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## EVIDENCE FOR ACTION

## A systematic review of supportive supervision as a strategy to improve primary healthcare services in Sub-Saharan Africa



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## ABSTRACT

**Background:** It may be assumed that supportive supervision effectively builds capacity, improves the quality of care provided by frontline health workers, and positively impacts clinical outcomes. Evidence on the role of supervision in Sub-Saharan Africa has been inconclusive, despite the critical need to maximize the workforce in low-resource settings. **Objectives:** To review the published literature from Sub-Saharan Africa on the effects of supportive supervision on quality of care, and health worker motivation and performance. **Search strategy:** A systematic review of seven databases of both qualitative and quantitative studies published in peer-reviewed journals. **Selection criteria:** Selected studies were based in primary healthcare settings in Sub-Saharan Africa and present primary data concerning supportive supervision. **Data collection and analysis:** Thematic synthesis where data from the identified studies were grouped and interpreted according to prominent themes. **Main results:** Supportive supervision can increase job satisfaction and health worker motivation. Evidence is mixed on whether this translates to increased clinical competence and there is little evidence of the effect on clinical outcomes. **Conclusions:** Results highlight the lack of sound evidence on the effects of supportive supervision owing to limitations in research design and the complexity of evaluating such interventions. The approaches required a high level of external inputs, which challenge the sustainability of such models.

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## 1. Introduction

Primary health care in Sub-Saharan Africa faces many challenges. Inconsistency in the quality of care delivered by health professionals affects both utilization of services and individual health outcomes. One possible contributor to poor quality service delivery is a lack of appropriate or effective supervision of frontline health workers.

The present study is a systematic review investigating the effects of supervision (or mentorship) provided under a supportive or facilitative model (compared with other models) on quality of care in low-resource primary health care (PHC) settings. The review was done in the framework of the Evidence for Action (E4A) Programme, which is active in six countries in Sub-Saharan Africa and aims to provide key recommendations for the implementation of supportive supervision systems to improve maternal, newborn, and child health (MNCH) in African PHC settings. The success and failure of supervision should be understood in the social and cultural context it is delivered [1] and therefore this

review looks at studies within Sub-Saharan Africa as an attempt to set a comparable contextual framework for supervision in a region where countries often have under-resourced health systems and can be characterized, in general, by remote, isolated health facilities where supervision is greatly needed [2].

This review looks at the primary healthcare setting, where providers are usually generalists expected to deal with the entire spectrum of health issues within a facility. MNCH care is an integral part of PHC, delivered alongside other services and often supervised together. Thus, this review takes a holistic approach by including studies on a range of specific PHC services, including but not limited to MNCH. This is based on the appreciation that key aspects of supportive supervision can be applied in all PHC services regardless of the qualitative differences between PHC services. In general, supervision visits are likely to address a range of services collectively.

Previous reviews have assessed the effect of clinical outreach visits on quality of care, health outcomes [3], and managerial supervision [4,5]. Due to the more “systems focused” nature of supportive supervision, as opposed to supervision for specific clinical skills, it is expected that any impact of supportive supervision is widely felt across the spectrum of different services provided by frontline health workers, including MNCH care.

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Kilminster et al. [6] broadly defined supervision within the health sciences as: “the provision of guidance and feedback on matters of personal, professional and educational development in the context of a trainee’s experience of providing safe and appropriate patient care.” Supervision within health systems is often either weak or absent owing to implementation challenges including the lack of training of managerial staff in supervision, time constraints, prioritization of clinical duties, and direct and indirect costs such as transportation, accommodation, and per diems. Where supervision systems are in place, they are often focused on inspection and line management, where mistakes are identified and blame apportioned, with no or only negative feedback. The study by Bosch-Capblanch et al. [4] showed that while supervision involved regular visits and played a role in performance and motivation, joint problem solving and feedback were minimal. Such models of supervision can have negative repercussions on staff retention, job satisfaction, motivation, and job performance [7].

Supportive supervision on the other hand is viewed as an optimal choice for clinical care settings because it upends traditional notions of supervision and focuses on facilitation instead of inspection [8]. Inspective approaches place the onus of fixing problems on the staff while a supportive or facilitative supervision aims to support staff to engage in problem solving through technical assistance, capacity building, and resource provision. Supportive supervision can promote quality improvements by strengthening relationships within the system, identifying and solving problems, and maximizing resource allocation [9]. This process of empowerment not only enhances professional development, but also promotes personal growth through concepts such as valuation and empathy [8] and can positively affect the work environment [10]. Kilminster and Jolly’s [11] review described the quality of the relationship as probably the single most important factor determining effective supportive supervision.

