



Making Supervision Supportive and Sustainable: New Approaches to Old Problems

EXECUTIVE SUMMARY

Supervision provides critical support for the delivery of health services. Despite recognition of the importance of supervision in managing human resources for health care, the “promise” of supervision is often not achieved in developing-country health systems. Supervision still tends to emphasize inspection and control by external supervisors, who often believe that workers are naturally unmotivated and require strong controls to perform adequately. At the same time, many line supervisors lack the requisite technical and managerial skills or have limited authority to resolve service delivery problems.

Numerous studies and projects have attempted to inform and improve supervision of primary health care and family planning programs in developing countries. While many supervision interventions have been effective on a pilot basis, sustained improvements have been elusive. Too often, short-term successes have faded through staff turnover, end of donor support, and failure to make the systemic changes in human resource management necessary to maintain gains in health worker performance.

Evidence favors a different approach to supervision. Research studies and program evaluations suggest a different approach to make supervision more conducive to improvement in health worker performance: *supportive supervision*. Supportive supervision expands the scope of supervision methods by incorporating self-assessment and peer assessment, as well as community input.

Supportive supervision shifts the locus of supervisory activity from a single official to the broader workforce. A key concept in supportive supervision is that it is a process implemented by many parties, including officially designated supervisors, informal supervisors, peers, and health providers themselves. Supportive supervision promotes quality outcomes by strengthening communication, focusing on problem-solving, facilitating teamwork, and providing leadership and support to empower health providers to monitor and improve their own performance.

Continuous implementation of supportive supervision generates sustained performance improvement. Instead of occurring only when an external supervisor visits a facility, supportive supervision takes place continuously, as ongoing performance monitoring and quality improvement become a routine part of health workers’ jobs. Supportive supervision occurs in multiple places: on the job, both formally and informally; in one-on-one meetings; in peer discussions; in meetings outside the work site; and when health workers review their own performance against standards.



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Supportive supervision is feasible. Recent experiences from countries in different regions show that supportive supervision offers a powerful alternative to traditional approaches. Research findings also provide compelling evidence for the effectiveness of key elements and tools of supportive supervision, including structured audit and feedback, self-assessment, and peer assessment. Supportive supervision requires:

- new thinking about who does supervision and how and when it occurs;
- motivation on the part of supervisors and staff alike to adopt new behaviors;
- locally appropriate and tested tools;
- time and investment to establish and take root;
- the commitment of top management and some decentralized decision-making authority;
- integration into existing human resource management systems rather than creation of a parallel system to “work around” problems.

More evidence of results and savings will help advocacy to expand supportive supervision. More evaluation of the costs of supportive supervision and its impact on health services performance will strengthen the case for health organizations to adopt supportive supervision approaches, as will better documentation and broader sharing of tools for supportive supervision. These activities will also reveal best practices for (1) motivating, training, and coaching external supervisors to perform supportive supervision and (2) motivating and enabling health workers to effectively conduct self-assessment, peer assessment, and internal supervision.

This paper is a publication of the Maximizing Access and Quality (MAQ) Initiative—an initiative of the United States Agency for International Development (USAID), cooperating agencies, country partners, and other collaborators to apply state-of-the-art methods to maximize access to and the quality of family planning and other selected reproductive health services.

INTRODUCTION

This paper distills lessons from recent efforts to improve the supervision of family planning and health programs in developing countries and identifies approaches that may be more effective and sustainable. It describes supportive supervision, an approach to supervision that emphasizes joint problem-solving, mentoring, and two-way communication between supervisors and those being supervised. It also expands the concept of effective supervision by exploring how self-assessment and peer assessment, as well as community input, can be seen as vital components of results-oriented, supportive supervision.

The paper's conclusions are based on a review of the literature of supervision; an informal, qualitative survey conducted among USAID reproductive health and child survival cooperating agencies; and discussions with MAQ participants. The agencies include John Snow International, Management Sciences for Health, University Research Co., LLC, EngenderHealth, Pathfinder International, the International Planned Parenthood Federation, JHPIEGO, the Johns Hopkins Center for Communication Programs, and INTRAH. The paper draws on responses summarizing the experiences of approximately 16 field programs. Based on review of these experiences in implementing such a style of supervision, the paper provides a framework for what supportive supervision means in practice and identifies key lessons from recent efforts, as well as gaps in our knowledge.

WHY WE SHOULD INVEST IN SUPERVISION

There is widespread agreement among those in the international health community that supervision is a critical part of human resource management for the delivery of basic health services.¹ As noted in an earlier MAQ Paper (Vol. 1, No. 3, p. 8), supervision is one of the key approaches to improving the quality of health care and the performance of health care providers, especially given the labor-intensive nature of health service delivery. This is particularly true in developing countries, where health program managers

recognize that supervision is “important to getting things done”² and where supervision remains one of the most direct ways for an organization to affect what its staff does.

At the same time, there is pervasive disappointment that the “promise” of supervision is frequently not realized or sustained. USAID and its cooperating agencies have invested significant financial and technical resources in trying to strengthen supervision systems in developing countries through supervisor training and development of supervisory tools and checklists, yet interventions to strengthen supervision systems often have not sustained their effects past a pilot phase or demonstrated results independent of other efforts to improve service delivery.

Why invest in supervision in health and family planning delivery settings in developing countries? Is there reason to expect that we can do better? The MAQ Subcommittee on Management and Supervision believes we can.

There are several reasons to be hopeful about realizing the promise of supervision. First, there is an emerging consensus on what supervision should entail—what the key functions of supervision are. Second, a growing body of experience from different settings suggests that expanding the realm of how supervision functions can be performed—with ways of doing supervision that involve health workers themselves, peers, even communities—may allow supervision to be accomplished more effectively and efficiently. Ample evidence supports the feasibility of using nontraditional, expanded supervision approaches in developing countries. There is also limited recent evidence that these alternative approaches achieve better health worker performance and outcomes than traditional supervisory approaches, and some evidence that these approaches may be more sustainable.

Growing, broad-based interest in improving quality of care has also strengthened the argument for improving supervision, to use supervision as a means to directly affect health worker performance and to build health worker capacity for problem identification and resolution.³ There is evidence that providing health

professionals with effective supervision can help improve the quality of health care and even patient outcomes.⁴ Moreover, a growing body of successful experience in developing countries shows how supervisors can be involved in leading quality and performance improvement.⁵

The push toward decentralization and deconcentration of health care management functions in many countries highlights the importance of supervision. When responsibility for oversight and technical direction is transferred from the central level to lower levels in the health service delivery system, these lower levels often have a great need for capacity-building to implement their expanded supervisory role.

This paper examines the experience of USAID cooperating agencies that are working to improve health and population services in developing countries by strengthening or redesigning supervision systems to make them more effective and sustainable. Learning from this experience begins with understanding what supervision is in the context of health service delivery systems.

THE KEY FUNCTIONS AND TASKS OF SUPERVISION

Supervision is the process of “directing and supporting staff so that they may effectively perform their duties.”⁶ Supervision may include periodic events, such as site visits or performance reviews, but it goes beyond such episodes to refer to the ongoing relationship between health care providers and supervisors. Supervision includes oversight and implementation of clinical and nonclinical tasks and activities that affect the organization, management, and technical delivery of health services, including control of work processes and systems, maintenance of facilities and infrastructure, and monitoring and improvement of systemwide performance and effectiveness. Beyond this technical role, there is also an important human dimension to

the supervisor-health worker relationship. In developing countries, where many health workers work alone or in small groups in remote sites, the supervisor may represent the only link to the larger health system.

