

Enhanced Supervision Approaches

Highlights from the Phase I: Landscape Analysis Findings Report

This brief provides a high-level overview of the HRH2030 program's landscape analysis that defines and documents supervision enhancements that improve health workforce and health system performance.

Background and Context

The strength of a health system—and ultimately the health of a population—depends upon health worker performance. However, insufficient support to build, manage, and optimize human resources for health (HRH) across broader workforce development functions results in insufficient quantity and quality of health workers in low- and middle-income countries. This in turn perpetuates health inequities and results in low quality health services, given direct linkages between health worker performance and health systems performance.

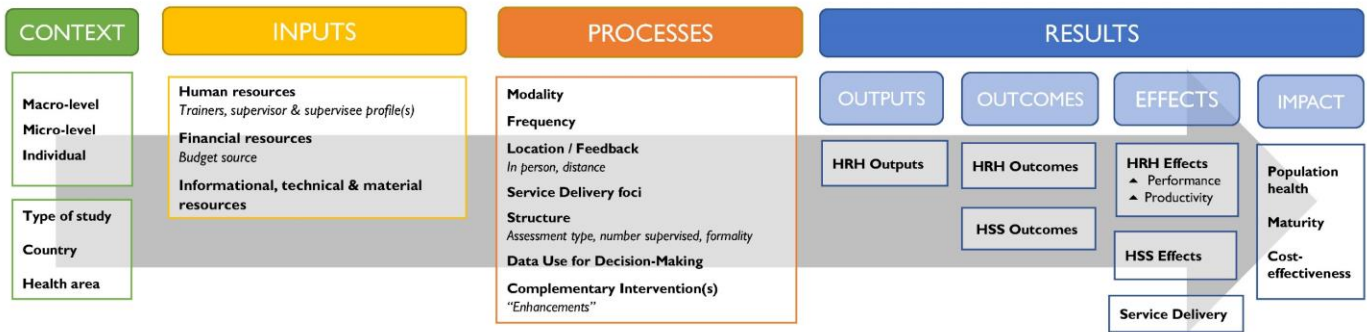
As such, effective health worker supervision approaches and practices are essential elements that help compensate for shortfalls in HRH training, management, and efforts to improve quality of health services. Defined as “a broad set of supervisory interventions that improve provider performance through team-based learning approaches, including supportive

supervision, the use of checklists, and in-person visits”, enhanced supervision is estimated to have the highest potential impact of all health systems interventions (USAID, 2017).

Although various systematic reviews, evaluations, and research have attempted to identify key components of effective supervision, evidence that documents strong correlations and causal relationships between supervision and clinical and health outcomes are limited. However, studies have shown lower-level outcomes that can be attributed to improvements in health worker performance, including increased knowledge, competencies, motivation, and job satisfaction.

This landscape analysis reviews documented supervision approaches and analyzes the characteristics and factors associated with improving health worker performance, health service quality, or system effectiveness.

Figure 1: Landscape analysis framework



Source: HRH2030 2019. Adapted from GHWA 2014, Dieleman et al. 2009, and informed by Campbell et al. 2013.

Methods

HRH2030 adapted the Dieleman et al. 2009 health worker performance conceptual framework to establish key enhanced supervision approaches, by classifying their context, inputs, processes, and results. Results were further disaggregated by outputs, outcomes, effects and impact improving health worker performance, health service quality, system effectiveness, and maturity. (See Figure 1.)

The database research aimed to identify literature documenting supervision approaches that met these criteria:

- 1) demonstrated positive results in at least one of the following: health worker and/or health system performance; service quality; or health outcomes;
- 2) identified interventional components, including the context, inputs, and processes;
- 3) considered scalability and sustainability in terms of cost effectiveness, further uptake, and maturity.

The resulting inventory of approaches were classified according to a detailed taxonomy according to the conceptual framework. Findings were produced through descriptive statistical and qualitative analysis.

Findings

Database search

The team undertook a database search of white and grey literature to gather evidence of supervision approaches, which were then reviewed according to defined criteria and analyzed according to the conceptual framework. From an initial yield of 66,945 results, 5,531 were relevant to the health sector, 4,309 were published in 2010 or later, and 1,699 were relevant to supervision. After title and abstract review, 87 were assessed and 69 met the Critical Appraisal Skills Program criteria. After further review based on strength of results, and the rigor of their documentation, a

total of 45 resources documenting enhanced supervision approaches were retained for the inventory.

Nearly one-quarter of the studies (24%) meeting inclusion criteria were case studies or published program reports; slightly more than one-fifth (22%) were randomized control trials; more than one-third (38%) were another rigorous quantitative method; 13% (6) were mixed methods; and 4% (2) were qualitative.

