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# Supportive Supervision in Madagascar Feasibility and Acceptability for Reproductive, Maternal, and Newborn Health

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Supportive supervision (SS) is one strategy to promote quality of care. It can be defined as “a process of guiding, helping, training, and encouraging staff to improve their performance in order to provide high-quality health care services.”<sup>1</sup> From 2016 to 2018, Madagascar’s Ministry of Public Health (MOH) and the United States Agency for International Development’s Maternal and Child Survival Program (MCSP) piloted an SS intervention that added several innovative components to the MOH’s traditional supervision model. The goal of the SS intervention was to refine SS approaches to make them more frequent, available, effective, and practical—especially important in terms of ensuring continuous support for providers located in hard-to-reach facilities (*centres de santé de base II*, or CSB IIs). To evaluate the SS model, MCSP interviewed providers and supervisors who participated in the SS activity about the feasibility and acceptability of the SS approach and how effective SS was at helping providers maintain post-training skills. Participants also offered feedback on SS implementation and suggestions for future improvements to the approach.

## Background

Since 2010, there has been almost no change in the country’s maternal mortality ratio, which continues to linger around 478 maternal deaths per 100,000 live births annually. Sepsis, birth asphyxia/trauma, and prematurity remain the leading causes of newborn death in Madagascar, and postpartum hemorrhage, pre-eclampsia, and unsafe abortion continue to be leading causes of maternal mortality.<sup>2</sup> Poor quality of care has likely contributed to high rates of maternal and newborn deaths. In 2014, MCSP began supporting the MOH in strengthening key reproductive, maternal, and newborn health (RMNH) clinical competencies among the nation’s providers. Working in 17 of the country’s 22 regions as of 2018, MCSP provided competency-based in-service training to hundreds of providers in RMNH. As learning from trainings tends to deteriorate over time, MCSP also supported the MOH in providing post-training follow-up through SS to help in long-term retention of skills. As with a traditional SS approach, the goal of the SS intervention (see Box 1) was to help providers better adhere to clinical performance standards, continue to develop professionally, and feel motivated and supported in their work long term.

From 2016 to 2018, MCSP supported supervisors in regional and district health management teams to conduct SS of providers in CSBs and hospitals in nine regions, some of which were very remote; before this intervention, the remote regions had not received

<sup>1</sup> Garrison K, Caiola N, Sullivan R, Lynam P. 2004. *Supervising Healthcare Services: Improving the Performance of People*. Baltimore, Maryland: Jhpiego.

<sup>2</sup> World Health Organization (WHO). 2015. *Madagascar: WHO Statistical Profile*. Geneva: WHO.

supportive supervision visits. MCSP trained and equipped supervisors to conduct onsite visits and mobile mentoring for four to five providers. Only providers who had participated in RMNH trainings received SS, which began approximately 6 months post-training. In early 2018, after 2 years of SS implementation, MCSP and the MOH conducted this evaluation to understand supervisors' and providers' views on SS, which are critical to understanding the approach's costs, benefits, and potential for widespread adoption.

## Methodology

MCSP developed two structured surveys, one for supervisors and one for providers. MOH and MCSP enumerators interviewed a convenience sample of 19 supervisors and 66 providers representing 33 CSBs in three regions (Atsinanana, Haute Matsiatra, Analamanga) from February to May 2018. Eligible CSBs included: those averaging at least 15 facility births per month and ranking among the highest 33% of CSBs in the region by delivery volume, those in accessible and safe locations, and those with permission of the CSB chief to conduct the evaluation. Two providers were interviewed per CSB if they had completed RMNH training, been stationed at that CSB for at least 6 months, and given consent to participate. In-person and phone interviews were conducted. Data were collected on paper and digital forms, compiled in Excel, and analyzed by MCSP. Survey questions were primarily focused on components of the enhanced SS approach supported by MCSP, but two additional supervision styles (self-supervision by providers and peer supervision of/by providers) were also included in the surveys for comparison purposes because they are commonly used in Madagascar.

