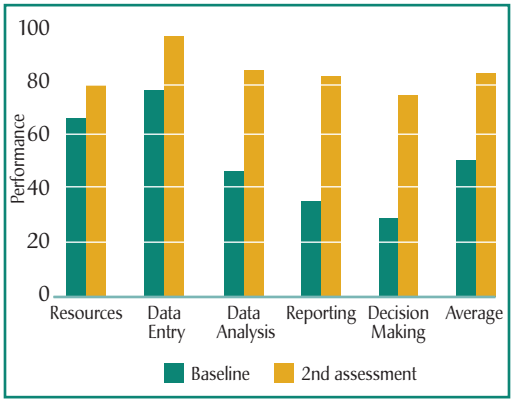
However, the expected empowerment of local teams did not happen because the task force decided to skip the key step of local action planning. The very structured, top-down mindset of members of the task force may have played a role in this decision. During a final field visit to Amolatar District it was clear that the performance improvement processes were not in place, and important performance gaps were still present. However, there were some successes such as district plans responding to performance assessment findings by prioritizing important local issues and dealing with some of them.

Uganda Protestant Medical Bureau

The Uganda Protestant Medical Bureau (UPMB) is a national umbrella organization with a network of over 250 health institutions (UPMB, 2009). UPMB's leaders asked the Project to assist in implementing the PS approach to improve its health management information system (HMIS). HMIS requires a routine reporting system that involves accurate and timely record-keeping on all the health services provided across the network. The issue was that the HMIS did not deliver reliable and timely collected information, which undermined the organization's capacity to make informed strategic decisions. UPMB attributed the source of the problem to lack of sufficient resources such as paper forms, calculators and computers.

The Project's baseline performance assessment revealed that difficulties with data analysis were the actual HMIS bottleneck. Knowing the issue had systemic roots, the UPMB secretariat used the PS approach to look for innovative ways to support performance of local and district registrars, including developing a web-based application that streamlines data entry and provides immediate analysis feedback. District supervisors supported the design and implementation of local action plans that fostered mobilization of local resources and initiatives to ensure the availability of forms, full data collection, compliance with reporting deadlines and display of key indicators graphs. Local staff, diocese supervisors and secretariat leaders realized that blaming a lack of resources had become an excuse that was progressively incorporated into the organization's culture, veiling the existence of several easy-to-solve issues that did not require additional resources or funding, but rather changes in attitude. Local staff's perception of HMIS began to change, and UPMB decided to institutionalize the use of PS. Results are illustrated in Figure1.

Figure 1: HMIS Performance Standards Compliance, UPMB



The Central America Experience

USAID's Central America Regional Program (G-CAP) asked the Project to support decentralization of HIV services in Belize, Costa Rica, El Salvador, Guatemala, Nicaragua and Panama. National health authorities decided to increase the number of hospitals providing HIV services to address barriers to access given the centralization of services, persistence of stigma and discrimination and weak nutritional care (Mendizabal, 2006). The Project applied lessons it had learned in Uganda, avoiding any direct confrontation with the established supervision systems, focusing on HIV service delivery and targeting a limited number of hospitals in a low-profile manner.

Following the five PS implementation steps, the process allowed local teams to bridge identified performance gaps, including improving logistics systems, acquiring basic equipment, addressing stigma and discriminatory practices and improving infection prevention practices. National authorities also addressed systemic cross-cutting issues, such as improving nutritional care guidelines, strengthening infrastructure deficiencies and addressing human resources shortages.

The national and regional management teams adjusted their usual supervision approach, aligning their plans to respond to the actual needs of hospitals. In Guatemala, the Ministry of Health's Hospital Management Unit incorporated PS into its plans and agendas. In Nicaragua, the general secretary of health led the PS implementation, adopting the performance standards for HIV treatment and care, including PMTCT, and expanding the use of PS beyond HIV services. Regional teams built partnerships with nongovernmental organizations to implement PS in their private clinics. In Panama, the national HIV program incorporated PS into its supervision plan. Costa Rican Social Security is using PS as the key intervention to facilitate the decentralization of HIV services, incorporating it into its management plans. El Salvador's national HIV program incorporated PS as one of its management responsibilities and created a budget line item to support these activities; hospitals have created PS teams to continue its implementation beyond the Project's intervention.

All of these local and systemic changes contributed to improvements in the performance and quality of decentralized HIV services as shown in Figure 2.