The following section summarizes the enhanced supervision approaches reviewed. Detailed findings are available in the full HRH2030 Enhanced Supervision Phase I: Landscape Analysis report.

Inventory of enhanced supervision approaches: Context

Determinants of health workers' performance and productivity are greatly influenced by factors related to the *macro-level* components such as the overall health system, socioeconomic/labor market and political components, as well as *micro-level* components such as workplace dynamics or factors affecting communities where health workers live and the individual attributes of these health workers.

At the macro level, many of the approaches documented were undertaken at the impetus of new or renewed national health sector policies, guidelines, or training programs, some influenced by political will. In many countries, the professionalization or increased responsibilities assigned to community health workers (CHWs) and renewed importance of primary health care (PHC) also placed importance on supervision to ensure performance and program effectiveness. Some literature cited national health goals, including a desire to increase equity and coverage to rural, remote and underserved populations.

At the micro-level, the contexts in which many approaches were implemented affected productivity and performance—especially for CHWs—due to high workloads, inefficient processes, vast geographic distances, limited access to

equipment and supplies, and limited community trust and health service utilization. Inadequate pre-service education often resulted in limited job readiness of health graduates. In addition, limited management and leadership skills for supervisors hindered supervision effectiveness. For this reason, **clinical mentoring** and **supervisor skills building** emerged as important supervision enhancements.

At the individual level, high HRH turnover and absenteeism as well as limited skills hindered service continuity and quality.

Inventory of enhanced supervision approaches: Inputs

Human resources. Across the resources reviewed, district staff were the most frequently cited supervisor profile (29%), followed by facility staff (18%) and CHWs (13%). For CHW programming in India, Ethiopia, Kenya, Pakistan, and Tanzania, delegating supervisory roles to CHW supervisors or peers was shown to be effective, with results including: improved CHW supervisee motivation, safety, communication, and improved skills and standards of care. **Delegating supervisory roles to both facility staff and CHWs** can increase supervisory contacts and improve accountability.

Financial. Most programs reviewed (78%) were NGO- or donor-funded, with the rest either unspecified (16%), costed both externally and locally (4%), or through a national budget (2%). The **paucity of nationally funded supervision systems** in the literature presents a limitation to the analysis.

Informational, material, and technical resources. About one-fifth of the literature reviewed showed **supervisor use of facility-level records** (22%) or training material (20%) to prepare for visits. Respectively, there were two approaches (4%) each using individual supervisee performance data; smartphones to “crowdsource” information from supervisees; or mHealth applications to support community health and CHW-focused supervision.

Most studies (53%) did not indicate the type of material resources provided for supervision. In 22% of literature reviewed, smartphones were a key input for the approach. The most frequently cited technical inputs were standards of care checklists, guidelines, or health worker job aids (73%). The primary modality for supervision approaches using these inputs included: 100% of task shifting approaches (4/4); 81% **quality improvement (QI) approaches** (13/16); and 77% of human resource (HR) management approaches (14/18). Sixteen percent of approaches used an mHealth application.

Inventory of enhanced supervision approaches: Process

Modality. The most commonly documented modality for supervision was standard HR management (40%), of which the majority employed a problem-based or competency-based approach. More than one-third of approaches used QI

(36%), enhanced with a variety of secondary modalities. Supervision interventions supported task shifting/sharing, and frequently used the QI modality and clinical mentoring as a complementary intervention, which was considered appropriate and effective for skills upgrading. Moreover, a “whole of systems approach” has shown improved health care outputs, provider competence, and fostering of enabling environments to support staff effectiveness.

Frequency and location of feedback. Supervisory frequency, location, structure, and feedback approach corresponded to intervention context and goals. Most visits were scheduled (93%), most with monthly frequency (60%), though weekly or continuous supervision took place after new skills building.

Feedback on almost all supervisory visits was delivered at the place of work. Some CHWs were supervised at a facility hub for efficiency. **Distance feedback complemented in-person visits** and improved communication, use of data and health worker responsiveness. **Network-wide communication** helped to reinforce standards of care/clinical guidance, provide activity updates, reinforce accountability, and recognize or motivate CHWs.