Limitations of this documentation activity include small sample sizes of providers/supervisors and limited sampling within eligible regions, meaning that the evaluation's results may be limited. In addition, because the MOPH's routine SS practices are not well documented, it was not feasible to compare traditional supervision and SS approaches. It was also not possible to analyze the impact of the SS approach on RMNH outcomes.

## Key Findings

### Providers

Of the 66 providers surveyed, 26% were doctors, 15% were nurses, 47% were midwives, and 12% were other types of health staff. All had worked at their CSB for over 1 year. Ninety-eight percent said that they had received onsite supervision since the SS activity began, and 39% reported having received mobile mentoring. Nearly all (95%) respondents said that they discussed data and/or reviewed data visualizations during supervisory interactions (on site or remote). A majority (86%) also reported that their supervisors had helped them identify quality improvement-related actions to take during supervision.

### SS Approach Components

- Mobile mentoring
  - Structured phone calls between supervisors and providers (weekly or monthly)
  - Informative text messages/quizzes (weekly)
  - Use of maternal and newborn health quality dashboard and other key service statistics to review indicators (monthly)
- Service quality improvement planning (quarterly)
- Site visits by supervisors (every 6 months for accessible facilities, yearly for hard-to-reach sites)
- Data quality assessment and data use for decision-making discussions (internal review quarterly, external review one to two times/year)
- Objective structured clinical examination/skills checklist evaluations (every 6 months for accessible facilities, yearly for hard-to-reach sites)

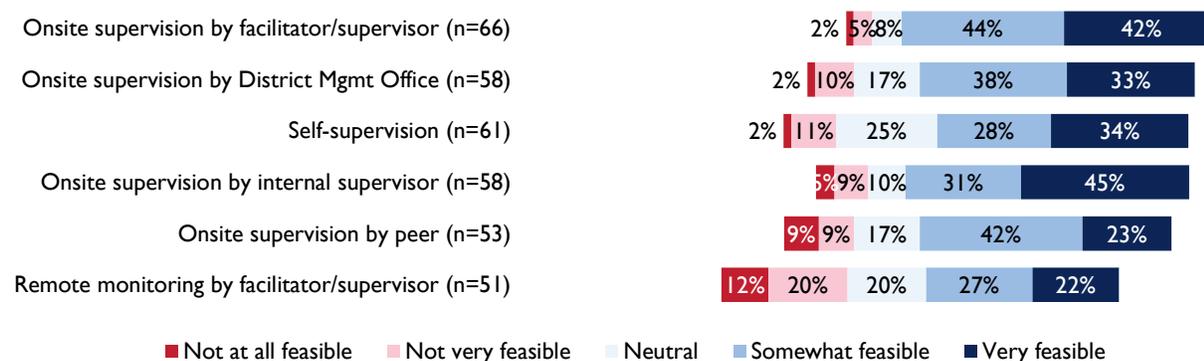
### Key findings

- Respondents rated onsite supervision by supervisors most highly of all types of supervision mentioned and felt that onsite supervision was more feasible than remote/mobile supervision.
- Fifty-eight percent of supervisors surveyed "strongly agreed" that SS helped them maintain the RMNH skills of supervisees.
- Providers and supervisors gave positive feedback about onsite visits, dashboard reviews, data quality assessment, and action planning while also noting a general preference for onsite supervision over mobile mentoring.
- The MOPH should continue to invest resources in supervision and experiment with SS modalities to strengthen quality improvement, incorporating lessons learned from this activity.

**Maintaining provider skills:** All providers surveyed agreed that the SS approach helped them to maintain their RMNH skills, with 29% “strongly” agreeing and 71% agreeing “somewhat.” For example, one provider said that SS “reminds us of theories and practices, especially simulation on a mannequin for a small number of [skills]. I forgot most of what we [were] taught in the training room because the volume of lessons [was] too high.”