We conducted a systematic review and meta-synthesis of peer-reviewed literature to assess the effectiveness of supportive supervision as a strategy for improving the quality of primary healthcare services including MNCH care services in Sub-Saharan Africa.

## 2. Materials and methods

This systematic review and meta-synthesis was done on both quantitative and qualitative studies of available literature filtered by inclusion criteria. Meta-synthesis allows for the review of information, sharing common features across contexts to garner insights on the commonality of factors that facilitate or constrain the realization of the outcome of interest.

### 2.1. Search strategy

A literature search was conducted on September 27, 2014. The general search terms used were “supervis\* AND health,” “supportive supervision,” “facilitative supervision,” “formative supervision,” “clinical supervision,” and “mentor\*” and the search was restricted to countries south of the Sahara. A list of databases and the exact search string used for each database is available ([Supplementary Material S1](#)). Only peer-reviewed articles were included and no language or date restrictions were applied. The included papers represent the time period 2004–2014, as no papers assessing the effects of supportive supervision in Sub-Saharan Africa before 2004 met the study criteria. While the area of interest was MNCH, the search was purposefully kept broad to capture all supervision studies reported in PHC settings in Sub-Saharan Africa.

### 2.2. Screening

The search generated 1108 papers (excluding duplicates) that were screened in two stages, the results of which are shown in [Fig. 1](#). All titles and abstracts at stage one and full text articles at stage two were screened independently by two reviewers, who subsequently discussed

any cases of disagreement. All included articles and borderline cases were finally read by all reviewers, and each discussed again for final inclusion. Eighteen papers met the inclusion criteria, full details of which are given in [Supplementary Material S2](#).

### 2.3. Quality assessment

To facilitate quality assessment of the papers included, a standard set of questions (first offered by Croucher et al. [12]) provided a “quality threshold” against which included studies were considered to assist in the interpretation of the results. Studies were not excluded on the basis of design quality, or failure to adhere to a particular reporting regime. Instead, the basic validity of the study findings was appraised at the data synthesis stage [13]. While using one set of criteria for all qualitative and quantitative studies within the review poses some epistemological questions, we felt that this approach allowed for quality assessment and consideration at the synthesis of findings stage to avoid excluding perhaps valuable contributions to the study area. All studies meeting the inclusion criteria were included and graded according to the quality criteria questions in [Table 1](#). The result of the grading is available as [Supplementary Material S3](#).

### 2.4. Analysis

The analytical approach taken is thematic synthesis, where data from included studies were grouped and interpreted according to prominent themes with the aim of identifying common elements across otherwise heterogeneous studies [13,14]. The analysis began with a deductive approach whereby themes were identified from existing literature and a codebook was developed to which subcodes were created inductively during the process of initial coding. All articles were coded in qualitative data analysis software: ATLAS.ti (ATLAS.ti GmbH, Berlin, Germany) and NVivo (QSR International, Melbourne, Australia). Article coding was done in duplicate to reinforce quality of analysis. The synthesis was conducted with a distinction between three analytic levels: firstly the actual primary data as presented in the article, secondly the authors’ interpretation of their results, and thirdly, the reviewers’ interpretation of the results, included in the discussion section.

## 3. Results

Eighteen peer-reviewed papers [7,15–31] were included in the synthesis, three [19,20,27] of these were based exclusively on qualitative data, 12 were based on quantitative data only [7,16–18,21,23–26,28,29], and the remaining three [15,22,30] reported a combination of both methods. There was considerable heterogeneity in study designs and outcome measures between papers, the characteristics of which are presented in [Table 2](#); however some similarities are noted on the type of supervision intervention under study. Of the studies that evaluated quality improvement interventions, three [15–17] implemented a Client-Oriented, Provider-Efficient services (COPE) program, which is a participatory, problem-solving quality improvement method that orients clients and providers to a rights-based approach to service delivery and uses self-assessment questionnaires for providers to evaluate their own performance along with client exit interviews and action planning tools. A further two studies [18,19] implemented a Mentoring and Enhanced Supervision at Health centers (MESH) program aimed at improving quality of care by addressing skills and knowledge gaps in health workers and systems based quality improvements. The other eight intervention studies each implemented different quality improvement programs with varying models and inputs to supportive supervision as shown in [Supplementary Material S4](#). The remaining five papers [7,20–23] did not evaluate specific interventions but conducted observational studies, two of which [7,20] were based on the Health Services Strengthening for Equity (HSSE): the Power and Potential of Mid-level providers project data.

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