Inventory of enhanced supervision approaches: Results

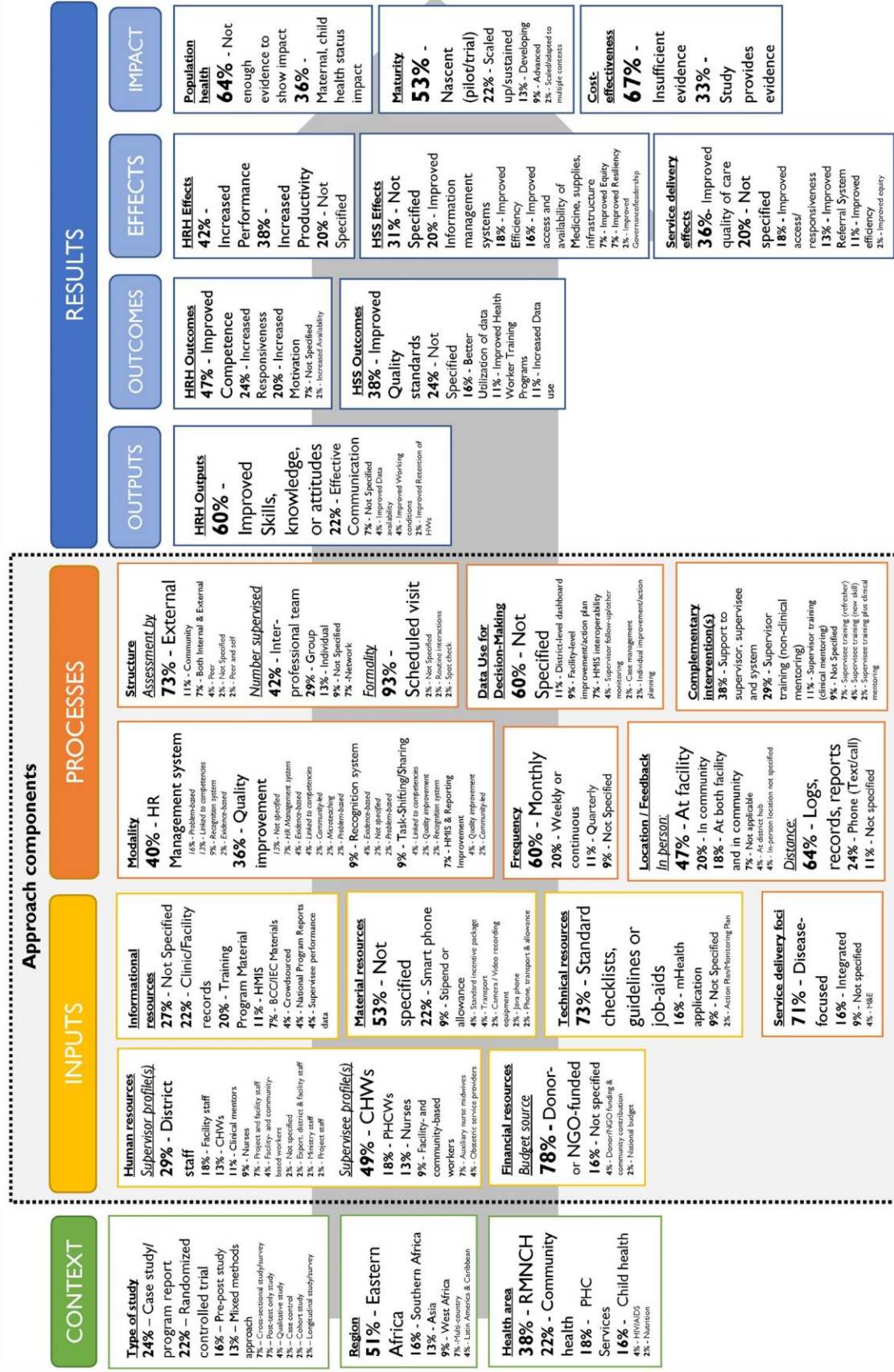
Outputs. Ninety-three percent of the reviewed approaches documented improvements in HRH outputs, most commonly in terms of: improved skills, knowledge, or attitudes (60%); or effective communication (22%) between supervisors and supervisees, health workers and clients, and among facility teams. Of the literature citing more effective communication as an HRH output, 80% also documented increased or better utilization of health system data.

Outcomes. The most common outcomes reported were improved health worker competence (47%) and improved health system quality standards (38%). The majority (57%) of resources that reported improved competence also reported improved quality, and vice versa (71%). While use of QI modalities most frequently demonstrated improved health worker competence (52%), HR management system modalities most frequently demonstrated improved health worker motivation (78%).

Effects. Increased health worker performance (42%), increased productivity (38%), and improved quality of care (36%) were the most frequently documented in this analysis.

Impact. Over half (53%) of approaches documented were in nascent stages (e.g., pilots, trials). An additional 13% were developing, 9% at advanced stages, and 22% scaled or sustained more broadly. QI was the most frequent modality among resources that demonstrated population health impact. Despite comprising only 38% of resources in the

Figure 2: Findings from inventory of enhanced supervision approaches



Source: HRH/2030 2019. Adapted from GHWA 2014, Dieleman et al 2009, and informed by Campbell et al 2013.

inventory, QI resources accounted for 56% of approaches that demonstrated population health impact, followed by HR management system modalities and task-shifting/sharing modalities, both at 19%. Two-thirds (67%) of literature reviewed lacked sufficient evidence of cost-effectiveness. Supervision goals differed, thus results were not compared.

