

AVSC Working Paper

No. 10 August 1996

FACILITATIVE SUPERVISION: A VITAL LINK IN QUALITY REPRODUCTIVE HEALTH SERVICE DELIVERY

Beverly Ben Salem and Karen J. Beattie

INTRODUCTION

AVSC has long been committed to finding innovative ways to help improve the quality of the clinical services clients receive. Through the development of approaches like COPE, inreach, and whole-site training, we are working to help all levels of service providers at clinics and hospitals become more responsive to the needs of clients as well as staff. These tools focus on giving clients and providers an important role in discovering and implementing ways to improve service quality.

Since traditional supervisory systems may not be conducive to "empowering" staff and clients to participate in problem solving, AVSC is now proposing a new approach, facilitative supervision, which complements our quality-improvement tools by giving clients and site staff the support they need to become part of the quality-improvement process.

Our work on supervision has focused on external supervisors—that is, persons who are responsible for geographic areas and who serve as intermediaries between a service-delivery point and an institution such as a Ministry of Health or NGO country headquarters. However, the principles of facilitative supervision can also apply to supervision within a given facility.

The first part of this paper defines facilitative supervision and explains how it differs from conventional supervision. The second part presents examples of the steps an institution can take to move from a traditional supervisory system to a facilitative system.

Thereafter, examples of facilitative supervision in action are given, followed by a discussion of ways to evaluate the success of this approach.

This paper is intended to be a companion piece to AVSC Working Paper No. 7, "Quality Management for Family Planning Services: Practical Experience from Africa."

DEFINITION AND BACKGROUND

AVSC defines *facilitative supervision* as an approach to supervision that emphasizes mentoring, joint problem solving, and two-way communication between the supervisor and those being supervised. This definition recognizes that supervisors play an essential role as intermediaries who can *facilitate* the implementation of institutional goals and who can *facilitate* local-level problem solving and quality improvement. The use of the term *facilitative supervision* does not imply criticism of conventional supervision systems. Rather, the aim is to focus attention on a key concept of supervision—joint problem solving—and to remind us that traditional "inspection" alone is not conducive to helping sites achieve continuous quality improvement. Ideally, management facilitates quality improvement by involving service providers in identifying and resolving problems. This may involve reorientation of systems as well as individuals.

When supervisory systems change to become more facilitative, it does not mean

BEST AVAILABLE

**“The bad leader
is he whom the
people despise.
The good leader
is he whom the
people praise.
The great leader
is he of whom
the people say:
‘We did it
ourselves.’”**

—Lao-Tzu

that management no longer has a directive role. Management remains responsible for determining the goals of the organization, planning the implementation of work, and making available the facilities, equipment, training, and other resources needed to achieve those goals.

Supervision and Continuous Quality Improvement

To help promote continuous quality improvement at all levels of clinic services, AVSC is developing tools and approaches that include COPE,² inreach,³ whole-site training,⁴ cost-analysis methodology for clinic-based family planning methods,⁵ and AVSC's approach to medical monitoring and supervision. (See Figure 1.) The use of these tools and approaches has repeatedly pointed to the need to focus special efforts on strengthening weak supervisory systems—the vital, “missing” link in quality management.

In the field of reproductive health, it is appropriate to focus on clients and how their needs are being met by clinic staff. However, while striving to achieve the aim of satisfying clients, it should be acknowledged that service providers also have needs. One basic need is for an appropriate and functional supervisory system.

Many obstacles to providing consistently high-quality services can be overcome by local staff after they become aware of their own ability to effect positive change. (This “empowerment” is one reason for staffs' enthusiasm for COPE, which helps staff resolve many problems on their own.) However, some items surpass capacities for action by local staff and instead are related to linkages (or the lack thereof) between service sites and higher levels of authority. In many instances, problems identified by staff reflect the need for supervisors to devote more time and provide more guidance to sites.

Conventional Supervision: Constraints and Missed Opportunities

Supervisors are essential to achieving an organization's mission. Not only do they perform the important task of interpreting the goals of the organization for staff, but they also coordinate the resources—people, time, materials, and money—necessary to achieve those goals.

A conventional model of supervision is often found in the health care systems in which family planning programs are situated. This conventional model emphasizes assessing actions in the past rather than

The purpose of AVSC Working Papers is to capture on paper AVSC's experience and to disseminate the results of AVSC-supported operations research. We welcome your comments and suggestions.

ACKNOWLEDGMENTS

This paper grew out of AVSC's work with its counterparts worldwide, including governmental institutions, NGOs, and the private sector to improve the quality of family planning services and to some degree has its roots in our work on medical quality assurance and on introducing COPE. Over the past year, many AVSC International staff members and consultants have provided input and comments on the drafts of this working paper. In particular, the authors would like to thank Libby Antarsh, Janet Bradley, Abu Faisal, Terrence Jezowski, Pamela Lynam, Yatshita Mutombo, Amy Pollack, Sylvia Vriesendorp, and Grace Wambwa. Special thanks go to Joseph Dwyer for his leadership in this area of AVSC's work and to Lynn Bakamjian for her support and encouragement. Special thanks also to Joanne Tzanis, who edited this paper.

This publication may be reproduced without permission, provided the material is distributed free of charge and the publisher and authors are acknowledged.

EDITORIAL COMMITTEE

Amy E. Pollack, M.D., *President*
Libby Antarsh, *Regional Director, Former Soviet Union*
Lynn Bakamjian, *Vice President/Director, Field Operations*
Charles Carignan, *Medical Director*
Joseph Dwyer, *Director, Regional Office for East and Southern Africa*
Pamela Beyer Harper, *Director, Communications*
Terrence W. Jezowski, *Vice President/Director, Planning*
Evelyn Landry, *Director, Evaluation and Research*
Cynthia Steele Verme, *Director, Special Programs*

This publication was made possible, in part, through support provided by the Office of Population, U.S. Agency for International Development (AID) under the terms of cooperative agreement CCP-3068-A-00-3017-00. The opinions expressed herein are those of the authors and do not necessarily reflect the views of AID.

AVSC INTERNATIONAL

79 Madison Avenue, New York, NY 10016
Telephone: 212-561-8000 Fax: 212-779-9439
e-mail: info@avsc.org

©1996 AVSC International
Printed on recycled paper.

