







Optimizing health worker performance to improve health care quality in low- and middle-income countries

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Preliminary findings

HRH2030 Landscape
Analysis on Enhanced
Supervision Approaches:

Best practices to improve health worker performance and service quality

The untapped potential of health worker supervision

- The supervision "status quo"
 - Limited accountability, supervisory capacity & resources
 - Fragmentation of private sector and community-based workforce
 - Limited continuity & data integration within health information flows
- Beyond other HSS interventions, enhanced supervision is estimated to have the highest potential impact (USAID 2017)
- How can enhanced supervision improve service quality? Impact population health?
- What are supervision "enhancements"?

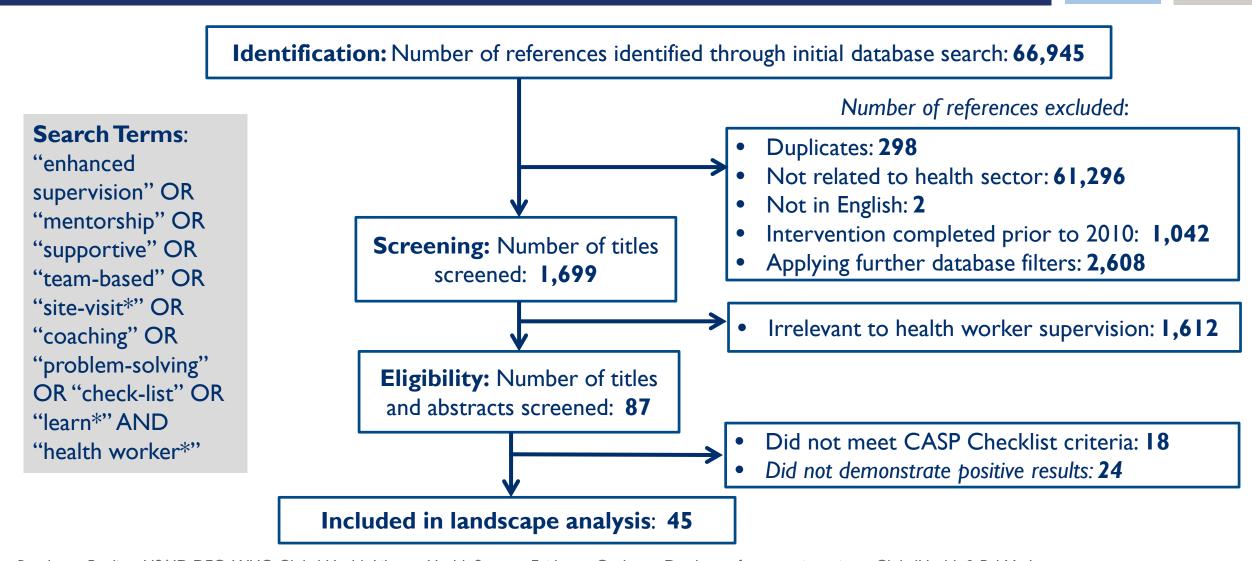
What is enhanced supervision?

"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."



AOTC Report: USAID, 2017

Database search methodology



HRH2030 Landscape Analysis Framework

PROCESSES RESULTS INPUTS CONTEXT **Modality OUTPUTS OUTCOMES** Macro-**EFFECTS** Human resources **IMPACT Frequency** level Trainers, supervisor & supervisee **Location / Feedback** profile(s) Micro-**HRH HRH** In person, distance **Population HRH Effects** level Financial resources **Outcomes** health **Service Delivery foci Outputs ▲** Performance Individual **Budget** source Structure Productivity **Maturity** Assessment type, # supervised, HSS Informational, technical & Type of Costformality **Outcomes** material resources study effective-**Data Use for Decision-HSS Effects** ness **Making Country Complementary** Health **Service** Intervention(s) area(s) **Delivery** "Enhancements"

- I. Positive results?
- 2. Supervision enhancements? (e.g., inputs, processes)
- 3. Scaled and/or sustained?