In the context of strengthening health and family planning services, numerous USAID cooperating agencies have analyzed the major objectives and activities of supervision in developing-country settings. Table 1 summarizes the main functions of supervision as described by several cooperating agencies that collaborate on MAQ. While the definitions use different terminology, the essential functions and activities of supervision are similar: defining objectives, monitoring performance, providing supplies, providing training, solving problems, and motivating and supporting health providers to improve their performance.

Kilminster and Jolly, in their systematic literature review of supervision in medical practice settings,⁷ defined a similar role for supervision in health care in the US and the UK. They argued that supervision in the health professions consists of three basic functions: management, education, and support. They defined supervision as “the provision of monitoring, guidance, and feedback on matters of personal, professional, and educational development in the context of the doctor’s care of patients” in order to “ensure patient/client safety and promote professional development.” The emphasis on patient safety *and* professional development of health care workers is worth noting, since the role of supervision in assuring these two goals has often not been made explicit in developing-country health systems. Supervision in developing countries has often been viewed only as an instrument through which to impose the health system’s needs on health care providers rather than as a means to address health workers’ multiple needs. However, the growing concern with quality assurance and improvement in developing countries is creating a climate where greater attention is paid to both patient and provider safety and human resource development.

Table 1. The Functions of Supervision

Management Sciences for Health ¹	EngenderHealth ²	URC/QA Project ³	INTRAH/PRIME II Project ⁴	JHPIEGO ⁵
Set individual performance objectives (the activities)	Address providers' needs for good management and supervision	Communicate and verify understanding of standards	Set clear job expectations	Plan and coordinate supervision activities
Monitor and evaluate performance	Address providers' needs for good supplies and site infrastructure	Monitor performance by assessing compliance with standards	Review performance and provide immediate performance feedback	Set performance objectives, manage conflict, deploy staff, develop work teams, improve staff motivation
Manage performance problems that arise	Address providers' needs for information, training, and development	Provide feedback on errors and suggest solutions	Ensure staff have adequate physical environment and tools	Assess skills, provide guidance and training
Motivate staff members and provide feedback, solve problems, and provide guidance, assistance, and support		Educate and train providers	Motivate and recognize good performance	Interpret, use, and share data
Provide training		Assist in the identification of problems impeding quality and in the development and enabling of solutions	Ensure staff have appropriate skills and knowledge	Manage supplies and equipment
Assist with resources and logistics		Motivate, coach, and empower staff to solve problems	Facilitate organizational support	Identify and solve problems
				Communicate effectively and provide constructive feedback

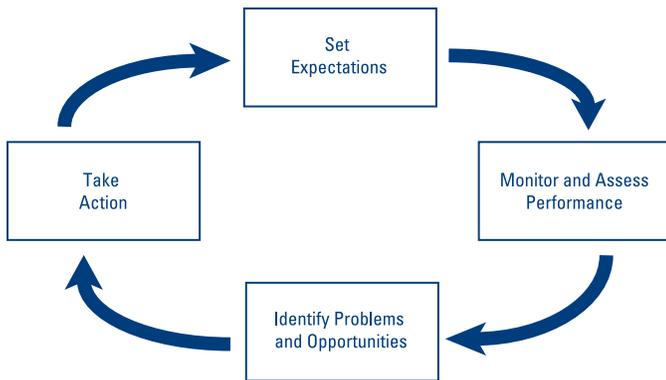
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4. INTRAH, "Supportive Supervision," *PRIME Page* (Chapel Hill: University of North Carolina at Chapel Hill, 2002).
5. L. Chege and R. Transgrud, "Defining a Performance Improvement Intervention for Kenya Reproductive Health Supervisors: Results of a Performance Analysis" (1999). http://www.reproline.jhu.edu/english/6read/6pi/super/tr_super1.htm.

The Supervision Process

At whatever level it occurs, the process of supervision may be thought of as consisting of four basic tasks, as shown in Figure 1. These tasks encompass the functions described in Table 1 and are consistent with the wide variety of approaches, tools, and methods used for supervision and quality improve-

ment interventions. To emphasize the ongoing nature of the process, the diagram shows an action loop with no starting or end points. The supervisor facilitates this process by communicating about, assessing, and facilitating the work of others. The supervisor's activities include the following:

Figure 1. The Process of Supervision



- **Set expectations:** A prerequisite for effective supervision is the existence of clear expectations or standards against which performance and results can be measured. Where these do not exist, the supervisor helps define and implement them.
- **Monitor and assess performance:** Once the standards or guidelines are set, the task of gauging the extent to which they are met becomes an ongoing activity that occurs at all levels of the system: for individual health care providers, within and among facilities, and at the district (regional) and national (central) levels.
- **Identify problems and opportunities:** Where there are gaps between expectations and results, the supervisor facilitates a team process for examining potential causes and possible solutions. By facilitating open communication and teamwork, the supervisor can help spot opportunities to improve the overall quality of care.
- **Take action:** The supervisor helps marshal the resources necessary (human, financial, material, political, institutional) and motivates and supports providers to implement interventions and activities to address performance gaps or opportunities for improvement. The process continues as new activities begin, with the establishment of expectations for results.

This loop describes what supervision is intended to do but does not prescribe how. Differentiating supervision functions from how these tasks are accomplished helps to expand the range of possibilities for improving supervision. In practice, supervisors can use a wide range of methods for carrying out these tasks. For example, a positive development in recent years in many health systems has been replacing the concept of a single, formal supervisor with a broader approach that involves multidisciplinary teams, as well as health workers themselves, in the supervision process. Similarly, political decisions to increase community participation have led to support in many countries for the creation of community health committees, users' committees, or other groups of community members that oversee health care delivery; such groups can also serve as agents of health care provider supervision. Peer review and peer supervision—engaging health care providers themselves in providing technical support to colleagues—is another promising approach, particularly for its applicability to the private sector.

In many countries, however, the practice of supervision does not effectively perform the four basic tasks shown in Figure 1. To understand how new ways of thinking about supervision can improve its effectiveness and sustainability, the next section reviews typical problems with supervision in health service delivery systems in developing countries and how these problems act as barriers to the effective performance of supervision functions.

SUPERVISION IN HEALTH PROGRAMS HAS TRADITIONALLY EMPHASIZED INSPECTION RATHER THAN FACILITATION

Supervision in family planning and primary health care programs in developing countries has traditionally used an inspection and control approach—that is, controlling workers' adherence to policies and procedures, based on an attitude that workers are naturally

unmotivated and require strong external controls to perform adequately. In most health service delivery systems, supervisors tend to focus on administrative issues, such as inspection of facilities (hours of operation, maintenance), use of resources (financial, material, human), supply logistics (quantity, maintenance of equipment, procurement), review of records, and communication of information and directives from higher to lower levels. In a climate of inspection and control, problem-solving is reactive and episodic. Supervisors often blame individuals rather than look for root causes in deficient processes. For this reason, traditional supervision systems have not tended to “empower” staff to engage in problem-solving and to take the initiative to improve service quality and access.

The tendency to focus on inspection arises in part from the lack of technical and managerial skills needed to engage health workers in analyzing problems and finding solutions. Supervisors in developing countries are often expected to deal with every type of problem, but they may lack the skills and knowledge to carry out that ambitious role. Supervisors who are not knowledgeable about the technical tasks that supervisees perform can monitor and support them, but they cannot effectively train them in these tasks.

Lack of skills, especially those related to communication, team-building, and facilitation, which are vital to directing and supporting health workers, is sometimes exacerbated by lack of interest on the part of supervisors in performing key supervisory functions or performing them well. This lack of interest is especially likely to affect individuals who become supervisors as a result of a promotion or political considerations rather than due to genuine interest in or aptitude for the supervisory role. For example, after an intervention to improve supervision in India by defining a clearer role and responsibilities for supervisors and shifting emphasis toward joint problem-solving, some supervisors reported that they did not like the more participatory, supportive style and preferred the status they enjoyed when supervision

was geared toward inspection and control.⁸ But even when supervisors want to be more effective, change can be difficult and threatening.