Figure 1 AVSC Quality-Improvement Approaches and Tools

Issues	Approaches	Tools
Problem identification and solution	<ul style="list-style-type: none"> • COPE (including self-assessment, client interviews, client-flow analysis, and action plan development) • Facilitative supervision • Medical monitoring 	<ul style="list-style-type: none"> • <i>COPE: Client-Oriented, Provider-Efficient Services</i> • Supervisor's program evaluation tools (draft) • <i>AVSC Medical Monitoring Handbook</i>
Access to services; linkages between services	<ul style="list-style-type: none"> • Inreach (including orientations, updates, and establishing referral systems) • COPE 	<ul style="list-style-type: none"> • Orientation handbook (draft) • <i>COPE: Client-Oriented, Provider-Efficient Services</i> • IEC materials
Technical competence; quality assurance	<ul style="list-style-type: none"> • Whole-site training (including orientations, updates, and skills training) • Medical monitoring 	<ul style="list-style-type: none"> • Orientation handbook (draft) • Guidelines (female sterilization, vasectomy, postpartum IUD, informed consent, etc.) • Curricula for clinical skills training (minilaparotomy, no-scalpel vasectomy, etc.) • <i>Family Planning Counseling: A Curriculum Prototype</i> • On-the-job training certification guides (draft)
Involvement of all levels of staff; ownership; meeting provider needs	<ul style="list-style-type: none"> • Facilitative supervision • COPE • Site assessment and evaluation • Medical monitoring • Provider interviews • Whole-site training 	<ul style="list-style-type: none"> • <i>COPE: Client-Oriented, Provider-Efficient Services</i> • Supervisor's program evaluation tools (draft) • Orientation handbook (draft) • Guidelines • Curricula for clinical skills training • <i>AVSC Medical Monitoring Handbook</i> • <i>Cost-Analysis Methodology for Clinic-Based Family Planning Methods</i> • MIS review (from Management Sciences for Health's <i>Family Planning Manager</i>)

NOTE: With the exception of the MIS review and national standards and guidelines, all handbooks, questionnaires, curricula, and other materials listed here were developed by AVSC International. Materials described as "draft" may not be available for distribution.

“When you visit and work with a site on a regular basis, the staff come to know you. They see that you’re not just there to check up on them and then forget about them.”

—Regional Supervisor,
Uganda

seeking opportunities that look to the future. In other words, the emphasis is on scrutinizing individual performances and assessing end results instead of collaborating with staff to improve work processes and to ensure that quality services are provided to clients.

This model, focusing on individuals rather than processes, does not take into account other factors that affect an individual’s ability to carry out her or his job. In addition, by focusing on the “subordinate and not the goal . . . the supervisor [is] not taking initiative to contribute to the aims of the organization.”⁶

Supervisory systems miss opportunities for improvement when they focus only on the things that go wrong. In addition, supervisors are often frustrated in their work because they cannot meet the need for support evidenced by those they supervise. Budgetary constraints, geographic constraints, and lack of supervisory training can result in missed opportunities for quality improvement.

Budgetary constraints

As with other aspects of medical services, supervision is often deficient due to budgetary constraints. Transportation and subsistence budgets for those required to cover a geographic area are often insufficient or unavailable, making it impossible for them to actually carry out supervisory duties. In order to conduct necessary visits, supervisors in some AVSC-supported programs in Africa reportedly have traveled in taxis hired by the day—a practical solution that’s not tenable for the long term. Visits conducted in circumstances such as these may be perfunctory and of short duration, thus jeopardizing the quality of the supervision provided.

Geographical constraints

Supervisors asked to cover many sites within a large geographic area may only be able to provide superficial supervision. In reality, much of the supervisor’s time is spent on the road, getting from place to place. When, as often occurs, it takes a day to travel to a site and a morning to complete protocol visits with district or site officials, a supervisor may only have a couple of hours

to spend actually observing services and talking to staff at the site before she or he must depart. On such a visit, the supervisor may not have an opportunity to talk with different levels of staff or to spend time looking into particular problems.

What a supervisor actually observes during a tour may not be relevant, simply because of the time of day when the “inspection” takes place. For example, if one of the supervisor’s tasks is to monitor the quality of clinical services, clients may be inconvenienced and services may be disrupted or rescheduled in order for the supervisor to observe interaction with clients, clinical technique, infection prevention procedures, and postsurgery monitoring. The resulting “snapshot” of services is distorted by the limited amount of time, the wide range of issues to cover, the perceptions of the few people with whom the supervisor interacts, and the very nature of an “inspection” visit. (See Figure 2.)

After such a visit, the supervisor may leave behind instructions for things to be changed, followed up, or improved, but since neither the supervisor nor the site staff knows when the next visit might occur, little accountability or responsibility exists for ensuring that these instructions are followed. With brief supervisory visits spaced far apart, there is little capacity in most systems for resolving problems, and opportunities for continuous quality improvement are few.

In contrast, with the facilitative approach, supervisors ideally spend more time actually working at each site—perhaps two days instead of two hours. Devoting this much time to a site allows the supervisor to better understand and work with site staff to identify and begin to resolve problems. This may initially be more costly than short visits; however, over time less of the supervisor’s time will be required as the capacity of site staff to monitor and rely upon themselves to solve problems grows.

Lack of supervisory training

In many instances, staff are promoted to the supervisory level because of their reliability and good work, technical expertise, or their tenure with an organization. These staff are then expected to supervise others,

Figure 2 Inspection: Process and Results

SUPERVISION BY INSPECTION

The process

- Establish targets
- Wait to see what happens
- Deal with what goes wrong

The results

- Staff feel threatened
- Failures and problems reach clients
- Costs increase, other problems arise

often without adequate training or preparation, under the assumption that the same qualities that enabled them to perform well in their previous jobs will apply to the new situation. In fact, they may be supervising staff whose jobs bear no relation to their own past experience. For example, some supervisors are expected to conduct medical monitoring, although they may not have the technical skills to do so and may receive no special training in techniques and approaches for medical monitoring.

In addition, few resources are devoted to training supervisors in the art of supervision. They receive little or no training to develop the communication and decision-making skills that would enable them to support quality improvement at the site level. When there is any training, it is often geared to the inspection model, informing supervisors about what checklists and reports are required in order to quantify results. Unfortunately, data that is collected to satisfy institutional requirements is rarely used by supervisors to help staff at the site level to monitor and evaluate their own activities.

Missed opportunities

Because of budgetary, geographic, and supervisory training constraints, many opportunities for improving the quality of services are lost. On the other hand, with appropriate training and with more rational use of time and resources, supervisors can become catalysts for establishing or improv-

ing existing quality-assurance procedures in sites for which they are responsible.

In COPE exercises, staff frequently identify training needs as a problem to be resolved at the site. Supervisors can play a role in planning for training, in gaining access to the necessary resources for training, and, if they have the requisite skills, in providing some of the training themselves.

Improving Quality through Facilitative Supervision

Ideally, facilitative supervisors play the important role of intermediary: their continuous feedback to higher levels of management on successes, constraints, and failures in the provision of services helps management plan future improvements. At the same time, their support to the sites and staff they supervise helps achieve the institution's goals. It is important to remember, however, that facilitative supervision is only part of a process leading to the achievement of improved quality of services—it is not a stand-alone intervention.

Site staff and service providers are experts on how services are provided; placing problem-solving tools in the hands of staff enables them to improve and maintain the quality of the services they provide; encouraging managers and supervisors to support this and to develop facilitative styles of management are essential steps in overall quality improvement.

In industry, managers are acutely aware of the costs of poor quality (for example, spending time to appraise what went wrong initially, then devoting the resources necessary to repeat work that is faulty). In every field of endeavor, poor quality results not only in time wasted to redo work, but ultimately in the loss of valuable customers. Those who provide family planning services are becoming more aware of the cost of poor quality in similar terms: when they are not treated with respect, when they receive poor-quality services, or when they do not receive the service they want, clients "vote with their feet" and do not return to a facility.

