Managerial supervision to improve primary health care in low- and middle-income countries

01 March 2012

The quality of the evidence in this review ranged from poor to very poor. Based on available data it was unclear whether supervision has any substantive, positive effect on the quality of primary health care in low- and middle-income countries. The long-term effectiveness of supervision remains unknown.

RHL commentary by Criel B and De Brouwere V

1. INTRODUCTION

A WHO publication defines supervision (as a managerial activity) as the 'overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work' (1). In health-care practice, supervision is linked to the delegation of tasks to auxiliary health-care staff. In low- and middle-income countries, where adequate numbers of qualified health-care personnel are often lacking, especially at peripheral levels of the health-care delivery system, supervision is largely limited to overseeing the work of auxiliary staff and community health workers. In health systems in low- and middle-income countries, supervision is generally viewed as one of the central tools for providing continuous training to less qualified health-care workers entrusted with clinical and managerial tasks for which they may or may not have formal training. Hence, the term supportive supervision is often used in this context rather than control-oriented supervision. Many health-care programmes rely on supervision to increase the quality of care. Although highly recommended, supervision is rarely carried out as a planned activity owing to the 'lack of transportation means, fuel, financial resources, as well as inadequate training (of supervisors) in supervisory skills' (2). Supervision, however, has a cost and assessing its effectiveness therefore makes sense. This Cochrane review (3) aimed to review the effects of managerial supervision of health-care workers in order to improve the quality of primary health care (PHC) in low- and middle-income countries.

2. METHODS OF THE REVIEW

The reviewers' selection criteria included randomized controlled trials, controlled before-and-after studies, and interrupted time series studies conducted in PHC centres in low- and middle-income countries. Supervision was defined as site visits from a central levels of the health system to PHC sites. Studies that aimed solely at improving the clinical skills of PHC workers were excluded. The reviewers searched the Cochrane Central Register of Controlled Trials for suitable articles. In the review, the data are presented in a narrative way without pooling the effects on the outcomes as studies and outcomes were diverse.

3. RESULTS OF THE REVIEW

Of the nine studies that met the inclusion criteria, three had compared supervision with no supervision, five had compared enhanced supervision (involving any measure to strengthen routine supervision) with routine
supervision, and one study had compared less intensive supervision with routine supervision. In the included trials, most of the outcomes of interest were measured as scores relating to health-care providers’ practice skills and knowledge and the providers’ or health-care users’ satisfaction with the services delivered and received, respectively. The majority of the outcomes were measured within nine months after the intervention(s). In two studies comparing supervision with no supervision, small benefits with regard to provider practice and knowledge were found. Seven other studies – five on enhanced supervision and two on more frequent supervision visits – demonstrated small, non-significant benefits related to the health-care workers’ performance. In the study which had compared less intensive supervision with routine supervision, reduced frequency of visits had no impact on the use of services.

4. DISCUSSION

4.1 Applicability of the results

The review concludes that it is uncertain whether supervision has any substantive, positive effect on the quality of PHC in low- and middle-income countries. The long-term effectiveness of supervision is also unknown. On the whole, however, the quality of the evidence presented in the review ranged from poor to very poor, which seriously limits the confidence that can be placed in these findings. In addition, the precise difference between managerial and clinical supervision is unclear in the review. In practice, these two aspects of supervision are closely interwoven. In the experience of the authors of the present commentary, supervision is largely a non-standardized activity. Hence, individual characteristics of the supervisor, the setting and context in which supervision takes place, topics covered within supervision, the associated oversight tasks, and the frequency and duration of supervisory interactions, all greatly influence the way supervision is conducted and perceived.

It is said that there are as many types of supervision as there are supervisors. This may be an exaggeration, but it points to the difficulty of comparing a managerial processes such as supervision in diverse circumstances (differences in health systems, regional differences, urban vs. rural variations, and differences in supervision of professional health-care workers vs. supervision of community health workers as well as differences in the supervision of general health services vs. supervision of specialized single-purpose health-care programmes). In the majority of the trials in this review, the outcomes were measured within nine months of the intervention. In some of the studies the impact of supervision was measured after only one intervention. This is at odds with the understanding that supervision is generally embedded in a longer-term relationship between the supervisor and the supervisee(s) and therefore its impact should be measured over a much longer time period. Owing to the very low quality of evidence for all of the outcomes assessed in the nine included studies the applicability of the findings of this review are limited. On the other hand, the results of this review cannot be the basis for abandoning supervision altogether. Rather, the findings should serve to motivate programme managers at all levels to reflect on the quality of the supervision they provide. Two of the three authors of the Cochrane review acknowledge most of the shortcomings of this review in a recently published paper on PCH supervision in developing countries (4).

4.2 Implementation of the intervention

Some key principles can help to improve supervision and its outcomes. Supportive supervision should be planned and organized as part and parcel of a wider policy of continuous training of health-care staff. Supervisors should help the supervisees to find solutions to the problems they encounter in their work and the latter should be encouraged to report all problems to their supervisors. This implies building a relationship of mutual trust.
Systematic routine observation of supervisees can help the supervisor to become aware of any misunderstandings on the part of the supervisees. The ultimate aim of supervision should be to support the supervisees in the provision of high-quality care to their patients and not to find faults with the work of the supervisees. At the end of each visit, supervisors should devote sufficient time to discuss their observations with the supervisees (positive as well as negative). Task-specific guidelines should be used as reference material in all discussions involving observations about the skills and activities of the supervisees (5).

4.3. Implications for research

Supervision in the health-care setting is a complex managerial intervention with many cultural, social and behavioural dimensions. This raises the question whether such an intervention is amenable to investigation by randomized controlled trials. Researchers may need to devise more appropriate study designs if randomized controlled trials are still deemed relevant. In any case, emphasis should also be placed on qualitative research to assess the impact of supervision. More specifically, addressing the “how” question could complement the current systematic review. For example, which methods of supervision (e.g. the use of a checklist vs. reliance on observation of routine activities or even discussions without observation, as is more often the case at the peripheral level) are likely to prove more effective? The authors of this commentary believe that the issues raised above put this review at the heart of the current debate in the field of health systems research – i.e. the need to develop scientifically sound methodologies to measure and compare the impact of interventions in complex systems. Realistic evaluation methodologies (6) seem a promising track in that respect.

References


This document should be cited as: Criel B and De Brouwere V. Managerial supervision to improve primary health care in low- and middle-income countries : RHL commentary (last revised: 1 March 2012). The WHO Reproductive Health Library; Geneva: World Health Organization.

Source URL: https://extranet.who.int/rhl/topics/improving-clinical-practice/managerial-supervision-improve-primary-health-care-low-and-middle-income-countries
Published on RHL (https://extranet.who.int/rhl)

Home > Managerial supervision to improve primary health care in low- and middle-income countries