Another pervasive problem is the lack of authority of line supervisors to take action, for example, to help solve a problem, reward good performance, or sanction poor performance. Supervisors who have not been given authority to act or make decisions based on performance have limited credibility with supervisees.

Limited approaches to conducting supervision pose another barrier to the effective performance of supervision. In general, supervision at health facilities around the world continues to be carried out primarily through site visits by an external supervisor. The site visit is typically short—a couple of hours during which the supervisor focuses on filling out forms and checklists and reviewing these results (rather cursorily) with the medical officer in charge at the facility. Often such visits are isolated events, not tied to what happened during a previous site visit or to what may happen during the next visit. This type of traditional, “event-oriented” external supervision focuses on only one part of the supervision process.

A related problem is that resources for supervisory activities—for example, transportation resources or human resources for supervision—are frequently unavailable, even when budgeted or mandated by organizational policy. Resource shortages result in infrequent, episodic visits that are narrowly focused on only part of the supervision process.

Finally, lack of planning, failure to define priorities, nonadherence to work plans, diversion of resources from planned allocations, lack of financial stability, and lack of accountability, and the low morale among health workers that often results from these conditions, are all systemic problems plaguing health systems in many developing countries. Such overarching problems in the health sector undermine the effectiveness of supervision at all levels of the system and can make attempts to improve supervision irrelevant.

Table 2. Typical Barriers to Effective Supervision in Developing-Country Health Systems

Problem	How It Limits the Performance of Basic Supervision Tasks
Narrow focus of supervision on inspection of certain areas	Emphasizes monitoring to the detriment of other key supervisory tasks, especially problem-solving and taking action
Punitive approach	Inhibits problem-solving and demoralizes staff
Lack of supervisory skills and knowledge	Inhibits supervisors from effectively performing any of the basic supervision tasks and undermines supervisor credibility
Lack of supervisor authority to reward or sanction performance	Deters supervisors and staff alike from taking action, because no consequences (positive or negative) result
Infrequent or irregular supervision due to lack of resources	Undermines continuity and limits supervision to only certain tasks, such as facility assessment
Lack of direction and accountability in the overall health system	Undermines the performance of all supervision tasks and demoralizes staff and supervisors alike

These issues are summarized in Table 2. The next section summarizes lessons from efforts to try to improve supervision through training and other interventions.

IMPROVING SUPERVISION REQUIRES CHANGING THE CONTENT *AND* THE OBJECTIVES AND NATURE OF SUPERVISION

There have been many projects and operations research studies conducted during the past two decades to improve the supervision of primary health care and family planning workers in developing countries. The most frequent attempts to improve supervision have involved increasing the frequency and duration of supervisory visits, changing the activities undertaken during supervision encounters, using multidisciplinary teams to conduct supervision, introducing tools for conducting supervision visits (for example, guidelines and checklists), and providing

additional training for supervisors. The effectiveness of such interventions has typically been evaluated in terms of increases in the number of activities or services performed by health workers. It has rarely been linked to health outcomes or improvements in services. An exception is the work of the Family Planning Management Development II (FPMD II) Project with Asociación Hondureña de Planificación de Familia (ASHONPLAFA) in Honduras, where the effects of a series of interventions to improve supervision (including the development of supervision policies, training of supervisors, and use of data to prioritize sites needing a supervisory visit) were measured in terms of changes in access to and quality and sustainability of the services provided. The lack of evidence of the effectiveness of interventions to improve supervision stems largely from the considerable methodological difficulties of demonstrating associations between supervision improvements and health outcomes, independent of other interventions or health system changes.

Providing tools and guidelines to structure the supervisory encounter. The introduction of checklists to guide supervisory visits has gained popularity in many developing-country health programs through donor-supported projects, particularly because such instruments lend themselves to focusing the supervision encounter on the services or activities of greatest interest to funding agencies. For example, operations research studies funded by the Primary Health Care Operations Research (PRICOR) Project in the 1980s found that providing guidelines, protocols, and checklists to supervisors could increase the level of activity of health workers in priority health services, at least in the short term.⁹ These studies also noted that when checklists attempted to be exhaustive, they typically became quite lengthy and actually hindered supervision by causing fatigue and mechanical use. Anecdotally, many of the MAQ cooperating agencies that completed questionnaires for this paper reported introducing supervision guidelines, manuals, and/or schedules to systematize supervision and make it more effective. Most such supervisory tools have been introduced without rigorous evaluation of their effectiveness on health worker performance. An exception is the prospective, controlled field trial by Loevinsohn et al.¹⁰ in the Philippines to test the effectiveness of supervisory visits based on an integrated checklist design to facilitate follow-up. They found that health worker performance, as measured by average combined scores on the 20 indicators measured by the checklist, improved by 44% (from 43% to 62%) in the experimental group but by only 18% (45% to 53%) in the control group ($p < .05$). The Ministry of Health of Uganda recently implemented national supervision guidelines, including checklists, for all levels of the system. These guidelines were developed using quality assurance principles to redesign the national supervision system; an evaluation of the impact of the guidelines on health worker performance is underway.

Increasing the frequency and/or duration of supervisory visits. Although the goal of many efforts to improve supervision is to increase the frequency of supervisory visits, there is little empirical basis for arguing for a particular minimum frequency. In the study cited above, Loevinsohn et al. also found a correlation between frequency of supervisory visits (ranging from monthly to every six months) and improvements in scores in their experimental group but not in the control group, suggesting that increasing the frequency of supervision helps only if the activities that occur during supervision are productive and directly related to improving health worker performance. Foreit and Foreit found in a controlled field trial conducted in a community-based contraceptive distribution program in Brazil that reducing the frequency of supervision visits from monthly to quarterly reduced costs considerably without negatively affecting program performance (as measured by new acceptors, revisits, and distributor turnover).¹¹ The authors speculated that a possible explanation for this finding was that most supervisory visits were concerned with collecting service data and contributed little to actual program performance; thus, reducing frequency did not matter.

Training supervisors. Performance analyses of supervision often find that health professionals charged with supervision responsibilities lack the knowledge and skills needed to perform these responsibilities effectively.¹² When surveyed, supervisors in developing-country health systems frequently comment on their need for more training, and training is probably the most common intervention used in an attempt to improve supervision practices. Areas in which supervisors need training that were cited in the survey of MAQ cooperating agencies included problem identification, problem-solving, time management, communication, monitoring, coaching, and technical/clinical updates. Like the use of checklists, training programs for supervisors are rarely subjected to

rigorous evaluation. Moreover, it is well accepted in the field of human performance technology that training alone will not produce sustained behavior change.¹³ In her review of supervision in family planning programs, Simmons noted that one-time training should not be expected to change supervisors' behaviors and that many of the skills needs for effective supervision are best learned on the job or through coaching and mentoring.¹⁴

Changing the focus of supervision. Another major trend in efforts to improve supervision has been to shift the focus of supervision encounters away from simply inspecting facilities and gathering service statistics to concentrate on the performance of clinical tasks and resolution of problems experienced by the health worker, as well as to increase feedback from supervisors. Such efforts have often been accompanied by the introduction of checklists and guidelines to reorient the supervisory encounter. Survey responses from MAQ cooperating agencies for this paper about practices in field projects consistently highlight efforts to refocus supervision toward activities such as assessing compliance with quality standards, transferring knowledge and skills, providing clear feedback to supervisees, identifying problems, and developing action plans. Anecdotal evidence suggests that focusing on the clinical performance of providers during supervision does increase adherence to standards, at least in the short term. However, there are few evaluations of the impact of such changes independent of other interventions to improve program effectiveness.