Providing high-quality services means meeting the needs of clients with a minimum of effort, waste, and rework. Problems can be anticipated and prevented by

"I thought supervision involved only checking on staff and supplies. Now I realize I also need to train, advise, and work with the staff."

— Clinical Services
Supervisor
Swaziland

"I wish I had known about COPE earlier. Since I learned to use COPE, my work as a supervisor is much easier."

— Nursing Supervisor,
Kenya

ensuring that staff members understand what quality is and feel responsible for providing quality services. In industrial settings, this is known as "moving quality assessment upstream."⁸

In the past two decades, theories have been advanced to challenge the traditional concept that assuring and improving quality is the result of external review, inspection of the end result, and a heavy investment in supervisors whose major function is to monitor staff.⁹ In these theories, the focus has shifted to anticipating and preventing problems rather than correcting them. Instead of finding fault and leveling blame at individuals, the emphasis now is on determining whether or not existing work processes are planned, designed, and implemented in such a way as to achieve the desired end result—a high-quality service that meets clients' needs. In this spirit, the facilitative approach suggests that improving quality should be a facet of every action or process that ultimately leads to delivery of a service. (See Figure 3.)

A facilitative supervisor constantly asks himself or herself the following questions: Are the services provided meeting the needs of clients? Are staff continuously assessing the quality of their work and the processes by which they do their work?

Facilitative supervision seeks to foster this kind of quality-improvement philosophy within an organization. As institutions begin to assess, define, and evaluate the kind of quality service they wish to provide,

supervisors can facilitate the process by interpreting institutional goals towards improving quality for site staff. At the same time, they can facilitate the process of quality improvement at the site level by helping site staff prioritize activities and gain access to resources and by providing appropriate technical assistance and support.

A critical role in problem solving

With COPE, AVSC embarked on a program of technical assistance to introduce specific quality-improvement ideas at the institutional and clinic level. In the numerous countries where COPE has been introduced, we have found that clinic staff usually identify problems that fall into two broad categories:

- Those that are within the power of site management and staff to solve
- Those with solutions that require the intervention of a higher level of management—the regional or headquarters level

In both cases, supervisors play critical roles in supporting the implementation of action plans developed locally to improve the quality of services.

For problems that can be addressed by local staff, the supervisor facilitates local problem solving by being supportive of staff action and by being available for discussion with staff if obstacles arise. Supervisors may also play important roles in helping to prioritize the actions that staff have identified so that items that may be critical in terms of health care safety (such as infection prevention or technical competency) are addressed immediately, before staff begin to tackle less urgent problems (such as the availability of informational materials or the lack of signs to direct clients to services).

There are a number of ways supervisors facilitate problem solving at the site level. For instance, if staff identify a variety of training needs, the supervisor may be able to conduct training or to identify someone else capable of conducting that training. Additionally, the supervisor may be able to identify the resources needed for training to take place at the site, thus increasing the impact of training at that facility.

When dealing with solutions for which staff need additional assistance, the

Figure 3 Conventional versus Facilitative Approach to Management

MANAGING QUALITY SERVICES

Conventional approach

- External review
- Inspection of end result
- Heavy investment in monitoring

Facilitative approach

- Involves all staff at all stages
- Gives staff tools for on-going assessment
- Is an ongoing, continuous process

supervisor's role is critical for staff to be able to accomplish their goals. In these instances, the supervisor facilitates either staff's access to resources or the articulation of a problem to higher-level management. For problems that cannot be addressed at the site level, the supervisor is the conduit to higher levels of management. By bringing such opportunities for improvement to the attention of higher authorities, the supervisor can be a catalyst for institution-wide improvements.

Key Concepts of Facilitative Supervision

The four key concepts that contribute to AVSC's definition of facilitative supervision are described below.

1. The supervisor is a catalyst for quality improvement.

More power should be placed in the hands of supervisors to make changes and improve services. Supervisors become the catalysts for change by creating an environment of teamwork in which change and improvements in the quality of services can flourish.

2. Joint problem solving, with full staff participation and using simple, practical tools, will foster the quality-improvement process.

Supervisors must know standard problem-solving steps: defining a problem, analyzing possible causes, identifying possible solutions, developing an action plan to implement solutions, and evaluating the results. Related to this philosophy is the notion that the site should be the focus of quality-improvement efforts. For example, if training is required, rather than sending some individuals to a central training location, training should, whenever possible, take place at the site and include as many individuals as possible. Similarly, the supervisor and site staff should join forces to identify the resources needed to improve the quality of services provided.

3. Facilitative styles of communication and support are essential.

A facilitative style of supervision emphasizes mentoring and coaching of individuals and groups. Good communication skills that facilitate dialogue with site staff are essential.

Supervisors must know how to facilitate discussions during group meetings, must acquire skills of giving and receiving feedback in an appropriate manner, and must learn how to listen effectively in order to improve communication. An understanding of adult learning processes is also key to communicating with site staff.¹⁰ Supervisors must learn when and how to use different styles of decision-making (that is, command, consultation, consensus, or delegation).

4. Supervisors must have solid technical knowledge for the duties they are to perform and must know how and where to gain access to additional support.

Supervisors must know the broad array of services that are available at a site, as well as what the national standards and guidelines call for in terms of the quality of those services. While they may not be technically proficient enough to evaluate all aspects of service delivery, supervisors must know how and where to gain access to additional support when needed.

Additional Factors

In addition to these four key concepts, a number of factors contribute to good supervisory skills, including:¹¹

- The ability to delegate and complete work through others
- The desire to achieve at high levels
- High expectations of achievement from others
- Confidence in one's own ability and the ability of staff
- The ability to instill a sense of value about the organization's goals in others

Identifying techniques for assessing the extent to which a specific supervisor meets the above criteria for excellence is a topic requiring attention in the future, as AVSC strives to provide technical assistance in the area of supervision.

The Supervisor's Role

As part of the ongoing process of developing supervisory systems, AVSC routinely holds brainstorming sessions with both ex-

"The facilitative approach helps staff adapt to changes because the staff are all participating in the change."

— Project Coordinator
New, J

“The COPE approach demystifies quality.”

— Provincial Nursing Officer, Zimbabwe

ternal and internal supervisors. When asked to identify their main responsibilities, participants cite a plethora of activities that fall into a few general categories: planning, training, monitoring, coordinating, visiting sites, motivating staff, problem solving, providing services, managing complications, collaborating with other organizations, evaluating services, and managing data needed for reporting.

Based on experience in clinical settings and on feedback from service providers, AVSC has performed a task analysis to illustrate the “facilitative” approach to supervision and to clarify how various aspects of supervisors’ duties fit into the framework. (See Figure 4.) In this model, the basic role of the supervisor is to address the needs of family planning providers to enable them to manage the quality-improvement process. Providers are at the center of the three principal functions of supervisors in the AVSC model. To be successful, supervisors must work effectively with those they supervise. The COPE process often points out the link between meeting providers’ needs and ensuring clients’ rights to quality services. These rights and needs serve as assessment tools and indicators. (See Figure 5.)