Landscape analysis taxonomy for classifying enhanced supervision approaches

PROCESSES

Peer and self

External

Individual

Network

Formality:

Group

Community

Internal (facility)

(district/project)

Number supervised:

Interprofessional

Routine interaction

Scheduled visit

Decision-Making

Action planning

Case management

interoperability

up/ other

Complementary

Intervention(s)

monitoring

Supervisor follow-

(individual, facility)

District dashboards

Spot check

Data Use for

HMIS

CONTEXT

Approach components

RESULTS

Macro-level Health system, socioeconomic, labor

market, political Micro-level

Workplace, community

Individual

Managers, health workers, clients

Type of study

- Case control
- Case study/report
- Cohort
- Cross-sectional
- Longitudinal
- Mixed methods
- Nonrandomized controlled trial
- Pre-post
- Post-test onlyQualitative
- RCT

Country / Region

Health area

- Child health
- Community health
- HIV/AIDS
- Nutrition
- PHC services
- RMNCH

INPUTS

Human resources

Supervisor profile(s) CHWs

- Clinical mentors
- District staff
- Doctor
- Expert, district & facility staff
- Facility staff
- Ministry staff
- Nurses
- Project staff
- Project & facility staff

Supervisee profile(s)

- ANMs
- CHWs
- Facility- or community based workers
- Midwives
- Nurses
- Obstetric care providers
- PHCWs

Financial resources

- Budget sourceCommunity
- Comme ■ Facility
- FacilityDistrict /
- regional
- Donor/NGO
- Donor/NGO & community
- National

Informational resources

- BCC/IEC materials
- Facility records
- Crowdsourcing
- HMISNational program

reports

- Supervisee performance data
- Training program material

Material resources

- Camera
- Java phone
- Phone, transport& allowance
- Smart phone
- Standard incentive package
- Stipend or allowance
- Transport

Technical resources

- Action or monitoring plan
- mHealth application
- Scorecards
- Standard checklists, guidelines and/or job aids

Modality Primary Structure Assessment by:

- Primary

 HMIS improvement
- HR ManagementQualityimprovement
- Recognition system
- Task shifting/sharing

Secondary

- Community-led
- Evidence-based
- Linked to competencies
- Microteaching
- Problem-based

Frequency

- Semi-annually
- Quarterly
- Monthly
- Weekly/continuous

Location / Feedback In person:

- In community
- At district hub
- At facility
- At both facility and in community

Distance:

- Phone (call/text)
- Email
- Logs, records, reports

Service Delivery foci

Disease-focusedIntegrated

M&E

xt) Clinical mentoring Supervisor training

(non-clinical, clinical)
Supervisee training (new skill, refresher)
Supervisee training &

clinical mentoring

 Support to supervisor, supervisee & system

OUTPUTS

HRH Outputs

- Supply
- ▲ Skill mix▲ Distribution
- ▲ Retention▼ Absenteeism
- ▲ Working conditions
- ▲ Skills, knowledge or attitudes
- ▲ Communication
- ▲ Data availability

OUTCOMES

HRH Outcomes

- ▲ Availability
 ▲ Responsiveness
- ResponsivenessCompetence
- Motivation

HSS Outcomes

- ▲ Quality standards
- ▲ Data use ▲ Utilization
- ▲ HRH training programs

EFFECTS

HRH Effects ▲ Performance

- lacktriangle Productivity
 - ▼ |

HSS Effects ▲ Governance/

- leadership ▲ Financing
- ▲ Information
 ▲ Medicine,
- supplies, infrastructure

Service Delivery

- ▲ Responsiveness
- ▲ Quality of care ▲ Referral

system

Population health

▲ Maternal, child health status

IMPACT

Disease
 prevalence

Maturity

- Nascent (pilot/trial)
- Developing
- AdvancedScaled up /
- sustained
 Scaled/adap
 ted to
- ted to multiple contexts

Costeffectiveness

- Evidence for cost effectiveness provided
- Insufficient evidence to demonstrate cost effectiveness