Sustaining Improved Supervision Practices

Most efforts to improve supervision have been pilot tests to demonstrate the efficacy of a particular approach and have ignored the issue of the long-term affordability of interventions that may have been

demonstrated to be feasible and effective. In only a small number of studies were costs clearly measured or even estimated. In the Philippines, Loevinsohn et al.¹⁵ reported that training supervisors to use a systematic checklist to guide supervisory encounters cost only US\$19.92 per health facility and only \$1.85 per health facility per year in recurrent costs for forms. Vernon et al.¹⁶ found that the costs of supervision could be reduced with better effects on health worker performance (measured in terms of rates of contraceptive distribution) by replacing one of two annual supervision visits with either group meetings of all district service providers with the supervisor (costing \$97 per year per supervised facility) or facilitated problem-solving following self-assessment by the supervised health workers (costing \$114 per supervised facility). Traditional supervision (two annual visits without specific orientation to problem-solving) cost \$118 per supervised facility. This limited evidence suggests that supervision can be improved within the resource constraints of many developing-country health systems. More work is needed to document the costs and results of supervisory mechanisms such as peer review and self-assessment and the costs of internal and external supervision.

Beyond the financial sustainability of improved supervision practices, there is even less evidence about how to successfully institutionalize these practices in developing-country health care organizations. As noted above, most of the successful experiences with improving aspects of supervision have been pilot efforts that have yet to be implemented on a sustained basis on a national scale. The many reasons for lack of sustainable improvements to supervision include funding shortfalls, inadequate training, and staff turnover. Pressure from donors or politicians to demonstrate short-term results has also exacerbated the problem by encouraging resource-intensive

interventions or the creation of parallel systems that cannot be supported without outside assistance. In general, however, the failure to translate short-term successes into lasting changes reveals a failure to make systemic reforms to the management and delivery of health care to support the gains in performance and quality of care that result from more effective supervision. A key lesson from successful quality and performance improvement interventions is that for change to be sustained and institutionalized, there must be an internal enabling environment conducive to initiating, expanding, and sustaining the change. This enabling environment includes policies, leadership, organizational values, and adequate resources to support improved practices.¹⁷ Short-term improvements in supervision thus cannot be sustained or successfully scaled up unless organizations strengthen their overall human resource management systems.

Making Supervision More Effective

Supervision, like the delivery of family planning and primary health care services, has evolved in response to the growing emphasis on quality, process, and system issues. Evidence from the past two decades points to the need to change not only the frequency, duration, and structure of supervisory encounters, but also the nature and objectives of supervision, to make it more supportive and facilitative.¹⁸

Concern about these issues has led to more emphasis on data collection and analysis, problem-solving, and teamwork in supervision, and to growing interest in the facilitative possibilities of supervision and in supervision as a solution to the problem of the gradual decline of health workers' technical skills after training. This evolution has also been supported by the development of clearer standards of care in both vertical and integrated programs.¹⁹

This thinking is supported by the literature on quality management, which emphasizes the importance of teamwork and of the listening, teaching, and facilitative roles of effective leaders.²⁰ It is also supported by a recent comprehensive review of the literature on effective supervision in postgraduate medical education clinical practice in the UK and the US, which found that the single most important factor associated with better supervisory or performance outcomes was the quality of the supervisory relationship. Effective supervisors were those who have "empathy, offer support, flexibility, instruction, knowledge, interest in supervision, [and] good tracking of supervisees, and are interpretative, respectful, focused and practical."²¹ Other factors that these authors cited as contributing to the effectiveness of supervision were clear feedback about strengths and weaknesses and recognition of the need for health workers to have some control over and input into the supervisory process.

In a study of the influence of managers' behavior on nurses' job satisfaction, McNeese-Smith²² identified several factors that affected nurses' job satisfaction and, indirectly, performance. Positive behaviors by supervisors included giving recognition, exhibiting leadership skills, being supportive of the team, facilitating nurses doing their job, setting standards, and creating open communication. Behaviors that negatively affected nurses were not providing recognition, lack of follow-up on agreements, criticizing in a crisis, and not communicating effectively.

Based on research and field experience about what has and has not been effective in supervision, the next section of this paper describes how new ways of thinking about supervision can lead to better health worker performance and, ultimately, improved health outcomes.

MAKING SUPERVISION SUPPORTIVE CAN LEAD TO BETTER OUTCOMES

Research studies and program evaluations recommend facilitating on-the-job learning, quality improvement, and problem-solving to make supervision more conducive to improvement in health workers' performance. These recommendations have coalesced, allowing discussion of a new approach to supervision, which the MAQ Subcommittee on Management and Supervision calls "supportive supervision." This section describes what supportive supervision is and how it is implemented. The next section summarizes evidence from field programs about the effectiveness of supportive supervision.

What Is Supportive Supervision?

Supportive supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources. Supportive supervision promotes continuous improvements in the quality of care by providing the necessary leadership and support for quality improvement processes and by promoting high standards, teamwork, and better two-way communication.

Supportive supervision is facilitative, fostering relationships that help improve individuals' skills and performance. Supervisors are intermediaries who implement institutional goals, solve problems at lower levels, and serve as a link to higher levels of authority to resolve lingering problems.²³ The supportive supervisor brings people and resources together to pursue clear objectives, assess results, and identify and solve problems, and develops relationships based on trust and responsiveness.

Supportive supervision focuses on the results of processes as well as individual performance. It encourages open communication and building team approaches that facilitate problem-solving. It focuses on

monitoring performance against expectations and using data for decision-making. Measuring performance also allows supervisors to be held accountable for results and helps foster continuous improvements in quality at all levels of the health system

In this paper, supportive supervision is synonymous with "facilitative supervision." EngenderHealth (formerly AVSC) has defined facilitative supervision as "an approach to supervision that emphasizes mentoring, joint problem-solving, and two-way communication between the supervisor and those being supervised."²⁴ Although EngenderHealth defines facilitative supervision in the context of a broader quality improvement approach that includes the use of its client-oriented, provider-efficient (COPE) technique, the principles and methods of supportive supervision are the same. Supportive supervision also embraces the concepts articulated in Management Sciences for Health's work on *team supervision*, in which joint problem-solving is the focus of the supervisory interaction, and supervisors act as on-the-job teachers who support their staff rather than as inspectors.²⁵

Another key aspect of supportive supervision is an explicit concern for meeting the needs of clients, both external and internal (staff members). Experience with using COPE for supportive supervision shows that emphasizing the needs of the client helps focus the entire facility on solving problems as they arise. This focus, in turn, improves staff performance and the quality of care.²⁶ Supportive supervision also addresses the human needs and aspirations of health workers themselves, recognizing that they need clear expectations, feedback, skills, and materials to effectively perform their jobs, and a safe working environment, recognition, and opportunities for professional development and advancement.

Supportive supervision makes continuous improvements in the quality of care possible by providing the necessary leadership and support for quality improvement processes, in the form of high standards, team-

work, and good communication. Indeed, many of the characteristics of supportive supervision parallel the emphasis of the quality movement, including a focus on the customer, team approaches, problem-solving, and strengthened systems and processes.²⁷

Finally, a key concept in supportive supervision is that it is implemented by multiple parties, including officially designated supervisors, informal supervisors, peers, and health care providers themselves. Whereas traditional supervision locates supervisory activity entirely in the person of the official supervisor, supportive supervision recognizes that supervisory activities to identify and solve problems, meet client needs, and motivate and support health providers in doing their jobs may be carried out by many actors, including health workers themselves.