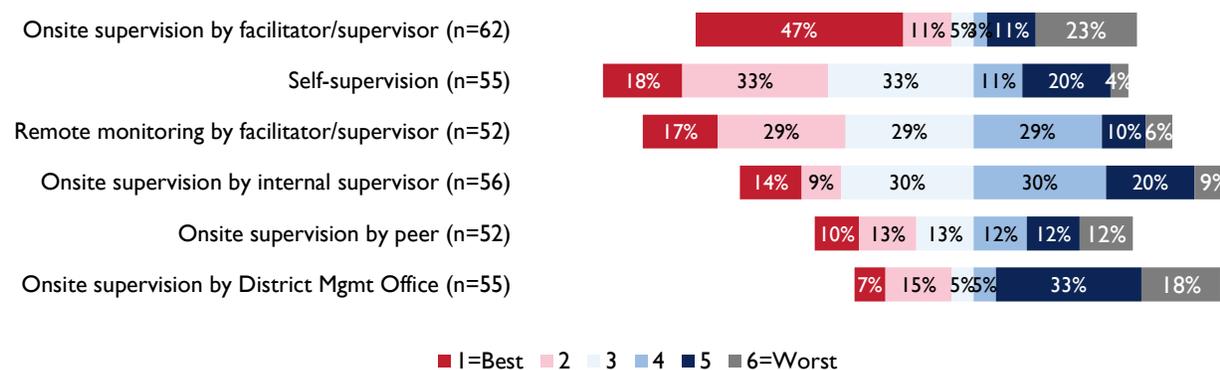
**Feasibility of supervision types:** Providers were asked how feasible they thought various types of supervision were. The two approaches deemed “very feasible” by the most providers were onsite supervision by a facilitator/supervisor (42%) and onsite supervision by internal supervisor (45%). Respondents were also asked about the feasibility of self-supervision and onsite supervision by peers (neither of which were included in the SS approach), with their responses on each shown in Figure 1.

**Figure 1. Provider opinions on the "feasibility" of different components of the supportive supervision package**



**Effectiveness of supervision types:** Providers were asked to rate each type of supervision from best to worst in terms of effectiveness in enhancing their knowledge and skills (see Figure 2). Of the 62 people who rated onsite supervision by a facilitator/supervisor, 47% said it was “best,” while 23% rated it “worst.” Providers indicating that this type of supervision was “best” felt that it enabled them to improve their skills immediately, with one provider commenting that, “Only onsite supervision can improve my knowledge because you can do demonstrations and correct me if I make mistakes.” Providers indicating that this type of supervision was worst felt that it was disruptive to their work, as they had to respond to the supervisor rather than carrying out tasks as usual. Providers also often ranked onsite supervision by the District Management Office negatively because they saw this type of supervision as more of an inspection rather than a learning opportunity. Other types of supervision were seen in a more positive light; one respondent described the various types of supervision in this way: “Onsite supervision observes our problem well. Self-supervision is done almost daily. Peer supervision gives me courage. Everything improves my skills in providing care.”

**Figure 2. Type of supervision for enhancing knowledge and skills, rated from best to worst by providers**



**Helpful practices and challenges experienced:** Providers were asked to describe supervisory practices that they found helpful, as well as challenges they experienced with the different types of supervision (Table 1). Despite many of the challenges mentioned associated with onsite supervision, respondents consistently preferred onsite supervision to mobile mentoring, describing onsite supervision as “better and more effective.”

