Supportive Supervision is a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on identification and resolution of problems, optimising the allocation of resources, promoting high standards, team work and better two-way communications. While many approaches like quality assurance, client-centred services, district team problem-solving have been proposed to improve the quality of health services, the supportive supervision approach improves services by focusing on meeting staff needs for management support, logistics, training and continuing education. The goal of supportive supervision is to promote efficient, effective, and equitable health care.

In the health sector including sanitation and hygiene, a cornerstone of supportive supervision is working with health staff to establish goals, monitor performance, identify and correct problems, and proactively improve the quality of service. Together, the supervisor and health workers identify and address weaknesses on the spot, preventing poor practices from becoming routine. Supervisory visits provide an opportunity to recognize good practices and help health workers to maintain their high-level of performance. However, moving from traditional, hierarchical supervision systems to more supportive ones requires innovative thinking, buy-in, and time to change attitudes, perceptions, and practices and integration of skill building linked to interpersonal communication and counselling.

Though there are many examples and case studies where supportive supervision has been used to improve health worker performance and immunization coverage, long-term and sustainable
results have not been thoroughly documented. UNICEF proposes to hold a workshop to explore various approaches to supportive supervision and its use as a tool to enhance quality of health services and develop a broad roadmap towards implementation of these in the health sector.

In the above context, members of MCH Community and Water community are requested to give their inputs on the following –

- Good practices on using supportive supervision in different sectors like health, drinking water and sanitation, education.
- Experiences of scaling and sustaining/embedding supportive supervision in the existing institutional mechanisms.
- What were the challenges related to operationalizing effective supportive supervision mechanisms for staff/workers?
- What effective steps were taken to address the challenges?

Your inputs would be useful to know if the concept of supportive supervision has been tried in other development sectors as a performance improvement and motivation tool and explore their relevance/application to the health sector with specific reference to front line health workers.

Thanks in advance.

Responses were received with thanks, from

1. **R.K. Sood**, Epidemiologist, District AIDS Programme Officer, Dharamshala, Himachal Pradesh
2. **Brijendra Singh**, Ex. General Manager, Public Sector, SPSA, Retired Director Family Welfare, Uttar Pradesh
3. **S.K. Chaturvedi**; Former Unicef Representative for NE/NW states
4. **Deepika Anand**, Independent Consultant, New Delhi
5. **Ravishwar Sinha**, Independent Consultant, New Delhi
6. **Shubhada Kanani**; NETNAA (Network for Nutrition Awareness and Advocacy); Former Professor at Department of Foods and Nutrition; M.S. University of Baroda, Vadodara; Gujarat
7. **Anil Kumar Sukumaran**; Independent Consultant; New Delhi
8. **Krishnamurthy**, Sukshema project, Karnataka Health Promotion Trust, Bangalore
9. **Lalit Mohan Sharma**, Institute of Rural Research and Development, Gurgaon
10. **Shiv Chandra Mathur**, Public Health and Education Specialist, EU-Institution and Technical Support, New Delhi
11. **Ashok Kumar Singh**, Vistaar Project, Intrahealth International, Lucknow, Uttar Pradesh
12. **Amungwa Athanasius Nche**, Health and Development Certified Training Professional, Cameroon
13. **Pankaj Kumar Singh**; District Health Society; Siwan, Bihar
14. **Karan Singh Sagar**, Maternal and Child Health Integrated Program (MCHIP), New Delhi
15. **Giridhara R Babu**, Indian Institute of Public Health, PHFI, Hyderabad
17. **Nirmal Kumar Pradhan**, PATH - Sure Start Project, Lucknow, Uttar Pradesh
18. **Abrar Ahmad Khan**, The Vistaar Project, Intrahealth International Inc., New Delhi
19. **Leila Caleb Varkey**, Independent Public Health Researcher
20. **Nandita Kapadia-Kundu**, John Hopkins University/Center for Communication
21. **Shyam Singhal**, WHO-India, NPSP, Madhya Pradesh
Summary of Responses

Supportive Supervision is creation of an environment that allows staff to develop professionally and enhances performance of staff regardless of the current level of performance. It is an ongoing process and an area that could make a huge difference in a staff’s performance and thereby on the quality of care offered, yet this is the area that is often not recognized enough or not invested in adequately.

The report of the Eight Joint Review Mission recommends that Supportive Supervision should be implemented at all levels to ensure quality of care as well as increased capacity and motivation level of staff through constructive feedback and handholding support. The report has indicated that currently the supervisory visits are not executed as per the NRHM guidelines and takes note of the missing element of supportive supervision in its entirety. Further, anecdotal evidence suggests that supervisory checklists are not used and filled, even if available and no proper documentation of the supervisory visits made is maintained.