Expanding the notion of who supervises has direct implications for where and when supervision occurs. While in traditional supervision approaches, supervision most often takes place only when an external supervisor shows up at a facility, supportive supervision occurs continuously, as ongoing performance monitoring and quality improvement become a routine part of health workers' jobs. Supportive supervision takes place on the job, both formally and informally, in one-on-one meetings, in peer discussions, in meetings outside the work site, and when health workers review their own performance against standards.

In sum, there are several key characteristics of supportive supervision:

- The focus of supervision is on problem-solving to assure quality and meet client needs.
- The entire team (including the external supervisor) is responsible for quality, so attention shifts from individuals to teams and processes.
- Health providers are empowered to monitor and improve their own performance.
- The external supervisor acts as facilitator, trainer, and coach.
- Health workers participate in supervising themselves and each other.
- Decision-making is participatory.

The hypothesis is that if providers are empowered and motivated to provide high-quality services and their needs satisfied, and if clients' needs are satisfied, then client satisfaction and outcomes will be enhanced. Box 1 summarizes these expected outcomes of supportive supervision.

Box 1. Expected Results of Implementing Supportive Supervision

Service delivery sites provide access to quality services that clients want or need.

Service providers and institutions continuously seek ways to improve the quality of their services.

Service providers and institutions are responsive to client needs.

Service providers and supervisors are continuously improving their own performance, have opportunities for increased job satisfaction, and see their work as part of a larger picture.

Supervisors provide encouragement and support to providers in continuously improving the quality of services.

Supervisors are able to help sites translate institutional goals into services that clients want and need.

Supervisors are able to provide management with information about the quality of services being provided and help identify constraints to improving that quality.

There is a reduction in the costs of poor quality.

Source: B. Ben Salem and K. J. Beattie, "Facilitative Supervision: A Vital Link in Quality Reproductive Health Service Delivery," AVSC Working Paper no. 10 (New York: EngenderHealth, 1996).

Implementing Supportive Supervision: Rethinking Who, How, and When

Implementing and institutionalizing supportive supervision present an enormous challenge for health systems, especially those dominated by longstanding hierarchies as reflected in traditional, inspection-and-control supervision.²⁸ Introducing a new approach to supervision represent fundamental organizational change. Implementing supportive supervision requires rethinking who does supervision, and how and when it occurs, and it represents a major change from traditional approaches to supervision (see Table 3). Yet, as will be discussed in the next section, it can be done.

Operationalizing this concept of expanding the locus of supervision to include peers and health workers themselves can be understood by viewing supportive supervision as happening at three levels: external supervision (from outside the health facility), internal supervision (from within the health facility), and self- and peer supervision (by health workers, of

themselves and each other). As depicted in Figure 2, these three mechanisms of supervision are simultaneous, complementary, and overlapping.

- **External supervision** is the process used to oversee the operations and performance of individuals and facilities within a larger system, such as a district, regional, or national health system. External supervisors make site visits; set and implement clear program goals and standards; jointly define performance expectations with supervisees; monitor performance against those expectations; allocate resources within the system; facilitate supervision at lower levels of the system; and follow up to solve problems that require intervention from higher levels of the health system.
- **Internal supervision** is the process in a particular facility or department to oversee the performance of individuals and the quality of service delivery. Internal supervisors set and monitor standards;

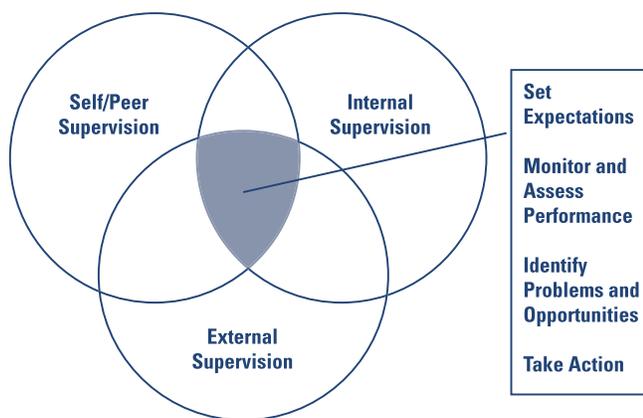
Table 3. Comparison of Traditional and Supportive Supervision

	Traditional Supervision	Supportive Supervision
Who performs supervision	External supervisors designated by the service delivery organization	External supervisors designated by the service delivery organization, staff from other facilities, colleagues from the same facility (internal supervision), community health committees, staff themselves through self-assessment
When supervision happens	During periodic visits by external supervisors	Continuously: during routine work, team meetings, and visits by external supervisors
What happens during supervision encounters	Inspection of facility, review of records and supplies, supervisor makes most of the decisions, reactive problem-solving by supervisor, little feedback or discussion of supervisor observations	Observation of performance and comparison to standards, provision of corrective and supportive feedback on performance, discussion with clients, provision of technical updates or guidelines, on-site training, use of data and client input to identify opportunities for improvement, joint problem-solving, follow-up on previously identified problems
What happens after supervision encounters	No or irregular follow-up	Actions and decisions recorded, ongoing monitoring of weak areas and improvements, follow-up on prior visits and problems

support and motivate providers with materials, training, and recognition; build teams and promote team-based approaches to problem-solving; foster trust and open communication; and collect and use data for decision-making.

- **Self- and/or peer supervision** is the process by which individuals monitor and improve their own skills and performance or that of their colleagues. The process encompasses setting clear performance expectations (including professional standards); assessing skills and measuring performance; eliciting customer feedback; and monitoring health outcomes, among others.

Figure 2. The Mechanisms of Supportive Supervision



Together, these three mechanisms of supervision help guarantee that the overall supervisory process provides adequate support and succeeds in accomplishing the core tasks of supervision: set expectations, monitor and assess performance, identify problems and opportunities, and take action. The shaded area of Figure 2 represents the full performance of the basic tasks of supervision through the contributions of each mechanism of supportive supervision.

The MAQ Subcommittee on Management and Supervision sees the interplay among these three mechanisms of supervisory activity as dynamic and fluid, with the relative importance and effectiveness of the three types of activities changing over time. The

ability of the system to self-adjust to address supervisory weaknesses or build on strengths is a strength of supportive supervision.

Ideally, a supportive supervision system involves all three; but in practice, many programs that attempt to implement supportive supervision may find that one supervision mechanism is initially emphasized over the other two. In the long term, the greatest impact is expected when all three types of supervision take place. Nevertheless, supervision can still be supportive even if all three types of supervision do not occur or occur to different degrees.

For example, when self- and/or peer supervision is highly effective, internal and external supervisors have more time to focus on improving other aspects of the overall quality of care. Conversely, if there are gaps in self/peer supervision, then internal and/or external supervisors will need to devote more time and resources to monitoring the performance of individuals.

The relationship between internal and external supervision is similar: where internal supervision is strong and effective, external supervisors can focus on other activities to improve the overall quality of the system (such as sharing effective approaches among facilities and addressing systemwide needs). But where internal supervision is deficient, the external supervision process must be refocused to address problems and fill gaps.

At present, there is more emphasis and dependence on external supervision in most developing-country health care systems. But external supervision is generally the most resource-intensive and logistically difficult mechanism. External supervisors generally occupy higher positions in the organizational hierarchy; they tend to have more skills and experience and usually receive higher compensation. Furthermore, external supervision is resource intensive: it usually requires travel and involves numerous people at a site.

In contrast, internal and self/peer supervision are generally done on site, with no travel, which means that staff members spend less time away from the job. Fewer people are generally involved in these processes, decreas-

ing the human resource costs associated with them.