Function: Address providers’ needs for good management and supervision

Activity: Help site staff understand and implement the quality-management process

Staff may need orientation to better understand the quality of their own services and may need guidance as they embark upon the quality-improvement process. The supervisor provides leadership and support for this process and for developing the team approach to quality management on site that will lead to increased quality and client satisfaction. If COPE has not already been done at the site, the supervisor introduces the COPE assessment tool (or arranges for a facilitator to do so) and supports site staff in resolving problems identified and evaluating quality at the site. Sites in which COPE has been previously introduced may benefit from conducting a COPE update. By arranging for the training of COPE facilitators on-site, the quality-improvement process can continue, with COPE updates carried out from time to time.

Specific tasks include:

- Orient site management and staff to the principles of quality and the quality-improvement process
- Prepare for and conduct the COPE introduction meeting
- Train COPE facilitators and assist in follow-up of the COPE action plan

Activity: Help site staff plan objectives and evaluation

The supervisor may need to orient staff and management at sites to overall program goals of the country and agency and help to develop site-specific objectives and work plans. Sites may need help with record-keeping and guidance to understand how to evaluate their progress by analyzing statistical report data. The supervisor acts as liaison between headquarters and sites to promote common awareness of needs and resource utilization.

Specific tasks include:

- Orient site staff to national and agency objectives and workplans
- Train staff to define, develop, and use objectives and workplans
- Train staff to use service statistics (including how to prepare graphs that are easy to read and interpret)
- Define, prepare, conduct, and report on supervision activities

Function: Address providers’ needs for good supplies and site infrastructure

Activity: Help site staff ensure availability of equipment and supplies

Staff may need training to correctly assess their needs for equipment or expendable supplies, as well as to establish systems for maintaining inventory records to ensure adequate stock levels. When stock-outs occur, the consequences can be devastating for clients and family planning programs alike: for the client, the result may be unintended pregnancy; for the program, confidence lost in the continuity of service provision may be impossible to restore.

Specific tasks include:

- Train staff to assess equipment and supply needs, apply reporting and ordering procedures, and keep an up-to-date inventory
- Ensure constant and reliable contraceptive supplies at all levels

Activity: Help site staff improve the physical aspects of their sites

A supervisor may bring good ideas about how to improve the physical layout of services based on observation or experience elsewhere. For example, some of the bottlenecks identified during the client-flow analysis section of a COPE exercise may be alleviated by making minor changes in how staff use their time or how clients move through the clinic. Sometimes it is necessary to identify and prepare areas that allow for privacy during family planning counseling and to designate areas in the wards where information about contraception can be given.

Specific tasks include:

- Organize internal environment to ensure privacy, comfort, and confidentiality
- Identify ways to improve the physical aspects of the site

Function: Address providers' needs for information, training, and development

Activity: Help site staff know and apply service standards, norms, and policy

Staff need to be made aware of national and agency clinical standards and policies. Service providers feel vulnerable when they lack clear directives and guidelines from in-country officials or when directives are outdated or contradictory. Service provision is adversely affected, and may even be withheld, if official authorization or clarification is not received.

For example, policies on spousal consent are the subject of confusion in many countries. Some individual providers insist upon having the signed consent of a husband before providing a permanent family planning method for a woman, even though the policies of the country do not require it. Access to services may be denied as a result.

Supervisors can provide links with other implementing agencies in their assigned geographical areas. By so doing, service providers can share information and mutual reassurance regarding program implementation, especially in the absence of official endorsement.

Specific tasks include:

- Identify national and agency service standards, norms, and policy documents

- Clarify concepts contained in these documents
- Provide these documents to site staff and orient staff to their use
- Update site staff on changes in standards and policies

Activity: Help site staff address clinical and nonclinical training needs

Staff may need guidance to determine needs for training and may need support from supervisors to understand the benefits to be gained from localized training. Supervisors help site staff plan and implement whole-site training (an integrated approach to training that views a service-delivery site as a system and treats staff as members of the team that makes the system work). This training usually consists of orientations and updates and makes the most of local resources. If external expertise is needed, the supervisor's role is to help staff gain access to that expertise.

For skill training, supervisors may also help to organize on-the-job training. Training may sometimes be conducted at a centralized training facility, but this should be restricted to cases in which, for example, the skill to be acquired is completely new to the institution or to the site. The task of supervisors in assessing the competency of trainees and monitoring their use of newly-acquired skills is extremely important. Supervisors must either be able to certify clinical trainees as competent, or have access to medical staff who can do so. Supervisors also serve as catalysts for ensuring that the medical quality of services is monitored on a routine basis and provide support or access to resources for medical monitoring, as needed.

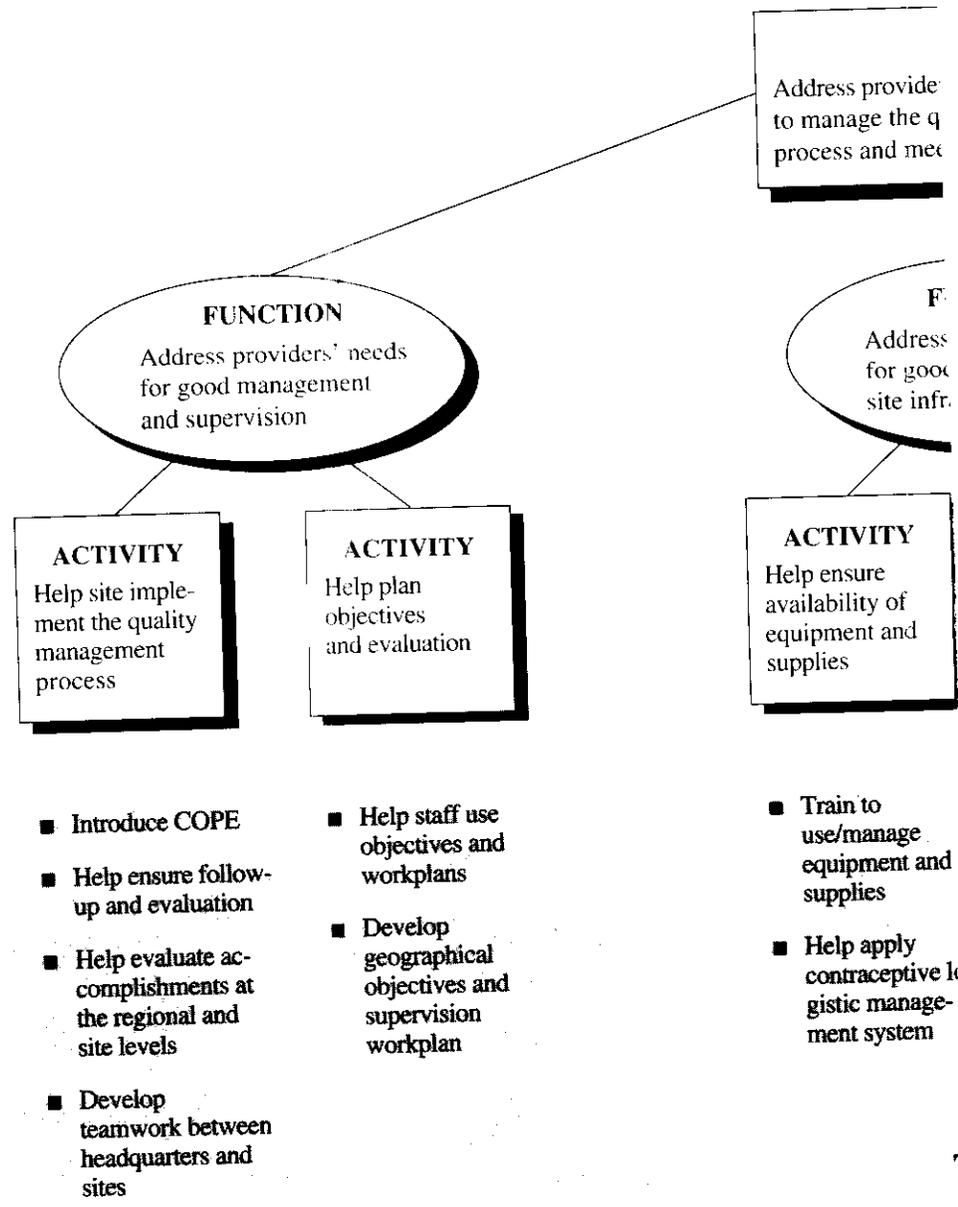
Specific tasks include:

- Define training needs and formulate training objectives and plans
- Identify the needs to be addressed by centralized training, regional training, and on-the-job training
- Plan centralized training and on-the-job training activities
- Prioritize on-the-job and centralized training activities

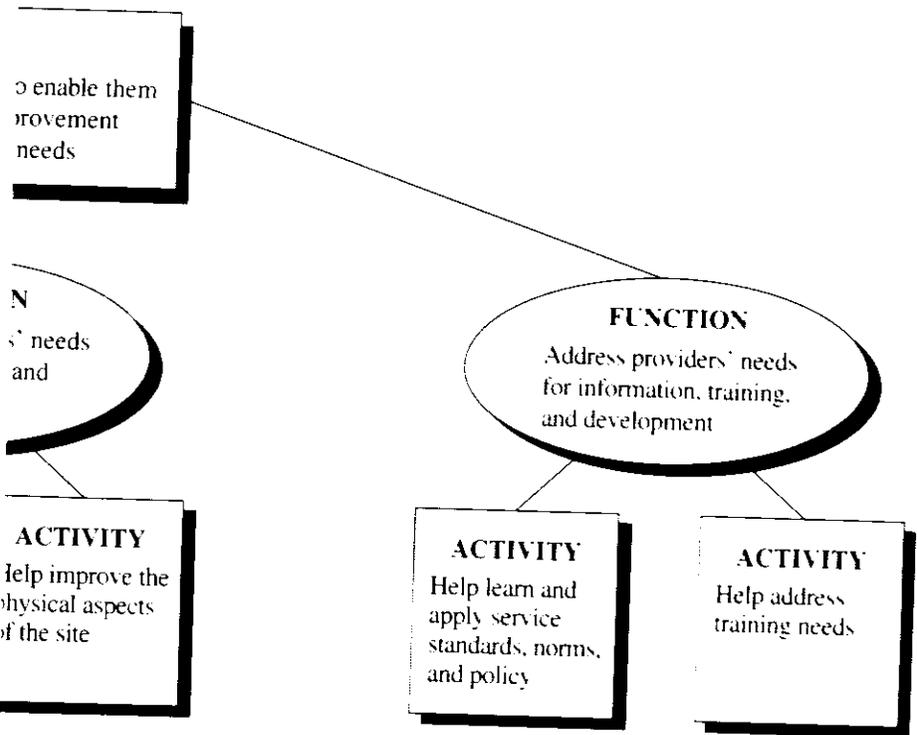
"Working with the staff on site gave me a good forum to identify gaps in training and supervision. It gives a framework for continual supervision, which seems more cost effective."

*- Nurse-Midwife
Supervisor
Kenya*

Facilitative Supervision



The Supervisor's Role



- Help apply standards for services infrastructure
- Help ensure site's physical and functional integration

- Inform site about clinical standards and policies
- Train to apply standards and policy
- Help monitor implementation of clinical standards and quality assurance

- Help assess site's training needs
- Help plan and implement training activities
- Help implement on-the-job training
- Manage human resources

Figure 5 Rights of the Client, Needs of the Provider

QUALITY SERVICES

Clients Have the Right To:

- Information
- Access
- Choice
- Safety
- Privacy and confidentiality
- Dignity, opinion, and comfort
- Continuity

Providers Have a Need For:

- Good supplies and site infrastructure
- Good management and supervision
- Information, training, and development

SOURCE: This figure is adapted from the wall chart "The Rights of the Client," produced by the International Planned Parenthood Federation, and from Huezco C. and Diaz, S., 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9:129-139.

MAKING THE TRANSITION TO FACILITATIVE SUPERVISION IN FAMILY PLANNING PROGRAMS

The process used to introduce facilitative supervision into a service-delivery system depends on the level of development of the family planning program, as well as the extent to which quality-improvement processes have already been instituted. In general, however, before introducing the concept of facilitative supervision, decision-makers within an institution must recognize supervision as a vital area that deserves investment of time and material resources. Creating an environment in which supervision can flourish is a prerequisite to making the transition to more facilitative styles of management.

So that they will understand that supervision is a key element in the process, policy makers and managers must be aware of the benefits that accrue to an organization that continuously seeks to improve quality. In addition to considering the costs of poor quality (notably that clients flee from poor-quality services), policy makers and man-

agers should understand the high cost of poor supervision. Resources are often used to support a nonfunctional system, just because "it has always been done that way."

Policy makers and managers should also consider the increased cost-effectiveness likely to occur when:

- Local staff try to resolve problems with existing resources
- All staff at a site are aware of the services that are available to clients and can effectively increase clients' awareness of those services
- Costly centralized training for a few individuals is replaced by relevant training (including orientations, updates, and skills training that will support and sustain services) for all site staff
- Medical quality is continuously monitored by site staff themselves (with support from the institution on a periodic basis)

An effective supervisory system can help bring about the benefits listed above, as well as help interpret institutional goals, standards, and guidelines for site staff.

Policy makers and managers need to be convinced of the value of facilitative supervision. Once the need for effective supervision is acknowledged and its benefits anticipated, adequate support must be provided to enable this former "missing link" to become the foundation for achieving programmatic and strategic objectives.

Introducing Facilitative Supervision in Three Stages

The following is a description of the three-stage process AVSC has used to introduce facilitative supervision in Africa. This approach should be adapted or modified as appropriate for different settings.

