

# Supervision in Primary Health Care – Can it be Carried Out Effectively in Developing Countries?

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**Abstract:** There is nothing new about supervision in primary health care service delivery. Supervision was even conducted by the Egyptian pyramid builders. Those supervising have often favoured ridicule and discipline to push individuals and communities to perform their duties. A traditional form of supervision, based on a top-down colonial model, was originally attempted as a tool to improve health service staff performance. This has recently been replaced by a more liberal “supportive supervision”. While it is undoubtedly an improvement on the traditional model, we believe that even this version will not succeed to any great extent until there is a better understanding of the human interactions involved in supervision. Tremendous cultural differences exist over the globe regarding the acceptability of this form of management. While it is clear that health services in many countries have benefited from supervision of one sort or another, it is equally clear that in some countries, supervision is not carried out, or when carried out, is done inadequately. In some countries it may be culturally inappropriate, and may even be impossible to carry out supervision at all. We examine this issue with particular reference to immunization and other primary health care services in developing countries.

Supported by field observations in Papua New Guinea, we conclude that supervision and its failure should be understood in a social and cultural context, being a far more complex activity than has so far been acknowledged. Social science-based research is needed to enable a third generation of culture-sensitive ideas to be developed that will improve staff performance in the field.

**Keywords:** Expanded programme on immunization, supervision, supportive supervision, traditional supervision, smallpox eradication, social science-based research, mid-level manager, senior-level manager.

## INTRODUCTION

The word “supervision” literally means “to over-see”. It implies that someone higher up the scale is watching to see that someone lower down is performing their job properly. As early as the Egyptian pyramid builders, supervisors oversaw teams of slaves pulling huge building blocks into place. Since then, those in power, including colonialists, exerted their influence over others by appointing supervisors and inspectors. This form of supervision was most often focused on outcomes and was usually not open to dialogue and consultation about the process. It often favoured ridicule and discipline to push individuals and communities to perform their duties. And it has not fulfilled its promise to improve primary health care delivery.

We propose that the legacy of the colonist-colonized and other unequal working relations have had a significant influence on the evolution of supervisory mechanisms for today’s developing world. With the fading of colonization came the sense of independence and empowerment, but often without a real understanding of accountability. We explore these influences in looking at the development of new and innova-

tive ways of conducting supervision, with particular reference to immunization and drug administration services in developing countries. Health systems originally evolved a “traditional” form of supervision based on the “over-seer”. A new model of “supportive supervision” has now evolved that includes encouragement, discussion with the staff member and shared efforts at problem-solving.

The formal literature concerning supervision in primary healthcare is limited. Most articles only look at the supervision of clients by nurses [1-7]. Our observation is that while health services in many countries have benefited from supervision of one sort or another, it is equally clear that in some countries, supervision of the performance of health staff who administer drugs and vaccines is not carried out, or when carried out, is done inadequately. In some countries it may be culturally inappropriate, and may even be impossible to carry out at all, whereas in other societies supervision may “fit” culturally well [8]. While record-keeping and various forms of surveillance are of a technical nature and do not require a face-to-face exchange, supervision involves a rather intimate interaction between human beings who are at different levels in organizational hierarchies. As such, there are endless possibilities for it to be disruptive.

## “TRADITIONAL” SUPERVISION

The more traditional supervisory visit focused on inspection and fault finding. Health workers often received little guidance or mentoring on how to improve their performance.

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They were “frequently left undirected, with few or no milestones to help assess their performance, until the next supervisory visit. Motivation [was] hard to maintain in such an atmosphere” [9].

While most primary health care services acknowledge the need for some form of supervision, we maintain that effective (traditional) supervision has been an abject failure in most primary health care settings in developing countries. For instance, inadequacy in the quality of primary health care facilities in Nigeria was felt to be the product of failure in a range of quality measures – structural (lack of equipment and essential drugs), and process (not using the national case management algorithm and lack of a protocol for systematic supervision of health workers). The study recommended that efforts to improve the quality of primary health care in Nigeria and similar less developed countries should focus not only on providing better resources, but also on low-cost, cost-effective measures that address the process of service delivery such as supervision [10].