While introducing supportive supervision requires resources initially to develop staff capacity to implement it, in the long term, organizations may end up spending less on supervision once external supervisors engage in more facilitative, team-based activities and health providers regularly perform self- and peer supervision.²⁹

EVIDENCE POINTS TO THE FEASIBILITY AND EFFECTIVENESS OF SUPPORTIVE SUPERVISION

Evidence from Field Experiences in Implementing Supportive Supervision

Responses to the survey of MAQ cooperating agencies commissioned by the Subcommittee on

The Supervisor's View of Supportive Supervision

"My role has changed. I have more autonomy than before and that has given me more confidence to support the clinics rather than to check up on them. I used to only go to the clinics to find faults, but now I go to support them. My job is to make sure that the clinics have enough supplies, to help them maintain equipment, to troubleshoot, to help with record keeping, and to train staff on the job where I can. I feel that they like me more in my new role and that makes my job more rewarding."

—Njagi Muchiri, FPAJ Area Manager for Nairobi, Kenya, cited in J. Bradley, "Using COPE to Improve Quality of Care: The Experience of the National Family Planning Association of Kenya"

Management and Supervision revealed that while many CA-supported projects are attempting to implement aspects of supportive supervision, there are few well-developed, ongoing examples of supportive supervision. Most of these experiences have been described in project reports but not rigorously evaluated, have been implemented only experimentally, or offer only partial evidence to substantiate the effectiveness of supportive supervision. Nonetheless, these experiences taken together, in different regions and in health systems at different levels of development, demonstrate the feasibility of supportive supervision and suggest that it offers a potentially powerful alternative to traditional supervision.

Table 4 provides a summary of how supportive supervision has been implemented in some of the "best evidence" programs and with what results. These six programs include four receiving technical support from EngenderHealth (in Bangladesh, Kenya, Nepal, and Tanzania); one supported by JHPIEGO, Management Sciences for Health, and the Center for Communication Programs (Brazil); and one supported by Management Sciences for Health (Honduras). Four are implemented by private-sector family planning organizations and two by government health agencies (national and state). All six experiences incorporate supportive supervision as part of a larger quality-focused approach: four as part of quality improvement including COPE and two as part of performance improvement.

Of the six experiences described, one (Brazil) is a demonstration project whose results are only now being scaled up. The Honduras, Kenya, and Nepal cases demonstrate the application of supportive supervision throughout an organization, although within NGOs providing a narrow set of services. The Nepal and Tanzania experiences are an interesting combination of

Table 4. Well-Developed Field Experiences in Implementing Supportive Supervision

Country/ Context	Interventions to Achieve Supportive Supervision	Results	Lessons
Brazil/PROQUALI, Secretariats of Health of Bahia and Ceará JHPIEGO, MSH, CCP ¹	Performance Improvement model (including setting standards for quality performance; training and technical assistance to increase provider and client capacity to perform at minimum standards; logistics and facility improvements; and accreditation system to motivate and reinforce continuous learning and improvement), self-assessments, external accreditation surveys, monthly progress review meetings; supervisors lead quality improvement teams.	At end of 18-month demonstration project, four of the five participating clinics received accreditation; service quality improved in all clinics.	The use of self-assessment and focus on quality improvement motivated and empowered both supervisors and health care providers. Performance improvements were greatest where baseline performance was moderate to high, where the project champion had formal position of power, and where staff resistance was lowest. The successful demonstration is now being scaled up to include approximately 25 more clinics in Bahia and Ceará states.
Bangladesh/ Ministry of Health, National Integrated Population and Health Program Quality Improvement Partnership EngenderHealth ²	Clinical supervision teams that supervise gov't and NGO facilities. The gov't-managed teams provide contraceptive updates and orientation, support use of COPE, conduct annual quality assurance site visits to assess essential health services. The Quality Improvement Partnership (QIP) has developed standards, guidelines, job aids, and curricula. QIP also supports 45 urban and rural NGOs with over 300 static clinics and 9,000 satellite clinics.	Data from annual visits show general improvement of quality of essential services at NGO sites. Composite indicators for clinic facilities, counseling, family planning, sexually transmitted infections, and vitamin A services all showed improvements in both urban and rural NGO sites.	A key lesson learned in designing a quality monitoring and supervision system for NGO clinics in the National Integrated Population and Health Program has been the importance of involving multiple stakeholders in the process, including urban and rural NGO managers, clinic managers, and national and international technical experts and donors.

Table 4. Well-Developed Field Experiences in Implementing Supportive Supervision (cont.)

Country/ Context	Interventions to Achieve Supportive Supervision	Results	Lessons
Honduras/ ASHONPLAFA Management Sci- ences for Health ³	Participatory workshops with senior management and selected supervisors from all levels of the organization to develop vision and strategies for improved supervision; new supervision manual, procedures, and tools developed to guide supervisory visits. Supervision now includes joint performance planning by supervisors and supervisees, with evaluation and determination of performance goals every two months; ongoing long-distance learning and annual supervisor workshops to develop and reinforce supervisor skills.	Increased open dialogue between supervisors and supervisees about performance planning and evaluation has led to high achievement of performance goals. Standards for supervisory excellence have been integrated into organization's overall quality assurance system. The proportion of ASHONPLAFA's operating budget obtained from local sources has continued to rise, from 51% before the supervision interventions to 63% 20 months after the launch of the new system. Client satisfaction has remained high (97%), and client access, as measured in couple years of protection (CYP), has likewise increased, from 185,808 in 1999, to 237,105 in 2000. At the beginning of June 2001, CYP was 105,434, indicating a continued upward trend.	Before the supervision system interventions, the operating units of the organization were under strong pressure to reduce operating costs to meet sustainability (self-financing) goals. Budgets, including funding for supervisory field visits, were cut, hindering the organization's ability to achieve its goal of improving service quality. However, support from senior management and employees throughout the organization for creative alternative approaches to strengthen supervision resulted in more effective supervision practices without increasing costs.

Table 4. Well-Developed Field Experiences in Implementing Supportive Supervision (cont.)

Country/ Context	Interventions to Achieve Supportive Supervision	Results	Lessons
Kenya/Family Planning Association of Kenya (FPAK) EngenderHealth ⁴	COPE, improved over time; whole-site training; supportive supervision	Staff at all 14 FPAK reproductive health clinics carry out facility self-assessment and problem-solving sessions every three months.	FPAK concluded that quality improved after introducing COPE and supportive supervision, whereas it had not improved after training, introduction of guidelines and supervisory checklists, and “legislating quality” from the central level; greater participation and empowerment in quality improvement, delegation of authority to improve quality, and encouragement to do self-assessment and act on it were needed to remove the blaming and punitive nature of the management system—to “trust employees to make decisions for themselves.” Early attempts to use COPE results to take punitive action and to use peer assessment rather than self-assessment failed—too threatening. COPE + supportive supervision is more labor intensive and requires motivation on the part of supervisors.
Nepal/Nepal Fertility Care Center EngenderHealth ⁵	“Quality of Care Management Center” (QOCCMC) staffed by NGO team but based in the MOH. Four field officers provide monthly 2–3-day whole-site monitoring-supervision visits to 24 FP clinics in 21 districts. Quick response to logistics and equipment problems. Coordination of training needs. Continuity between visits. Monthly monitoring of uniform set of quality of care indicators. Strong “customer orientation” on the part of QOCCMC staff.	Increases in aggregate scores (combining all 24 service sites) for all quality of care indicators over two years.	The client-oriented approach of QOCCMC staff, due to their being NGO employees, was a distinct departure from the traditional attitude of the gov’t bureaucracy. The focus on performance of the whole site, not individuals, fostered teamwork and shared responsibility.