The three-stage introduction of facilitative supervision as used in Africa takes approximately two years, although the time may vary within each institution.¹² Each stage in the process begins with a workshop that is followed by on-the-job training in order to model and practice supervision techniques and to provide "coaching" to the team of supervisors. (See Figure 6.)

Initially, the supervision workshops are facilitated by the institution's supervisors

with support from AVSC staff. As soon as possible, the process is taken over by the institution itself.

Stage I

In Stage I, a workshop is organized to focus on:

- Assessing institutional and service site interest in quality improvement
- Introducing the concept of quality management and helping staff think about quality in relation to their jobs
- Discussing the roles and needs of facilitative supervisors
- Developing communication skills
- Understanding links between supervision and training (including an introduction to adult learning theory)
- Introducing COPE and inreach

In the initial orientation workshop, emphasis is placed on changing the supervisor's attitude from "policing" sites to facilitating the quality-improvement process. Although not listed as a topic on the program, the

workshop process allows participants to identify the strengths and constraints of their current supervisory system.

Simple tools and approaches to assist in local problem solving (such as COPE and inreach) are introduced. Workshop participants consider the use of site-level family planning committees for discussion of activities and results and also discuss the ways adult learning theory might be applied in supervision. Discussion focuses on the supervisor's role in the context of local problem solving and quality improvement and on the materials and support the supervisor will need in order to carry out this role. Participants discuss the linkage between supervision and training and the technical skills required by supervisors.

Requirements will vary from region to region and from supervisor to supervisor, depending on the supervisor's background and on the current needs of the institution. These might include technical skills in infection prevention, technical competence in the provision of specific family planning methods or procedures, or the skills needed to provide a general family planning orien-

"Supervision has become easier as we have understood it better. The facilitative supervision approach also makes us more useful and accepted by our staff."

- Child Supervisor
Kenya

Figure 6 Three-Stage Introduction of Facilitative Supervision

STAGE I

Focus: Orientation

- Introducing the concept of facilitating continuous quality improvement
- Becoming aware of the importance of having communications skills
- Understanding linkage between supervision and training
- Discussing the roles and needs of supervisors
- Introducing the AVSC quality-improvement tools (such as COPE and inreach)

STAGE II

Focus: Assessing the Quality-Improvement Process

- Setting objectives using tools introduced in Stage I
- Developing and prioritizing training plans
- Understanding the mentoring process

STAGE III

Focus: Developing Complex Supervisory Skills

- Designing long-term training plans for the site
- Using measurable indicators for evaluation
- Introducing key concepts of training-of-trainers design

**“As a supervisor,
I now feel happy
when I see
staff at all levels
so interested
in gaining new
knowledge. I also
see them using
the knowledge
among themselves
and with clients.”**

—Workshop Participant,
Tanzania

tation, to give a contraceptive technology update, to read and use site and other data to improve the quality of services, or to give an update on counseling skills. During the workshop, participants review the materials and guidelines available to assist the supervisor in performing these roles. (See Figure 1.)

After the workshop, supervisors can begin to put these principles into practice in performing their routine work with support from their institutions (and from AVSC, if required). They can immediately begin to put into practice the communication skills they have acquired. If possible, they should observe COPE exercises conducted by a trained facilitator—or better still, facilitate COPE themselves with support from someone who has experience in conducting COPE. Participating in COPE gives supervisors an opportunity to learn more about the process and to begin thinking about how they might support their site in implementing an action plan for solving problems identified through COPE. Planning for training activities can also be practiced because the identification of training needs is always an important outcome of COPE exercises.

Stage II

Workshop topics in Stage II include:

- Managing the quality-improvement process
- Setting objectives using the tools previously introduced
- Organizing whole-site training (skills training, orientation, and updates for all staff at the site)
- Performing on-the-job training and mentoring
- Coordinating between sites and headquarters
- Collaborating with other agencies

During the second workshop, lessons learned in Stage I are reinforced. Supervisors begin to address the ways to help site staff set their own objectives by facilitating a COPE exercise and by assisting staff in prioritizing the actions they have identified for themselves. Participants begin to focus in more depth on the training needs identi-

fied by COPE participants—how to prioritize them, how to develop training plans, and how to garner the necessary resources to achieve the desired result. Supervisors have role-play sessions in which they can test their knowledge of adult learning theory in the process of mentoring. Through a mixture of support, coaching, mentoring, and training, site supervisors are oriented to consider the needs of individual staff and to determine how to prioritize those needs.

When they return to their posts, supervisors again incorporate what they have learned into their routine work, with support from their institutions. They may conduct follow-up COPE exercises, sharpen their training and mentoring skills, or develop coordinated training plans.

Stage III

The workshop in Stage III introduces more complex supervisory skills, building on the lessons learned in the two previous stages, including:

- Training of trainers
- Utilizing statistics and reports as a means of evaluating the quality of services
- Using additional evaluation tools
- Networking

Topics covered in the workshop include the design of long-term training plans, ways to use records and statistics to improve quality, and methods of designing and evaluating programs using measurable indicators. To help participants increase their skill in training design, the workshop trainers introduce key concepts of training that might be used to conduct a training-of-trainers workshop and discuss the use of on-the-job training guides for obtaining standardized outcomes. This enables supervisors to provide training during supervisory visits and to design site training programs.

Workshop trainers explain that client reports and statistics can be more than items that must be prepared in order to meet the needs of the bureaucracy. Participants are encouraged to discuss the content of reports with site staff, so that staff will view them as indicators of client satisfaction and of strengths and weaknesses in service delivery. For example, if the number of new clients

coming to a service has dropped recently, supervisors are encouraged to discuss this with staff to determine the possible causes of the drop and the corrective actions they can take. If the number of new clients has suddenly increased, this again is cause for discussion, because the reasons for the increase may be something that should be shared more widely in the institution.

AVSC is currently testing an evaluation tool to help supervisors measure progress in improving quality more objectively than can be done using COPE action plans.¹³ This tool, jointly designed by AVSC, the Tanzanian Ministry of Health, and UMATI (Uzazi Na Malezi Bora Tanzania, the Family Planning Association of Tanzania), is organized around the same principles as COPE: clients' rights and providers' needs. It is intended to complement the COPE process and aid in local problem solving, while still allowing the supervisor to measure progress over time, to aggregate information for more than one site, and to be able to provide information to the institution on the outcomes of their efforts to continuously improve the quality of services.

EXAMPLES OF FACILITATIVE SUPERVISION IN ACTION

Tanzania

In Tanzania, the family planning program has expanded rapidly during the past five years. Although services are now available in more than 3,000 service-delivery points throughout the country, many of these are small dispensaries and health centers that can only provide a limited number of family planning methods.

Until recently, permanent and long-acting methods were available in only the two largest urban areas. At present, in-country institutions, with support from AVSC International and other donors, are expanding the number of sites that offer all available modern contraceptive methods (to a total of more than 100 by the year 2000). Key to this program expansion are six zonal doctor-nurse teams whose role is to facilitate the integration of permanent and long-acting methods into existing family planning service-delivery points.