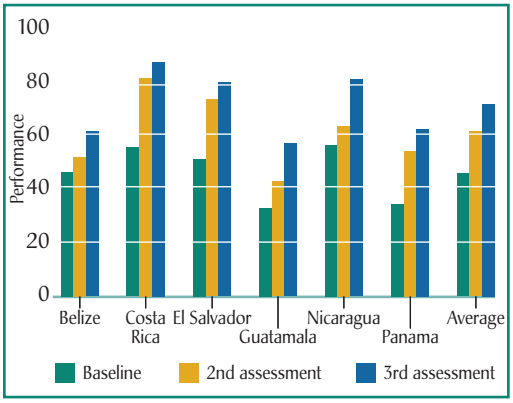


Figure 2: Average Compliance with HIV Service Performance Standards, Central America

Keys to Success

In addition to improving adherence to good practices and performance standards, PS produced system changes among participating organizations. Even in the more challenging experience at the Uganda Ministry of Health, there is evidence of some positive change at the district management level, like incorporating local issues identified during performance assessment into district-level planning.

The Capacity Project's experiences demonstrate that supervision is effective when it starts by triggering performance improvement processes that empower local staff, and when supervisors pay attention to—and support—the needs derived from local action plans to close identified performance gaps. Health workers feel more connected to the organization when it seems responsive to their needs, and when their feelings of invisibility, isolation and abandonment are reduced. Supervisors feel that their visits are useful and appreciated, and that PS creates a link among the different levels of the organization playing complementary roles for improving performance and quality of service delivery.

The following are the most important lessons learned during these eight PS implementation experiences.

1. **The PS approach must be tailored to system-specific issues**. Organizations with more rigid and parceled structures made the implementation of PS more difficult. This was especially true for upper-level organizational bodies where administrative boundaries and power-sharing made negotiations more challenging. By contrast, frontline health workers and district management teams were open-minded and enthusiastic about the benefits of using the PS approach.
2. **Learning organizations can help to facilitate PS implementation**. UPMB and Costa Rican Social Security are very different organizations working under very different conditions. But both are learning organizations, willing to innovate and rapidly incorporate promising and successful practices. In both organizations, strong and dedicated leaders championed the implementation; having them on the intervention side expedited the implementation. These leaders made timely decisions, motivated local teams, mobilized additional resources and removed unexpected obstacles. Local teams also had a considerable degree of autonomy for decision-making.
3. **Selecting only one service delivery or management issue—HIV, PMTCT or HMIS—helps to focus PS efforts**. During the experience with the Uganda Ministry of Health, Project staff learned that it may be difficult to address the whole supervision system or activities in an organization.
4. **Framing visiting supervision as a professional development opportunity may reduce resistance to change**. PS should be framed as a professional upgrading opportunity for supervisors, avoiding a confrontational approach that would meet with their resistance.
5. **PS efforts improve efficiency and effectiveness**. When managers identify a service delivery issue, they frequently choose training as the solution. This is mainly because they lack the tools to dig out the real causes of poor performance. PS offers them a district-wide perspective of common issues that cannot be solved by local health teams on their own; managers also gain insight into the root causes of these issues, allowing them

When implementing a new PS program:

- *Select a single service delivery or management issue to start*
- *Use a very low profile and avoid looking threatening*
- *Identify innovators in the organization who can become champions for PS*
- *Make an actual demonstration of the methods and tools*
- *Provide continuous support to avoid "business as usual" responses to challenges.*

Visit the HRH Global Resource Center to find, share and contribute human resources for health knowledge and tools. For those working at the country or global level, the HRH Global Resource Center provides information to:

- Improve strategic planning and decision making
- Strengthen reports and presentations
- Support HRH advocacy
- Enhance professional development
- Save time.

to invest in training only when it is appropriate, thus permitting resource reallocation for other interventions that usually are not on their radar.

6. **Use a step-wise process for implementing PS**. Managers implementing PS should find an initial niche to implement the approach and defend it, keeping a low profile during this stage (Reis and Trout, 1986). Changing well-established practices like visiting supervision may be difficult; any direct confrontation should be avoided. Identify a specific health program, district or activity whose leaders are concerned about the poor results of current service delivery or supervision systems. Managers should delay any scale-up attempt until they have strong evidence of the benefits of PS.

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