Table 4. Well-Developed Field Experiences in Implementing Supportive Supervision (cont.)

Country/ Context	Interventions to Achieve Supportive Supervision	Results	Lessons
Tanzania/MOH, Family Planning Association of Tanzania, Marie Stopes EngenderHealth ⁶	Training of project-hired area teams in facilitative supervision; area teams provided supervision to 120 gov't and private clinics. In 1997, area teams began training gov't District Health Management Teams (DHMTs) in facilitative supervision tools and approaches; package of DHMT reproductive and child health training and supervision tools developed in 1998. Supervision approach includes increased involvement of gov't supervisors in problem-solving at both public and private sites; annual quality self-assessment (Quality Measuring Tool) by facility staff.	Increase in use of self-assessment (26% of sites at baseline to 77% in 1999); increased participation of supervisors in COPE; increased feedback and support by supervisors; better coverage and scores on QMT self-assessment.	Strengthening supervision was only one part of a larger quality improvement effort that also emphasized COPE and whole-site training.

1. ReproLine, "Lessons from the Field: Performance Improvement Case Studies: Brazil Case Study," http://www.reproline.jhu.edu/english/6read/6pi/case/case_brz.htm, cited 8/30/01.

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5. H. Stanley, D. R. Shrestha, M. Barone, and M. Linehan, "The Quality of Care Management Center in Nepal: Improving Services with Limited Resources," AVSC Working Paper no. 13 (New York: EngenderHealth, 2001).

6. J. Bradley, E. Mielke, G. Wambwa, J. Mashafi, and M. Nasania, "Family Planning Services in Tanzania: Results from a Project to Improve Quality, 1996-1999" (New York: EngenderHealth, 2000).

public and private collaboration in that supervisory teams are employees of a private-sector organization but are providing support to public-sector staff and facilities. The fact that the supervision teams in Nepal are NGO staff rather than MOH employees was noted as possibly contributing to the successful implementation of supportive supervision. EngenderHealth has noted elsewhere that COPE often has greater success in nongovernmental institutions than in public-sector facilities and has speculated that this difference is attributable to the relatively greater control that NGO staff have over financial and human resources.³⁰ The Brazil case offers perhaps the best potential evidence for the success of scale-up of supportive supervision in public-sector health systems, although the expansion of PROQUALI throughout the two state health systems in Bahia and Ceará is still in an early stage.

Evidence for the Effectiveness of Specific Elements of Supportive Supervision

Another source of evidence for the effectiveness of supportive supervision is the findings of research on specific elements of supportive supervision or tools used. While there are limits to how far evidence for the effectiveness of individual elements of supportive supervision can be generalized to the approach as a whole, several studies do provide evidence for the effectiveness of key elements of supportive supervision.

Structured audit and feedback. In Nepal, a randomized controlled trial of the effects of audit and feedback by district health officers using a structured checklist that focused on prescribing practices in primary health care facilities resulted in statistically significant differences in adherence to standard treatment schedules (22.2% in the control versus 40.5% in the intervention districts).³¹ Zeitz et al. found in an uncontrolled trial that supervisors' use of a checklist for diarrhea case management during monthly visits to rural health facilities in Nigeria resulted in improvements in history-taking, physical

examination, disease classification, treatment, and counseling.³² In Mexico, Kim et al. found that structured observation and focused performance feedback by supervisors, accompanied by joint identification of opportunities for improvement, increased facilitative communication and provision of information to clients by rural doctors.³³ The supervisor feedback, two-way discussion of how the provider could improve, and identification of skills to develop through assignments to be recorded in a homework log served to add an educational dimension to supervision that resulted in measurable improvements in provider performance.

However, an operations research study carried out by the Quality Assurance Project in Niger found that changing the content of the supervision encounter to examine health worker compliance with Integrated Management of Childhood Illness (IMCI) standards and provide structured feedback on key areas of IMCI performance resulted in significant improvements in performance only when the health workers also received on-site IMCI training.³⁴ Feedback alone, without training of health workers in IMCI standards, did not improve health worker performance. At the same time, among health workers who received IMCI training after feedback on their clinical performance from supervisors, improvement was found only in those areas that were targeted in supervisor feedback; performance of clinical tasks that were not the focus of feedback deteriorated. This finding suggests that supervisory feedback may have an impact on performance only when providers have the necessary knowledge and skills to perform in accordance with standards.

Self-assessment and peer review. There is ample evidence in the health field that self-assessment is a useful method for self-instruction and some evidence that self-assessment can be effective in causing desirable behavior change.³⁵ The study by Kim et al. of the effectiveness of self-assessment and peer review as interventions to reinforce training in interpersonal

skills in Indonesia provides convincing evidence of the effectiveness of these two mechanisms of supervision in maintaining and, in some cases, increasing improvements in health worker performance after training.³⁶ Interestingly, in the Indonesia study, self-assessment and peer review had a greater impact among providers with more than 10 years of experience, suggesting that experienced providers were better able to use and apply lessons from self-assessment and peer discussions than were their less experienced colleagues.³⁷ In their Mexico work, Kim et al. found that asking doctors to audiotape their own consultations and listen to the tapes to critique their own communication performance increased the power of self-assessment and proved to be a strong source of motivation to improve. They concluded that self-criticism (from the self-assessment exercises, including the audiotaping) was a far more compelling motivator than outside criticism (from the supervisors).³⁸ However, Kilminster and Jolly concluded in their review that self-supervision alone was not effective and that some input from an external supervisor or colleague was needed for improvements to be achieved in performance.³⁹

In Kenya, Stanback et al. conducted a rigorous evaluation of the impact of a one-time supportive supervision visit that focused on reinforcing messages about adherence to new guidelines for reproductive health service delivery, after health workers participated in training workshops to introduce the guidelines.⁴⁰ They found that adding the supportive supervision visit, and a package of materials designed to help the trainee transfer information on the new guidelines to colleagues, resulted in statistically significant gains of approximately nine percentage points in knowledge and practice scores beyond the gains achieved through training alone.

In an operations research study on the impact of self-assessment and peer feedback on health worker

compliance with standards for fever care in children in Mali, Kelley et al. found that combining self-assessment with peer feedback, when done regularly, can have a significant effect on compliance with standards.⁴¹ However, it is clear that self-assessment requires resources. All the individuals interviewed from the intervention pool characterized the extra work required by the intervention as burdensome. The researchers reported that the intervention cost about \$6 per provider.

Challenges in Implementing Supportive Supervision

It is also important to consider the risks of supportive supervision. Having too many actors with diffuse responsibilities can make supervision a non-system with no one in charge—no one ultimately responsible for ensuring that supervisory tasks take place. Overreliance on self-directed teams can place unreasonable or unrealistic performance expectations on the workforce.

Part of the challenge of the transition to a more facilitative approach to supervision is that change can be threatening and daunting. It is more labor intensive. It requires motivation and behavior change on the part of supervisors. Some may believe that it is not achievable in developing-country settings. The experiences described above suggest otherwise. Supportive supervision, especially when implemented in a larger context of quality improvement, has been shown to increase quality of care indicators, provider satisfaction with the support provided by the health system, and problem-solving at the facility level.

Even when the hurdle of effecting change at various (and sometimes all) levels of an organization can be cleared, sustaining such improvements over time can be an even greater challenge. Most field experiences in implementing supportive supervision are still fairly recent and only now addressing scale-up issues.

LESSONS IN IMPLEMENTING AND SUSTAINING SUPPORTIVE SUPERVISION

What lessons can be drawn from these experiences?