Working with supervisors from the Tanzanian Ministry of Health (MOH), the

zonal teams ensure that service quality is strengthened. The MOH supervisors are trained to assist sites in identifying what they need to provide quality family planning services (be it management support, training, or equipment) and in meeting those needs internally or with external assistance. Supervisors form teams with site staff to try to eliminate problems before they occur.

Serving as middle managers and trainers, these teams help transform the MOH goals of expanding the number of service sites that provide permanent and long-acting methods into reality. They facilitate communication between the sites and their zonal or central headquarters and between public sector and private sector service providers. They improve linkages between the various sites in their area as well as between each site and its respective headquarters. They work to introduce and implement protocols for clinical methods and assist in resource management, helping to leverage additional resources for family planning services. They improve the supervision of sites, and promote the concept of whole-site training.¹⁴

Bangladesh

In Bangladesh, the family planning program has been in place and an array of permanent and long-acting methods have been available for a much longer period of time than in Tanzania.

The number, type, and scope of service-delivery points are also much greater. In collaboration with the Directorate of Family Planning and with support from the U.S. Agency for International Development, AVSC is conducting a client-centered, clinic-based family planning services program in six sub-districts (*thanas*) in Bangladesh. This program includes a focus on improving local-level planning and supervision systems.

The supervisory system in Bangladesh is well-established, and there are different levels of supervision: from the central to the district level, from the district to the thana level, and from the thana level to local health centers. AVSC works to improve local planning in this system by establishing or strengthening coordinating commit-

"COPE led to changes in the attitudes of staff. We now have more teamwork—staff began to participate in all activities as needed without saying, 'This is not my job.'"

— Regional Medical Officer
Tanzania

"I now feel that I am participating in implementing quality of care at the National Hospital, and am not a spectator."

— Workshop Participant,
Kenya

tees and by introducing COPE. The facilitative supervision process described in this paper is being adapted to meet the needs of the Bangladesh program. In addition, the project emphasizes whole-site training and improving the referral systems between the different levels of services.

The Directorate of Family Planning also manages Family Planning Clinical Supervision Teams (FPCSTs). The role of these mobile teams is to work to assess the medical quality of family planning and maternal and child health services in specific geographic areas. These teams are responsible for the supervision of clinical family planning services in all governmental facilities, as well as those administered by NGOs.

In 1993, the Directorate requested AVSC's assistance to help increase the FPCSTs' effectiveness in medical supervision and on-site guidance to service providers. AVSC works with the FPCSTs to develop their supervisory training and skills for medical site visits, contraceptive technology updates, and workshops; to develop a responsive system for tracking medical complications; to orient teams on infection prevention procedures; and to help teams introduce COPE. AVSC also works with the Directorate to monitor and evaluate this introduction process.

EVALUATION

AVSC believes that the evaluation of this approach to supervision should follow the same principle as the approach itself—it should be conducted by the supervisors and site staff themselves, with assistance from outsiders such as AVSC, as necessary.

Program Evaluation Tools

AVSC has developed a set of program evaluation tools that can be used annually by the supervisors and family planning teams at each site.¹⁵ The tools, which have been developed and tested in Tanzania, are meant to be adapted for use in other countries as well.

The tools differ from traditional supervisors' checklists in three ways.

First, the tools relate to COPE and therefore should be introduced to the sites as such and should be used in a similar way.

Site staff are encouraged to evaluate their services with the supervisor in a nonthreatening, awareness-raising fashion. Although some objectivity may be lost, the data collected will be principally the property of the site staff, rather than of the headquarters. As such, the results stand a better chance of being used by the sites and their supervisors as impetus for discussion and as measurements of progress.

Second, the tools are designed for site staff and supervisors to be able to look at the progress of an individual site over time and to evaluate the program as a whole rather than to compare the progress of different sites.

Finally, the indicators of quality in the tools are closely linked to the COPE assessment guides and are organized in a similar way. As in COPE, the indicators correspond to the rights of the client and the needs of providers. (See Figure 5.) The program evaluation tool consists of ten checklists, as follows:

Clients' right to

- Information
- Access
- Choice
- Safety
- Privacy and confidentiality
- Dignity, opinion, and comfort
- Continuity

Providers' need for

- Good supplies and site infrastructure
- Good management and supervision
- Information, training, and development

Each checklist requires the supervisor to observe and talk with staff about specific topics. For example, under clients' right to access, supervisors are asked to raise questions with staff, such as: Is the clinic open at least five days per week? Are MCH/FP services housed in the same building? What methods are available? Are there signs that indicate the location of the family planning clinic? Can single women or adolescents receive services? Can men pick up condoms without going into the MCH, family planning, or outpatient departments? Can pill clients routinely obtain more than six packs of pills?

Are pregnancy tests available? Once the evaluation is completed, the checklists are scored, using a simple scoring system.

AVSC is now considering ways to weight the responses to each item so that items of priority (such as indicators of good infection prevention procedures or technical competency) are distinguished from other important, but less critical items (such as signs for clients indicating where to go for services). Supervisors are encouraged to discuss the scores with staff and to reassure staff that the scores are meant to help the site measure its own progress, not to compare the site's score with the scores of other sites.

Because these tools are a standardized instrument, supervisors are able to aggregate results from several sites to determine which problems appear to be system-wide (thus needing institutional attention), and which problems appear to be location specific. The results can be useful to headquarters staff in determining where to focus institutional energies in improving quality of services. They can also be used to provide information to technical assistance agencies and donors on progress made in improving quality.

Challenges in Evaluating Quality-Improvement Approaches

How one evaluates the contribution of "quality" to the success of a reproductive health program remains an area of debate and discussion. Adding to the complexity is the desire to evaluate the cost-effectiveness of quality improvement approaches at the same time that programs are being asked to do more—to reorient family planning programs to incorporate screening and treatment for reproductive tract infections, to increase integration of services, to focus on postabortion care, to serve men and adolescents—while funding for reproductive health services seems ever more tenuous. Within this context, the seemingly greater cost of this more intensive approach is worrisome to many, yet our belief (shared by many others) is that the additional costs can be offset by reducing the costs of poor quality.

Another challenge is that we are hypothesizing that if providers' rights and needs are

satisfied, if providers are trained and oriented toward high-quality service provision, and if functional supervisory systems are in place that assist in local problem-solving, then clients' knowledge and satisfaction will be enhanced and their reproductive health rights and needs will be met. The challenge of evaluation is ultimately to demonstrate the validity of this hypothesis.

Evaluation strategies must be flexible. It is important to pay attention to lessons learned and adaptations needed when new approaches are under development. Identifying objectives and indicators up front may be difficult because outcomes may not have been anticipated.

Evaluation strategies will likely utilize qualitative as well as quantitative methods to document the process of the development and introduction of new strategies, as well as to document both predicted and unanticipated problems or outcomes. Intervening variables that may occur after a project has started (such as changes in fees charged or the introduction of a social marketing activity, as was experienced in one project) may make it difficult to separate out the impact of quality-improvement approaches.

CONCLUSIONS

Introducing facilitative supervision requires change, and change can be difficult to manage.