Several examples from the field were shared attempted to incorporate Supportive Supervision in programming in different ways. The experience from Uttar Pradesh and Jharkhand shared interventions by the Vistaar Project. The project worked towards improving supportive supervision in ICDS and Health and Family Welfare departments. The project adopted a multi-pronged approach consisting of capacity building of supervisors in knowledge, skills and attitudes for effective supervision, training of supervisors for technical competence in critical areas of work to support frontline workers and took up system level measures to facilitate more effective supervision. The project evaluation showed increase in the frequency of interaction between the supervisors and supervisees and the frontline workers reported that the quality of interactions became more supportive, encouraging and oriented towards problem solving.

Further, the Sure Start Project in Uttar Pradesh identified that providing supportive supervision to ASHAs is an important component to be addressed. The project engaged in ASHA mentoring and VHSC strengthening and deployed NGO supervisors at block level who did one on one counseling with the ASHAs, training her in IPC skills and providing support with village level planning at VHSC meetings among other things. This process provided the needed support to the ASHAs. Similarly, in Haryana, IRRAD trained the defunct VHSC members and empowered the village women to work towards improving sanitation and disposal of domestic waste water in their village.

Another strategy RAPID – “Regular Appraisal of Programme Implementation in a District” was shared being implemented by MCHIP project which is based on premise of supportive supervision. The strategy has been tried for two thematic areas - immunization and newborn
health. The exercise identifies gaps, promotes onsite correction, capacity building and regular follow-up to ensure that the system improves and delivers what it intends to deliver. In the similar context, there are some models currently existing in Andhra Pradesh, Assam and Uttar Pradesh which have roped in community departments of medical colleges to provide supportive supervision to the routine immunization program.

**Challenges related to operationalizing Supportive Supervision**

Supervisory structures in primary health care are non-functional due to lack of institutional vision; role clarity; lack of purpose; inadequate skills and capacity of supervision along with a non-conducive environment. Following are some of the challenges related to operationalizing of effective supportive supervision mechanisms -

1. **Unclear Performance Expectations & Lack of Role Clarity and Ownership**
   - Due to variety of tasks often there is a lack of prioritization and ownership

2. **Lack of Objective Appraisal Systems**
   - There is lack of accountability and vague systems of appraisals which leads to low motivation and poor performance

3. **Inter-Staff Conflicts** which remain unaddressed

4. **Authoritative Approach to Supervision Followed**
   - Supervisory control exhibited through an inspection and policing approach rather than a corrective approach
   - Supervision at times limited to filling checklist without the required hand holding support leading to low motivation amongst staff
   - Supervisors devote more time to material management at the cost of discussing service delivery related processes followed by the health worker
   - Lack of recognition for the good work and fire-fighting done by the worker

5. **Episodic Problem Solving** due to irregular and erratic visits

6. **Lack of Follow up and continuity and no plans for supervisory visits in place**

7. **Insufficient Supervisory Cadre**
   - High numbers of supervisory positions remain vacant making it difficult to achieve the objective of regular supervisory visits
   - Existing supervisors provide support to various vertical programs leading to poor quality of supervision and may not always possess the clinical competencies
   - Logistics like mobility support for supervisory visits are insufficient

8. **Inadequate Orientation and Training of Supervisors** to practice supportive supervision

**Effective Steps to Address Challenges**

1. **Setting Clear Job and Performance Expectations among workers**
   Supervisors should work directly with the workers to set clear goals, standards and expectations

2. **Provide Handholding to support what is expected and how to do it**

3. **Setting in Place the Institutional Mechanisms for supervision**

4. **Provide Pre-Service Training to in Supervision** and build capacity of supervisors to provide and sustain supportive supervision
   Supervisors should be oriented towards the differences between control supervision and supportive supervision
   Bringing a mind-set change from inspection/policing approach to a coaching/mentoring approach & shift from blame to a shared responsibility with the staff
Inculcate supportive supervision in the syllabi right through the training centres including ANM/Nursing Training centres, MLTCs and Administrative Training Colleges

5. **Supervisors must focus on facilitation**
   - Focus on mentoring, joint problem solving and two-way communication
   - Maintain Supervisory notes and document good practices. This will inculcate use of reporting formats and checklists helping supervisors take stock of the situation, performance of the worker and take curative action / follow-up action
   - Encourage local problem solving and ownership at facility level

6. **Conflict Management**
   - Supervisors must address conflicts creeping in the workforce on a continuous basis
   - Individual personality traits and individual capacity levels should be dealt with on a case to case basis

7. **Immediate Performance Feedback Mechanism**
   - Provide onsite support, regular monitoring & feedback, problem solving and action planning
   - Continuously address gaps and weaknesses while giving due importance to the positive factors and opportunities

8. **Motivation through Reward and Recognition**
   - Local mechanisms for providing financial/non-financial reward and recognition
   - Arranging exploration visits for the staff