The eradication of smallpox was the first major triumph for vaccination. Yet supervision of local staff does not appear to have been an important element of success. From 1959 onwards, smallpox vaccine was systematically delivered to populations in carefully orchestrated campaigns. The smallpox eradication campaign was conceived as a global, top-down programme, and assumptions were made that it could be run in a “culture-free” way the world over. Its effectiveness was monitored by intense disease surveillance and its goals were target-driven. Supervision was achieved by determining whether the goals had been reached [11]. This approach was immensely effective as judged by the eradication of the disease. It was not, however, without its critics [12].

To build on the extraordinary success of smallpox eradication, in 1974, the World Health Organization created the Expanded Programme on Immunization (EPI). The top-down approach was continued. EPI assumed a global imperative for immunizing the world’s children that could only be achieved, it was thought, by standardization. This resulted in global policies and global training materials being developed.

The main EPI training tools were the senior level managers training course (SLM), the mid-level managers’ training course (MLM), and the peripheral level training course called “Immunization in practice” (IIP).<sup>1</sup> A later version of the MLM contained a module on supervision, the first time in the history of immunization that this management tool had been incorporated into the main body of immunization programme culture.

The three series were all developed by industrialized country experts and were then field tested on programme managers in developing countries before being finalized. However, the field testing was about whether the course participants understood the modules and could complete the exercises, not about whether the material was appropriate to

the culture it would be used in. Nor was the impact of supervision training evaluated.

## “SUPPORTIVE” SUPERVISION

From a feeling of dissatisfaction with the old model emerged a new paradigm for supportive supervision. The Maximizing Access and Quality Initiative (MAQ) described supportive supervision as “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—promoting high standards, teamwork, and better two-way communication” [13].

By 2001, the move away from traditional supervision had begun. Decisions were made in WHO Headquarters, in some of the Regions and elsewhere to re-write the training modules, including the module specifically on supervision “*Guidelines for Implementing Supportive Supervision: A step-by-step guide with tools to support immunization*” [9]. This guideline clearly laid out the new principles of supportive supervision.

While we believe these guidelines provide the basis for improving supervision in most of the developing world, there is also scope for yet more innovative approaches to supervision. Independence, autonomy, community participation and empowerment without the cultural or political climate to ensure that supervision can be conducted may not create an environment conducive to improving outcomes. Health workers at the periphery are often faced with complex problems over which they may have little control, scant resources, and few problem-solving skills. No amount of traditional supervision will overcome this situation. However, the new paradigm of supportive supervision might – where supervisors sit along side the health worker and attempt to solve the problems together.

The new guidelines [9] captured ideas from across a wide spectrum of leaders in the immunization field. They identified four main steps involved in developing training and capacity building, identifying a new element in this area – “supportive” supervision:

- Conducting training needs assessments.
- Providing pre- and in-service education.
- Conducting supportive supervision, including continuing education.
- Monitoring and evaluating training programmes.

As well, the Global Alliance for Vaccines and Immunization (GAVI) partners identified supportive supervision as a high priority and a critical gap in immunization training. Supportive supervision was also noted as one of the five key elements needed in “Reaching Every District” to accelerate progress toward GAVI’s goal of achieving 80 percent DTP-3 coverage in 80 percent of developing country districts [14].

None the less, in some modern training materials, supervision is still hardly mentioned – for instance the most recent immunization guideline published by the U.S. Agency for International Development (USAID) dismisses supportive supervision in five sentences out of a 270-page field guide [15].

<sup>1</sup>Current versions of the SLM, MLM and IIP material can be found on the WHO/EPI web site at <http://www.who.int/vaccines/documents.html> (viewed February 2004).

## EVALUATING SUPERVISION STYLES

Exceptionally, managers have recognized that proper supervision, along with appropriate drug and vaccine supply, is a prerequisite for training [16]. And there is already some evidence that supportive supervision works. For instance, a study of Integrated Management of Childhood Illness (IMCI) in Uganda revealed that health workers who received at least one supportive supervisory visit that included observation of case management within the last 6 months performed better than those who were not visited by the supervisor [17]. A study of on-the-job training in Turkey [18] demonstrated that follow-up supervisory visits resulted in a marked improvement in staff performance. And it is not just those staff who are supervised who seem to benefit. The supervisors themselves have been shown to benefit from support by the parent organization [19].