Many institutions and organizations around the world—particularly in the field of health care where medical hierarchies dictate a conventional supervisory approach—may find this change daunting. Some may believe that what has become the conventional approach to supervision—inspection or policing employees—has been around a long time and does not need alteration. Others who have worked long and hard to reach supervisory status may aspire to become "inspectors" in the same mold as their predecessors. Still others may believe that changing to the kind of supervisory approach suggested here will take more time, resources, thought, and attention than is possible, given the level of resources available.

We at AVSC hope that this paper suggests that there is much to be gained, both

"The program was very far away, but now we have it in our hands."

— Regional Supervisor
Uganda

“Facilitative supervision and COPE let staff take more responsibility. This makes our workload lighter as all staff help with what was formerly seen as only the job of the supervisor.”

— Regional Supervisor,
Kenya

individually and institutionally, from a transition to more facilitative styles of supervision. We believe that efforts expended in this labor-intensive approach will reap significant rewards in terms of improved services, especially when contrasted with the cost and consequences of poor quality.

We hope that the following expected outcomes will help managers determine that changing to a more facilitative approach is worthwhile:

- Service delivery sites that provide access to quality services that clients want or need
- Service providers and institutions that continuously seek ways to improve the quality of their services
- Service providers and institutions that are responsive to client needs
- Service providers and supervisors who are continuously improving their own performance, who have opportunities for increased job satisfaction, and who see their work as part of a larger picture
- Supervisors who provide encouragement and support to providers in continuously improving the quality of services
- Supervisors who are able to help sites translate institutional goals into services that clients want and need
- Supervisors who are able to provide management with information about the quality of services being provided, to identify constraints to improving that quality, and to assist in future planning
- A reduction in the costs of poor quality

Some institutions may have already made progress toward incorporating some facilitative supervision ideas into the system in which they work. If changes throughout the system are required, these can be undertaken gradually. Effecting change in systems requires time, but the process is already well underway in a number of countries in which AVSC works (notably in Bangladesh, Kenya, Tanzania, Zimbabwe, and Uganda).

Over the past 50 years, great strides have been made toward increasing clients' access to reproductive health services. These last few years of the twentieth

century present an opportunity to consolidate the gains made in access by improving the quality of those services.

Site staff and service providers are the experts on how services are currently provided: building on this expertise with problem-solving tools that staff can use is the keystone to improving the quality of those services. Facilitative supervision is one approach which may contribute to improved and sustainable quality services.

Beverly Ben Salem is assistant regional director for AVSC International programs in east and southern Africa. Karen J. Beattie is associate director of AVSC's Evaluation and Research Department.

Notes

1. Dwyer, J., and Jezowski, T., 1995, Quality management for family planning services: Practical experience from Africa, *AVSC Working Paper No. 7*, New York: AVSC International.
2. AVSC International, 1995, *COPE: Client-oriented, provider-efficient services*, New York; Lynam, P., Rabinovitz, L. M., and Shobowale, M., 1993, Using self-assessment to improve the quality of family planning clinic services, *Studies in Family Planning* 24(4):252-260.
3. Lynam, P., et al., 1994, Inreach: Reaching potential family planning clients within health institutions, *AVSC Working Paper No. 5*, New York: AVSC International.
4. Definition of whole-site training: "An integrated approach to training that views a service-delivery site as a system and treats staff as members of the team that makes the system work."
5. Papke, T., 1996, *Cost-analysis methodology for clinic-based family planning methods*, New York: AVSC International.
6. Lyles, R. I., and Joiner, C., 1986, *Supervision in health care organizations*, New York: John Wiley & Sons, p. 5.
7. Berwick, D., and Plsek, P., 1992, *Managing medical quality*, Program two: The principles of total quality management. [Video], Woodbridge, NJ: Quality Visions.

8. Ibid.
9. Berwick, D., Godfrey, A. B., and Roessner, J., 1990, *Curing health care: New strategies for quality improvement*, San Francisco: Jossey-Bass Publishers.
10. Knowles, M.S., 1980, *The modern practice of adult education* (revised edition), New York: Cambridge Book Company; Knowles, M.S., 1984, *The adult learner: A neglected species* (revised edition), Houston: Gulf Publishing Company; and Brookfield, S. D., 1988, *Understanding and facilitating adult learning*, San Francisco: Jossey-Bass Publishers.
11. Lyles, op. cit., pp. 9, 10.
12. AVSC's experience thus far has focused on working with external or "zonal" supervisors responsible for supervision within a geographic area. Adaptations to these stages would be needed for site-level supervisors, but the same basic principles would apply.
13. Bradley, J., 1995, Program evaluation tools (draft documents), Kenya: AVSC International.
14. Bradley, J., unpublished presentation to AVSC Social Science Committee, April 25, 1995, New York: AVSC International.
15. Bradley, J., 1995, Program evaluation tools (draft documents), Kenya: AVSC International.

Bibliography

- AVSC International. 1995. *COPE: Client-oriented provider-efficient services*. New York.
- Berwick, D., Godfrey, A. B., and Roessner, J. 1990. *Curing health care: New strategies for quality improvement*. San Francisco: Jossey-Bass Publishers.
- Berwick, D., and Plsek, P. 1992. *Managing medical quality*, Program two: The principles of total quality management [Video]. Woodbridge, NJ: Quality Visions.
- Bradley, J. 1995. Program evaluation tools (draft documents). Kenya: AVSC International.
- Bradley, J. Unpublished presentation to AVSC Social Science Committee, April 25, 1995. New York: AVSC International.
- Brookfield, S. D. 1988. *Understanding and facilitating adult learning*. San Francisco: Jossey-Bass Publishers.
- Dwyer, J., and Jezowski, T. 1995. Quality management for family planning services: Practical experience from Africa. AVSC Working Paper No. 7. New York: AVSC International.
- Dwyer, J., et al. 1991. COPE: A self-assessment technique for improving family planning services. AVSC Working Paper No. 1. New York: Association for Voluntary Surgical Contraception (AVSC International).
- Eiseman, E., and Ben Salem, B. A new approach: Site training. AVSC News, vol. 33, no. 2 (Summer 1995).
- Huezo, C., and Diaz, S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9:129-139.
- International Planned Parenthood Federation. "The Rights of the Client" (poster).
- Knowles, M.S. 1980. *The modern practice of adult education* (revised edition). New York: Cambridge Book Company.
- Knowles, M.S. 1984. *The adult learner: A neglected species* (revised edition). Houston: Gulf Publishing Company.
- Lyles, R.I., and Joiner, C. 1986. *Supervision in health care organizations*. New York: John Wiley & Sons.
- Lynam, P., et al. 1994. Inreach: Reaching potential family planning clients within health institutions. AVSC Working Paper No. 5. New York: AVSC International.
- Lynam, P., Rabinovitz, L. M., and Shobowale, M. 1993. Using self-assessment to improve the quality of family planning clinic services. *Studies in Family Planning* 24(4): 252-260.
- Papke, T. 1996. *Cost-analysis methodology for clinic-based family planning methods*. New York: AVSC International.