**Table 1. Helpful supervisory practices and challenges experienced during supervision, according to providers**

Helpful practices	Challenges experienced
<ul style="list-style-type: none"> <li>• During onsite supervision, practicing skills on mannequins and with real clients using checklists</li> <li>• Getting real-time feedback from supervisors (on site)</li> <li>• Reviewing knowledge through questions and reminders of theory and best practices (on site)</li> <li>• Watching demonstrations and simulations on mannequins performed by supervisors (on site)</li> <li>• Repeating difficult practices, like newborn resuscitation (on site)</li> <li>• Reviewing data dashboards (on site)</li> <li>• Monitoring action plans (on site)</li> </ul>	<ul style="list-style-type: none"> <li>• Not always having time for supervision (on site)</li> <li>• Supervision interfering with patient care (on site)</li> <li>• Integrated supervision being overwhelming and “too much work” (on site)</li> <li>• Not having real cases available to work on during a supervision visit (on site)</li> <li>• Some supervisors not being “decision-makers who can give firm solutions” (on site)</li> <li>• Action plans not being shared with supervisees</li> <li>• Having insufficient space or equipment to conduct effective supervision (on site)</li> <li>• Network issues (e.g., difficulties making/receiving phone calls) impeding mobile mentoring (remote)</li> </ul>

**Suggestions for improvement:** Individual providers’ suggestions for improvement included making onsite supervision visits shorter (no longer than 1 day at a time); planning supervision visits for times when providers do not have other work; having supervision visits take place at the district level; having onsite supervision visits once per quarter and telephone calls once per week; having two supervisors visit the facility (one supervisor works with clients while the other carries out supervision with the provider); providing more phone credit for providers and supervisors; increasing supervision frequency, especially during higher-volume months; and sharing action plans and supervision reports with supervisees so that they are aware of needed action items.

## Supervisors

Of the 19 supervisors surveyed, 15 were doctors, one was a nurse, and three were midwives. A majority (79%) had received training on the SS approach, and all respondents reported including data dashboards, skills checklists, data quality assessments, and quality improvement action planning in their supervisory duties. When asked about the number of onsite supervisory visits they had made in the previous 6 months, one person said none, 37% said one to three visits, 47% said four or more visits, and one reported having made eight onsite visits. The average onsite supervision completion rate was 78%, while the average mobile mentoring completion rate across all supervisors was 76%. Roughly half (47%) said they had provided SS to staff at hospital level.

**Maintaining provider skills:** Most supervisors surveyed agreed that the SS approach had helped them to maintain their supervisees’ RMNH skills, with 58% “strongly agreeing,” 37% agreeing “somewhat,” and 5% giving a “neutral” response. One supervisor remarked that “supervision strengthens the capacity of the provider and supervisor at the same time.”

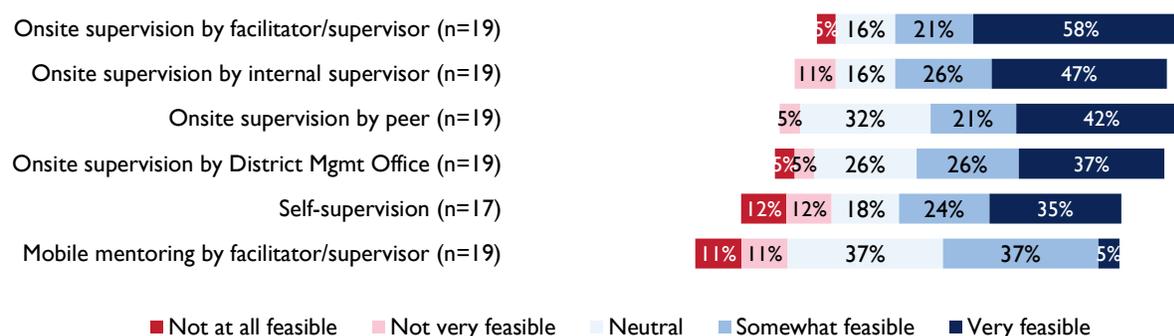
**Time needed for SS:** Views were mixed on whether the time allocated to SS implementation disrupted supervisors’ normal activities. About one-third of respondents said that SS did create a disruption, while two-thirds said that it did not (Table 2).