We believe the challenges for supportive supervision include addressing staff motivation and accountability. Staff should be fully aware of the part they play in making a difference for the health and overall well being of their communities. A 1995 review of the immunization programme in India documented how the pervading form of supervision had arisen from a combination of a strong organizational hierarchy and lack of emphasis on and belief in the possibility of accountability at low organizational levels [8]. We suggest that in order to improve accountability, planners and supervisors should begin this process at the time of staff selection which should be based on well defined roles and activities described in terms of reference (TOR) to be performed by the individual. The TORs should remain the basis for the on-going supervisor-subordinate relationship.

Worryingly, those placed in the role of supervisor have often lacked the technical, managerial, or supervisory skills needed to carry such a task out well – making it unlikely that supervision would be truly supportive. Earlier EPI training modules of the 1980s did not result in a global cadre of competent supervisors.

The contrasts between the types of supervision are summarized in Table 1.

## A CASE STUDY OF SUPERVISION FAILURE

A review carried out in a South Pacific nation during 2003 [20] showed that almost no supervision of any category was being carried out at any level. It prompted the evaluation team to ask some fundamental questions about supervision in the context of health service delivery in that country. The survey suggested that serious errors and omissions in service delivery were attributed to a number of factors including a lack of supervision. A range of reasons was offered why supervision was not being carried out or was carried out inadequately. Some responses suggested a deep cultural and/or attitudinal discomfort with the process, for both supervisor and supervisee. When supervision occurred, it was not effective in improving staff performance.

Most health centres had not been supervised in a year, others never. Official estimates of the rate of supervision visits were less than 1% coverage nationally. According to guidelines, supervision should have been every 3 months but actually only occurred when there was a problem. If there was no problem, there was no supervision. Even centres that were close to a city were only supervised less than once a year, suggesting that neither time, money nor transportation were true limiting factors.

One field visit evaluation noted: “The building looked very untidy, dirty and dusty with lots of cobwebs. There has been no vaccine since January because the gas ran out. There is no standby gas cylinder. Training materials are locked away in a cupboard. Injection practices are not safe as needles are still attached to vials and are left there for maybe hours or days. There are no displays of any health policies on the board.” Almost any form of supervisory visit would have detected the serious state this health centre was in and should have been able to intervene.

While elements of supervision were perceived as unwelcome and intrusive, there was a high emotional need for approval from those higher up the chain of command that would acknowledge the extraordinary efforts invested by individuals to make the system work, often under extreme circumstances (it was like the son whose father never came

**Table 1. Comparison of Traditional and Supportive Supervision [13]**

Action	Traditional Supervision	Supportive Supervision
Who is designated to perform 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 will supervision happen	During periodic visits by external supervisors	Continuously: during routine work; team meetings; and visits by external supervisors
What will happen 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; onsite training; use of data and client input to identify opportunities for improvement; joint problem-solving; follow-up on previously identified problems
What will happen after the supervision encounter	Irregular or no follow-up	Actions and decisions recorded; ongoing monitoring of weak areas and improvements; follow-up on prior visits and problems

to watch his ball game). Health centre staff may have had an unreasonable expectation that a supervisor could solve all their problems. Supervision that was carried out generally focused on administrative issues rather than practical actions. When they did visit, supervisors did not use a checklist.

The reasons stated by staff for not carrying out supervision were as follows:

- Lack of transport (commonly stated)
- Lack of time/opportunity (commonly stated)
- Funding not released
- Poor relationship between hospital and provincial staff
- Personality issues

The review highlighted the fact that supervision is a complex task with many difficulties to overcome during personal interactions. *“Sometimes it is difficult to supervise someone who is a man and a “family man” because he is important and respected”*.

The report suggested that the activity currently called “supervision” was not working and should be redesigned. Even though some elements of supervision might continue, they should be framed in a different way with different wording. Assumptions implicit in “supervision” should be questioned. For instance, it may not be necessary to visit a health centre to perform part of this new role. Instead, the use of other reporting tools should be explored.

#### HOW DOES WESTERN SOCIETY SUPERVISE?

We propose that little supervision of the traditional or supportive types is actually carried out in industrialized countries. Even though most industrialized countries run successful health services, they do not depend on classical supervision by an external person to maintain staff practices. Most health care workers operate in an hierarchical structure where the “boss” is in the same building as the employees carrying out the service. Thus there is a day-to-day, even moment-by-moment supervision where the boss is an integral part of the team. He/she takes leadership and may provide on-the-spot training as required. There is mutual respect, and an understanding on the part of the employee that the boss has certain power and authority (even to the extent of hiring and firing). Although audit of some sort is carried out in many settings, external review of health activities is an exception, not the rule. Staff are universally threatened by such visitations from outside. It would be fair to say that oversight of work by a senior team member (the boss) is normal and acceptable. In a rural health centre context, this translates to the officer in charge – usually a senior nurse. But supervision by an external person is likely to be considered as highly threatening.