Discussions and Recommendations

Enhancements to supervision approaches that **integrate evidence-based, quality-driven tools and processes** that streamline health workforce performance management with other health system performance data and information flows have demonstrated improvement for health workforce performance, health systems, and service delivery. These enhancements can be most effective when they are adapted to context and address performance determinants at the macro-, micro- and individual levels.

Enhancements include:

Inputs

- **Using health management information system (HMIS) and performance data to inform supervision priorities**, whether across sites or service areas. Linking human resource information systems (HRIS) with HMIS can help target resource allocation to improve quality and equity, and promote continuity despite high turnover or absenteeism of both supervisors and supervisees.

Processes

- **Incorporating QI methods** such as group problem-solving or collaborative improvement initiatives to support supervisees so that they can understand quality gaps, consider ways to address underlying factors, and use relevant data to continuously monitor and adapt actions.
- **Ensuring more timely, multi-level feedback loops**, including to communities, supervisees, and facility teams, across health worker networks, and to districts and national programs.
- **Integrating digital data** to promote efficiencies by making data available at multiple levels, such as through district-level dashboards, and to reduce supervisory workload by automating some tasks. These supervision data should be integrated with the HMIS to further inform health system performance and aggregated or disaggregated according to various decision-makers' needs.
- **Use digital technologies to adapt and apply standardized checklists** to capture health worker performance, including development of algorithms for customized feedback and automated data flows.
- **Clinical mentoring** effectively complements supervision, especially where pre-service education and training are

inadequate and when health workers have an enhanced scope or new skill to acquire, such as through task shifting/sharing.

- **Applying a “whole of system” approach** where health systems are inherently weak may be necessary to strengthen not only support to supervisees, but also build skills for supervisors themselves and improve health workers' working conditions, including ensuring the availability of medicines, supplies, equipment, infrastructure, water and electricity.
- **Engaging communities** can enhance supervision by promoting feedback loops with supervisors on service availability and quality, as well as by improving communication and encouraging service utilization.

For practitioners and policymakers alike, we recommend taking forward supervision enhancements by scaling and replicating successful models across service areas and geographically across health districts, while recognizing the need to contextualize interventions. Further research is recommended to assess the outputs, outcomes, effects, and impacts of the same enhanced supervision approach across different country contexts, health areas, sectors, and different types of health workers (e.g., public and private sector, facility- and community-based).

More evidence or lessons learned on how to scale and sustain country-led and domestically-financed supervision systems are needed; interventions reviewed within this landscape analysis were almost exclusively donor-supported. There should be efforts to sustain successful project-supported supervision systems by supporting local ownership, including transitioning supervisory skills, human, technical, and financial resources. More operations research and documentation of supervision implementation inputs and processes—including the costs of various enhancements—is recommended, especially within national or scaled systems.

Conclusion

Health worker supervision can have the greatest impact on strengthening health systems when it is enhanced by: using evidence-based, quality-driven tools and processes that integrate health worker performance management with other proven health system management approaches shown to positively impact service delivery. Enhanced supervision could fulfill its potential by: being adapted, scaled and sustained beyond a single health worker type or disease area; demonstrating cost-effectiveness within other health systems strengthening initiatives; and being more rigorously evaluated to demonstrate its impact on service delivery quality and population health impact.



Program Partners

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- American International Health Alliance (AIHA)
- Amref Health Africa
- Open Development
- Palladium
- ThinkWell
- University Research Company (URC)

About HRH2030

HRH2030 strives to build the accessible, available, acceptable, and high-quality health workforce needed to improve health outcomes.

Global Program Objectives

1. **Improve performance and productivity of the health workforce.** Improve service delivery models, strengthen in-service training capacity and continuing professional development programs, and increase the capacity of managers to manage HRH resources more efficiently.
2. **Increase the number, skill mix, and competency of the health workforce.** Ensure that educational institutions meet students' needs and use curriculum relevant to students' future patients. This objective also addresses management capability of pre-service institutions.
3. **Strengthen HRH/HSS leadership and governance capacity.** Promote transparency in HRH decisions, strengthen the regulatory environment, improve management capacity, reduce gender disparities, and improve multi-sectoral collaboration for advancing the HRH agenda.
4. **Increase sustainability of investment in HRH.** Increase the utilization of HRH data for accurate decision-making with the aim of increasing investment in educating, training, and managing a fit-for-purpose and fit-for-practice health workforce.



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