**Table 2. Supervisor assessment of whether supportive supervision implementation disrupted their normal activities**

Question statement	Responses	n	Percentage (n = 19)
The time allocated to supportive supervision disrupts your normal activities	Strongly agree	1	6%
	Somewhat agree	5	28%
	Neutral	0	0%
	Somewhat disagree	8	44%
	Strongly disagree	4	22%

**Feasibility of supervision types:** Supervisor responses mirrored provider responses on feasibility of the approach. Figure 3 shows that 58% of the supervisors felt that onsite supervision of a facilitator/supervisor was the most feasible of all the approaches. Supervisors were also asked about the feasibility of providers supervising themselves and being supervised by peers (neither of which was included in the SS approach). Respondents reported thinking both were relatively feasible.

**Figure 3. Onsite supervision by facilitator/supervisor reported feasible by respondents**



**Benefits, helpful practices, challenges experienced, and suggested improvements:** Supervisors described the benefits of SS, supervisory practices they found helpful, challenges they experienced implementing different types of supervision, and suggestions for future improvements (Table 3).

**Table 3. Benefits, helpful practices, challenges, and potential improvements of practices, according to supervisors**

Helpful practices	Benefits of supervision
<ul style="list-style-type: none"> <li>Reviewing/analyzing dashboards and doing data quality assessments</li> <li>Doing demonstrations and practicing skills on mannequins</li> <li>Reviewing reference documents and verification lists</li> </ul>	<ul style="list-style-type: none"> <li>Improving relationships between colleagues</li> <li>Increasing providers' curiosity and desire to learn</li> <li>Increasing providers' satisfaction with onsite supervision</li> <li>Building better habits among providers</li> </ul>

Helpful practices	Benefits of supervision
Challenges experienced	Suggestions for improvement
<ul style="list-style-type: none"> <li>• Insufficient time for supervision</li> <li>• Logistical issues (poor roads/equipment, insufficient funds for phone and travel)</li> <li>• Disrupting patient care (with supervisors sometimes having to step in and do a supervisee’s work)</li> <li>• Poor quality of supervision if provider/supervisor relationship is poor</li> </ul>	<ul style="list-style-type: none"> <li>• Giving supervisors the CSBs’ daily service delivery schedules in advance for better timing of SS visits</li> <li>• Sending two supervisors per visit so that one can assist clients while the other concentrates on supervision</li> <li>• Using quarterly review meetings to conduct supervision (especially for hard-to-reach CSBs)</li> <li>• Reinforcing that supervision is for improvement, not punishment</li> <li>• Training CSB in-charges in supervision to better provide continuous onsite supervision, with district supervisors supplementing with mobile mentoring</li> <li>• Ensuring funding to cover supervision-related costs</li> </ul>

## Program/Policy Implications

Providers and supervisors expressed positive attitudes toward SS and the enhanced SS approach, reporting that each variety of support is helpful in refreshing and/or maintaining providers’ post-training RMNH knowledge, skills, motivation, and confidence. Respondents rated onsite supervision delivered by facilitators/supervisors most highly of all types of supervision mentioned, with more supervisors describing it as “very feasible” than any other method, and more providers describing it as “very feasible” and the “best” method than any other method. These results are encouraging given that in some contexts, providers view onsite supervision as punitive or demotivating, while some supervisors view it as burdensome or impractical. In terms of feasibility, providers and supervisors felt that onsite forms of supervision were more feasible than remote/mobile supervision—an important finding given that a goal of the mobile interventions was to make supervisory support more accessible, frequent, and available to providers located in remote or hard-to-reach sites.

Going forward, Madagascar’s MOH should continue to experiment with SS modalities to strengthen existing continuing education and quality improvement/assurance approaches. The MOH should incorporate lessons learned from this activity (e.g., supervisors must always share action plans at the end of each supervisor visit/call; discussing real-time data and data dashboards during supervisory visits/calls is helpful; supervisors should be mindful of facility schedules and provider availability when arranging face-to-face visits) and document effective and ineffective approaches. Regional and district authorities should prioritize regular supervision-related activities in their annual work plans and adequately budget for implementation. MCSP provided capacity-building support to district health management teams in 10 districts to organize, maintain, and conduct different supervision activities using their own resources.

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