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

Characteristics of enhanced supervision approaches reviewed (n=45)



- 76% from Sub-Saharan Africa
- Diverse methodologies used
 - 24% case study/program report
 - 22% RCT
- All focused on primary or community health care service delivery improvement
 - Half dedicated to supervising CHWs
 - Many disease- or program-specific
 - District management team-led supervision
- Some policy-led approaches
 - PHC, CHWs, service equity, or task shifting
- Majority donor-funded (78% additional
 16% unspecified)



Preliminary findings from inventory of enhanced supervision approaches (n=45)

CONTEXT

Type of study

24% - Case study/ program report 22% - Randomized

controlled trial 16% - Pre-post study

13% - Mixed methods

approach

7% - Cross-sectional study/survey 7% - Post-test only study

4% - Qualitative study 2% - Case control 2% - Cohort study

2% - Longitudinal study/survey

Region 51% - Eastern

Africa

16% - Southern Africa 13% - Asia

9% - West Africa 7% -Multi-country

4% - Latin America & Caribbean

Health area

38% - RMNCH

22% - Community health

18% - PHC Services

16% - Child health

4% - HIV/AIDS 2% - Nutrition

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

Approach components

INPUTS

resources

records

20% - Training

4% - Crowdsourced

11% - HMIS

Program Material

7% - BCC/IEC Materials

4% - National Program Reports

4% - Supervisee performance

Material resources

22% - Smart phone

4% - Standard incentive package

2% - Camera / Video recording

2% - Phone, transport & allowance

Technical resources

73% - Standard

checklists.

iob-aids

application

focused

4% - M&E

16% - mHealth

9% - Not Specified

2% - Action Plan/Monitoring Plan

Service delivery foci

71% - Disease-

16% - Integrated

9% - Not specified

guidelines or

53% - Not

specified

9% - Stipend or

allowance

4% - Transport

2% - Java phone

27% - Not Specified

22% - Clinic/Facility

Human resources

29% - District

18% - Facility staff

11% - Clinical mentors

7% - Project and facility staff

4% - Facility- and community-

2% - Expert, district & facility staff

Supervisee profile(s)

49% - CHWs

18% - PHCWs

13% - Nurses

9% - Facility- and

community-based

7% - Auxiliary nurse midwives

4% - Obstetric service providers

Financial resources

78% - Donor-

or NGO-funded

16% - Not specified

4% - Donor/NGO funding &

community contribution

2% - National budget

Budget source

workers

13% - CHWs

9% - Nurses

based workers

2% - Not specified

2% - Ministry staff

2% - Project staff

staff

Supervisor profile(s)

PROCESSES

Informational

Modality 40% - HR

Management system

16% - Problem-based 13% - Linked to competencies 9% - Recognition system

2% - Evidence-based 36% - Quality

improvement

13% - Not specified 7% - HR Management system

4% - Evidence-based 4% - Linked to competencies 2% - Community-led

2% - Microteaching 2% - Problem-based

9% - Recognition system 4% - Evidence-based

2% - Not specified 2% - Problem-based

9% - Task-Shifting/Sharing

4% - Linked to combetencie. 2% - Quality improvement

2% - Recognition system

7% - HMIS & Reporting

Improvement 4% - Quality improvement

2% - Community-led

Frequency

60% - Monthly 20% - Weekly or

continuous 11% - Quarterly

9% - Not Specified

Location / Feedback In berson:

47% - At facility 20% - In community 18% - At both facility and in community

7% - Not applicable 4% - At district hub 4% - In-person location not specified

Distance:

64% - Logs, records, reports 24% - Phone (Text/call)

11% - Not specified

73% - External 11% - Community

Structure

Assessment by

7% - Both Internal & External 4% - Peer

2% - Not Specified 2% - Peer and self

Number supervised

42% - Interprofessional team 29% - Group

13% - Individual 9% - Not Specified 7% -Network

Formality 93% -

Scheduled visit

2% - Not Specified 2% - Routine interactions 2% - Spot check

Data Use for **Decision-Making**

60% - Not Specified

11% - District-level dashboard 9% - Facility-level

improvement/action plan 7% - HMIS interoperability 4% - Supervisor follow-up/other