Supportive supervision requires motivation on the part of supervisors and staff alike, to adopt new behaviors. Supportive supervision requires changes in human behavior. Supervisors are the critical catalysts for change and must themselves be convinced of the need for and value of the supportive supervision approach. Supervisors need to model appropriate behaviors, and supervisors' commitment is needed to sustain the approach. Such change is not easy to obtain and will require multifaceted intervention strategies based on overcoming individuals' resistance to change, building on readiness to change, developing new skills needed to effect the change, and adapting the work environment to reinforce the change. Ben Salem and Beattie cited several personal characteristics of supervisors as contributing to effective supportive supervision, including the ability to delegate and complete work through others, the desire to achieve at high levels, confidence in one's own ability and the ability of staff, and the ability to instill a sense of value about the organization's goals in others.⁴²

The attitudes of supervisors and providers toward service delivery must also change, to be integrated rather than vertical, and client focused rather than provider focused. Supervisors need to adopt approaches that facilitate work, convey support, and build self-confidence among staff.

At the same time, the reports on the experiences of cooperating agencies with supportive supervision repeatedly note that health workers often derive satisfaction from self-assessment, joint problem-solving, and other participatory processes that promote involvement, ownership, and commitment to

improvement. Supervisors also need support from their superiors and positive reinforcement to sustain supportive supervision. Such support may come from both within the health system or organization and outside, such as from clients, community organizations, NGOs, or professional associations.

Supportive supervision offers a wide range of mechanisms to accomplish supervisory tasks. It is important to explore the alternatives for implementing supportive supervision to determine what is workable in a given situation. Sometimes there are no internal supervisors, or external supervisors may have inadequate time and resources to provide the support required for good performance. In such situations, peer support may be a feasible and effective alternative to external supervision. For example, in a recent survey of private nurse-midwives in Kenya who have been trained by PRIME in the area of postabortion care, about 50% of the providers surveyed stated that they are members of a group of nurse-midwives organized to support each other's work in reproductive health, and most of these had contacted, or been contacted by, a peer for assistance.⁴³

Supportive supervision requires locally appropriate and tested tools. The tools and techniques of supportive supervision, such as structured guidelines for external supervision and self-assessment instruments, have shown to be readily usable by health workers and supervisors in a wide range of settings.⁴⁴ Responses from the survey emphasize the need for simple tools, not long, involved ones that end up dominating the supervisory encounter. Tools to help supervisors understand what they are to do and how to do it and defined standards of clinical practice facilitate supportive supervision, giving providers and supervisors alike clear objectives to which they can direct their efforts. Self-assessment tools must be easy to use and be able to be interpreted by the staff using

them. There is also a critical need for tools to address both client and community needs and incorporate these into supervision to improve quality and performance.⁴⁵

Supportive supervision takes time and investment to establish. Because supportive supervision involves behavior change, it is not a “quick fix” that can be implemented through one manual or training course. It requires relatively more of frontline supervisors than traditional supervision. EngenderHealth has articulated a three-stage process for introducing supportive supervision in a developing-country institution, taking approximately two years. Cooperating agencies implementing elements of supportive supervision uniformly underscored the need for investment in:

- developing in supervisors the skills needed for supportive supervision (such as facilitation, interpersonal, problem-solving, and analytical skills);
- orienting staff to its tools and methods (peer review, performance assessment tools);
- upgrading the technical or clinical skills of those assigned to provide external supervision.

Teaching these skills poses a challenge to health care programs, which generally have scarce resources and must meet numerous critical learning needs.

Top management must be committed to supportive supervision. Support from senior officials is vital to introduce and sustain supportive supervision and quality improvement processes in general. Senior managers must become involved in and visibly support new initiatives to improve supervision. Investing in supportive supervision should be linked to accountability for results, and rewards or recognition for making supervision more supportive. Moreover, this top management support must be nurtured, in light of the high potential for turnover at this level, especially in the public sector. This lesson also suggests that

where top management does not fully embrace supportive supervision, it is not appropriate to try to instigate the approach from the bottom up.

Supportive supervision should be integrated into the existing human resource management system, rather than introduced as an isolated intervention or parallel system. The key to improving sustainability is to build capacity for improved supervision into existing systems and processes, rather than imposing entirely new systems from the outside, since changes and improvements that “work around” current systems and processes are generally less sustainable.⁴⁶

Build on success. One way to improve the sustainability of change is to focus on results and build on success. In practice, this strategy means identifying some desirable and achievable results and then implementing the most promising approaches for attaining those results. Each success builds support and momentum for further change. Therefore, when supportive supervision is introduced, efforts must be made to help external supervisors build confidence in the new way of doing things and to motivate staff to invest in peer support and self-assessment. Several respondents to the survey commissioned for this paper noted that an important factor in sustaining quality improvement processes was for staff to achieve an early “win”—in other words, to motivate teams to continue with quality improvement activities, it was important for these teams to achieve tangible results early in the process. In the absence of quick results, teams often get discouraged and abandon efforts.

Some decision-making authority must be decentralized for supportive supervision to work. Frontline supervisors and health care providers must be empowered to make some decisions to solve problems and implement changes in the management and design of services. If such authority is not delegated, efforts to institute supportive supervision will generate frustration and ultimately fail.

Long-term sustainability depends on public-sector institutions embracing supportive supervision. For supportive supervision to take hold in a country, it requires the legitimacy that acceptance by the Ministry of Health and major donors affords. Most of the experiences described in the literature on implementing aspects of supportive supervision have taken place in private reproductive health organizations. Ongoing experiences in Brazil (PROQUALI), Kenya (the Family Planning Association of Kenya's collaboration with the Ministry of Health), and Uganda (the Quality Assurance Department of the Ministry of Health) need to be followed and analyzed to understand how to successfully institutionalize supportive supervision in public-sector health systems.

RECOMMENDATIONS FOR MAQ

This review of the promise and practice of supportive supervision leads to several recommendations for consideration by MAQ.

Document experiences and best practices.

Improved tools to guide supportive supervision and self-assessment are needed. For example, many checklists are being created in different countries, some taking considerable resources to develop (the Uganda national supervision guidelines, for example). Greater sharing of such tools for supportive supervision and of evaluation results from using them would help advance the state of the art.⁴⁷ Best practices need to be identified from successful approaches to motivating, training, and coaching external supervisors to perform supportive supervision and to motivating and enabling health workers to effectively conduct self-assessment, peer assessment, and internal supervision. Identifying best practices should include defining the costs of the three mechanisms of supportive supervision (external,

internal, and self/peer supervision) in different settings. Also needed is further study of supportive supervision over time, to better understand what factors help to sustain it.

Study scale-up, including the startup and recurrent costs of supportive supervision. There is very little information about the costs and cost effectiveness of supportive supervision in developing-country health systems. More documentation is needed of the startup and recurrent costs of the various mechanisms of supportive supervision in different country and organizational contexts. EngenderHealth has suggested that supportive supervision requires considerable investment in staff development and capacity-building initially, but that, in the long run, programs may end up spending less on external supervision and training after supportive supervision has been established.⁴⁸

Evaluate the impact of supportive supervision on the performance of health services. The reports of how various organizations are implementing aspects of supportive supervision are mainly descriptive, and, with some exceptions, generally do not provide objective evidence of supportive supervision's impact on health worker performance, client satisfaction, or other outcomes. While it is difficult to isolate the effects of an intervention in field settings, more attempts to evaluate the impact of supportive supervision would help to expand its adoption. Long-term follow-up on the sustained effects of supportive supervision in sites where it has been in place for several years would greatly enrich our understanding of institutionalization issues.

Advocate supportive supervision. Better documentation of the impact of supportive supervision and its costs will help to provide a stronger case for advocating for the expansion of supportive supervision.

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