Sometimes even a senior team member may not be perceived as “one of us”. For instance, Japanese managers brought in to manage factories manufacturing Japanese cars in European countries have found resistance to their methods that are not culturally acceptable. The “boss” is perceived as an outsider in this example and is seen as a threat.

#### DISCUSSION

Supervision is finally being recognized as a difficult function to conceptualize, to train and to execute. While it sounds like the panacea to all health systems ills, the reality is quite different. “Any form of supervision can be costly and requires staff time, costs for per diem, and travel to remote sites. Health budgets frequently do not allocate sufficient funds or personnel to conduct supportive supervision, making regular visits difficult to finance and coordinate. Furthermore, supervisors need support and authority from higher levels to be able to implement supervision, or make changes to improve services at a health facility” [9].

What are the reasons for poor or absent supervision? There may be systemic reasons – no transport, no money for *per diem*, staff too busy with other duties to put aside valuable time in traveling long distances to peripheral facilities. However, many of these reasons are superficial. Why is there no transport or money? Is supervision expensive? There would seem to be a general lack of commitment to supervision at all levels of the hierarchy.

Is there an embarrassment factor? Senior staff may be reluctant to reveal that others are not performing well. As a member of another tribe, the supervisor may simply be unwelcome and unable to voice criticism of anyone without generating hostility. In many of the poorer developing nations, resources are scarce; this has resulted in health workers having to face many problems including how to provide adequate services with inadequate resources. Consequently, users of the services complain about low quality of care which is often associated with the rude behavior of staff [21]. It might be supposed that this rudeness has several origins, perhaps partly the embarrassment of not being able to provide high quality care. In situations of scarcity, supervision is especially important to maintain standards and listen to the problems of health workers and clients and translate these to those upstairs.

Is there a resentment factor? Do staff object to supervisors “parachuting in” to see what is happening and criticizing? Do they feel an invasion of personal space? Perhaps the interaction implies criticism even when not overt. And the visitor may be perceived as simply not understanding the constraints that field staff operate under. *“She doesn’t seem to understand I can’t behave like that to the village people who come to the clinic”*. *“Of course there is no gas for the fridge – no-one has sent us any for six months”*.

But will the new model of supportive supervision work? We are not the first to suggest that problem-based learning and continuous supportive supervision need to be institutionalized [22]. But more importantly, we suggest that insufficient attempt has been made to understand the supervisor-supervisee interaction and the problems faced by attempting to communicate across this barrier. There are bound to be culturally-specific issues that influence this, but are not acknowledged. Communication skills are rarely taught that might overcome the communication barrier.

At least some of the shortcomings currently experienced by health services in many developing nations may be due to their colonial past that did not develop managerial capacity

nor promote innovation. As a consequence, there has been little or no attempt to develop culturally sensitive supervisory tools. Those playing major roles in shaping the health and well-being of communities and societies have not generally been held sufficiently accountable and responsible for their actions.

## CONCLUSIONS

Quality of care and service delivery must be assured by those in accountable positions. In situations of scarce resources, it is particularly important to maintain standards of practice when huge demands are placed on staff, often resulting in less-than-ideal behaviour. It is precisely in such situations that staff need to know there is support from their superiors, and managers need to know that the scarce health dollar is being used to best advantage. We believe there should be "accountability to all by all". The service providers should feel satisfied with their input and the service recipient should be satisfied with the output.

Traditional supervision, based on a top-down colonial model, was originally attempted as a tool to improve health staff performance. This has recently been replaced by a more liberal "supportive supervision". While this is undoubtedly an improvement on the traditional model, we believe that even this version will not succeed to any great extent until there is a better understanding of the human interactions involved in supervision. Wide cultural differences exist over the globe regarding the acceptability of this form of management. More social science-based research is needed to enable a third generation of culture-sensitive ideas to be developed that will improve staff performance in the field. It is to be hoped that the next generation of training materials covering supervision in health services will take into account the societal elements described above.

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