2% - Case management 2% - Individual improvement/action

Complementary intervention(s)

38% - Support to supervisor, supervisee and system

29% - Supervisor training (non-clinical mentoring)

11% - Supervisor training (clinical mentoring) 9% - Not Specified

7% - Supervisee training (refresher) 4% - Supervisee training (new skill) 2% - Supervisee training plus clinical mentoring

RESULTS

OUTCOMES

OUTPUTS

HRH Outputs

Improved

knowledge,

or attitudes

22% - Effective

Communication

7% - Not Specified

4% - Improved Working

2% - Improved Retention of

4% - Improved Data

availability

60% -

Skills.

HRH Outcomes

47% - Improved Competence 24% - Increased Responsiveness 20% - Increased Motivation

7% - Not Specified 2% - Increased Availability

HSS Outcomes 38% - Improved Quality

standards 24% - Not

Specified 16% - Better Utilization of data 11% - Improved Health

Worker Training **Programs** 11% - Increased Data

EFFECTS

HRH Effects

42% -Increased Performance 38% -Increased Productivity 20% - Not Specified

HSS Effects 31% - Not Specified 20% - Improved Information

management systems 18% - Improved Efficiency

16% - Improved access and availability of Medicine, supplies,

infrastructure 7% - Improved Equity 7% - Improved Resiliency 2% - Improved Governance/leadership

Service delivery effects

36%- Improved quality of care 20% - Not specified 18% - Improved

access/ responsiveness 13% - Improved

Referral System 11% - Improved efficiency 2% - Improved equity

IMPACT

Population health

64% - Not enough evidence to show impact

36% -

Maternal, child health status impact

Maturity

53% -

Nascent (pilot/trial)

22% - Scaled up/sustained 13% - Developing

9% - Advanced 2% - Scaled/adapted to multiple contexts

Costeffectiveness

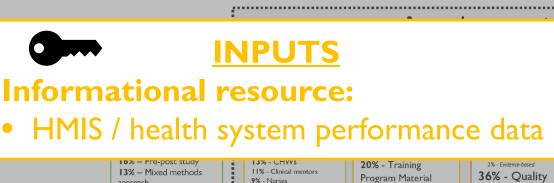
67% -Insufficient evidence

33% -

Study provides

evidence

Preliminary findings from inventory of enhanced supervision approaches (n=45)





PROCESSES

Modality:

Quality improvement (QI) methods

Feedback:

Multi-level, timely feedback loops

Data use for decision-making:

HMIS interoperability

Complementary interventions:

- Clinical mentoring
- Community engagement

Adapted from Dieleman et al 2009, and informed by Campbell et al 2013.

Source: HRH2

9% - Not specified

24% - Phone (Text/call)
11% - Not specified

OCESSES

<u>Assessment by</u>
73% - External

11% - Community
7% - Both Internal & External
4% - Peer
2% - Not Specified
2% - Peer and self

Number sut

professiona 29% - Group 13% - Individua 9% - Not Specifie 7% -Network

Formality 93% -

Schedule 2% - Not Specified 2% - Routine interac 2% - Spot check

Data Use for Decision-Ma

Specified
11% - District-len
9% - Facility-level
improvement/acti

improvement/acti
7% - HMIS intero
4% - Supervisor follomonitoring
2% - Case managem
2% - Individual improplanning

Complemen intervention 38% - Support

supervisor, su and system 29% - Supervisor training (non-clinical mentoring) 11% - Supervisor training

(clinical mentoring)
9% - Not Specified
7% - Supervisee training (refresher)
4% - Supervisee training plus clinical

RESULTS

DUTCOMES

HRH Outcomes
47% - Improved
Competence

HRH Effects 42% -Increased

Population health 64% - Not

RESULTS

Outputs, Outcomes or Effects:

Noteworthy achievements



Impact

HRH Outputs

60% -

Scaled up and/or sustained over time

provides evidence

specified 18% - Improved access/

responsiveness

13% - Improved

Referral System

11% - Improved

2% - Improved equity

efficiency

Supervision enhancement:

Use HMIS to inform and prioritize sites and/or service areas

HMIS + clinical mentoring	Achieved task-shifting among mid-level providers for higher-quality HIV and TB services in Uganda	Naikoba et al. 2017
HMIS + mHealth app + weekly calls + job aid	Facilitated performance feedback for CHWs delivering nutrition services in India, who were more motivated, self-efficacious, and solved more technical problems	Kaphle, Matheke-Fischer and Lesh, 2016
HMIS + mHealth app + checklist + QI	Improved quality of care for private sector & CHW providers in malaria and FP services across Africa and Asia	Lussiana et al. 2016
HMIS + mHealth	Increased CHW data use, productivity, and accountability for adhering to iCCM / child health standards of care	Biemba et al. 2017

Potential for **cost-effectiveness** (Campbell *et al.*, 2014; Biemba *et al.*, 2017)



Supervision enhancements: Quality improvement (QI)

Of the 16 supervision approaches having QI as the <u>primary</u> modality:

Outputs

• 63% [10] improved HRH skills, knowledge and attitudes

- Outcomes 69% [11] improved HRH competence
 - 50% [8] documented improved quality standards

Effects

- 81% [13] improved HRH performance and/or productivity
- 56% [9] improved the quality of care

Impact

56% [9] improved population health ... compared to 17% [3/18] of HR management as primary modality



Supervision enhancements:

Digital data integration & multi-level feedback loops

District-level dashboards

- Promotes efficiency
 - Automates some supervisory tasks

Manzi et al., 2012 Agarwal et al., 2016

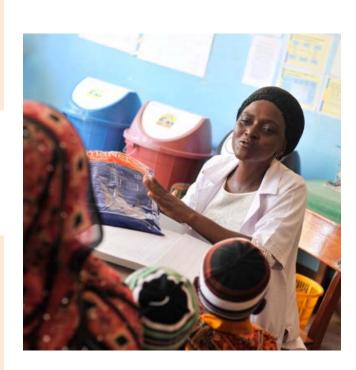
Interprofessional or network support

 Reinforces formal visits and promotes self-efficacy Okuga et al., 2015 Mkumbo et al., 2014

Data review meetings & facility improvement plans

Improved health
 worker competencies
 in data-driven
 decision-making,
 including for CHWs

Aikins et al., 2013 Manzi et al., 2018



Supervision enhancements:

Complementary interventions

Clinical mentoring

- Addresses pre-service education and performance gaps
- Where CPD is limited; for enhanced/new scopes of practice

Anatole et al., 2013 Manzi et al., 2014 Som et al., 2014 Ajeani et al., 2017

"Whole-ofsystem" approach

- Strengthens supervisor capacity
- Strengthens health system: enabling environment, safety, equipment and supplies ->

Green et al., 2014
Deussom et al., 2014
Battle et al., 2015
Gueye et al., 2016
Kok et al., 2018

Community engagement

- Provide feedback on service quality / utilization, especially for CHWs
- Problem-solve; maintain or improve facility; advocate
- Appropriate where there are issues of accessibility, perceived quality, trust, and/or utilization

Okuga et al., 2015 Gueye et al., 2016

Discussion & next steps

- More country-led assessments of more advanced approaches; longer evaluation periods
- Limited detail of implementation approach, resource requirements
- Limited comparisons of supervision enhancements in different contexts, with different objectives
- We know what works. How can we scale and sustain it?
- Using the conceptual framework and taxonomy to review supervision enhancements (including the HCPPR) could help strengthen the evidence base & further define trends

Data-driven prioritization for supervision | QI methods | Effective feedback loops | Community engagement | Clinical mentoring | Address broader health system shortcomings