9. **Overall, a supervisor must**
   - Respect staff’s current abilities and strive to enhance employee’s performance by addressing gaps between existing and required skills/knowledge
   - Ensure improved coordination of available workforce and work towards continuous quality improvement
   - Propagate team work, joint ownership and work towards developing relationships with staff
   - Address shortcomings in worker performance through a corrective and preventive action rather than punitive action

**RECOMMENDATIONS**

Some of the recommendations proposed during the discussion are as follows –

- There should be a realistic and manageable Supervisor to Supervisee ratio to achieve the objective of providing supportive supervision and to ensure high quality interactions / hand-holding support.
- Priority areas requiring supportive supervision should be identified and focus should be on package of services that are critical which could influence mortality indicators.
- Providers’ skills strengthening should be complemented with timely response to address systems issues i.e supply chain, referrals systems from district officials which require better liaising by the supervisor between facilities and program officers.
- Ensuring that the supportive supervision meetings and supervisory visits are undertaken at the level of CMO, BMOs and MOs as well as CHO and PMU staff.
- Inculcate the culture of quality of supervisory support provided including use of checklists, tools, mentorship.
- Supervision of quality of supervisor’s inputs is essential and a gradation within the program with inbuilt recognition is required.
- Ensuring that the Supervisor has a strong clinical background so as to be able to provide on the job training during the visits. Hence the supervisor should continue to be in touch
with clinical practice and the system should create opportunities for these supervisors to balance field visits and clinical practice.

- A mechanism of sharing information with high level functionaries should be established which will also serve as supervision of the work conducted by supervisors.
- To provide critical attention to “Quality of Care”, it would be worthwhile investing in a supervisory cadre completely dedicated to the cause of quality.
- Undertake a time-activity pattern audit as part of action research / rapid appraisal surveys to assess the amount of Supervisor’s time that goes into which activity.
- Explore use of technology for effective supervision considering huge number of front line workers needing support.

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**Comparative Experiences**

**Uttar Pradesh and Jharkhand**

**Strengthening Systems for Supportive Supervision in 8 districts of Uttar Pradesh and 14 districts of Jharkhand: USAID-supported Vistaar Project** *(from Abrar Ahmad Khan, The Vistaar Project, Intrahealth International Inc., New Delhi and Ashok Kumar Singh, Vistaar Project, Intrahealth International, Lucknow, Uttar Pradesh)*

The Vistaar Project with ownership and support of the state and district level Health and ICDS systems initiated interventions for capacity building of frontline workers and strengthening the system of supervision. The intervention design included a multi-pronged approach consisting of capacity building of supervisors in knowledge, skills and attitudes for effective supervision, supervisors training for technical competence in critical areas of work to support frontline workers and system level measures to facilitate more effective supervision. [Read More](#)

**“RAPID” Implementation – Using a Supportive Supervision Approach at Scale** *(from Karan Singh Sagar, Maternal and Child Health Integrated Program (MCHIP), New Delhi)*

The MCHIP project supported the Government of India in strengthening its Universal Immunization Program through implementation of a supportive supervision and review approach known as RAPID – Regular Appraisal of Program Implementation in a District. The model uses a process of guiding, supporting and assisting staff to perform well in the assigned tasks and include a need based capacity building intervention. The process contributed to improved quality in immunization services and led to improved coverage. Currently, RAPID is being implemented in 32 districts of Uttar Pradesh by UNICEF with participation of Government Medical Colleges and has been approved by Govt. of Jharkhand to be conducted in 24 districts. [Read More](#)

**Uttar Pradesh**

**ASHA mentoring and VHSC strengthening under the Sure Start Project** *(from Nirmal Kumar Pradhan, PATH - Sure Start Project, Lucknow, Uttar Pradesh)*

Sure Start’s focus was to engage in ASHA mentoring and VHSC strengthening. Sure Start deployed NGO supervisors at block levels. The supervisor had to do one-on-one counseling with the ASHAs, teaching them appropriate use of IEC tools, counseling for birth preparedness and danger sign recognition. The supervisors helped ASHAs maintain the Village Health Indicator Register. This process bought about a gradual improvement in removing bottlenecks to the ASHA’s work. The project also developed a systematic six days training curriculum for ANM/ASHA supervisors on ASHA mentoring.

**Efforts towards Supportive Supervision failed in the absence of continued institutional mechanisms** *(from Brijendra Singh, Ex. General Manager, Public Sector, SIPS, Retired Director Family Welfare, Uttar Pradesh)*

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Under the USAID funded IFPS (Innovations in Family Planning Services) project, measures were undertaken to improve supportive supervision with the capacity building of supervisors, support for field visits, on-site validation of skills and availability of quality services. However, in absence of an integrated institutional mechanism and rapidly expanding new focus areas, the efforts could not be integrated into the institutional memory and supportive supervision remained a potential opportunity to be explored in future.

**Himachal Pradesh**

**Organizational Development Workshop led to Team Building and Proactive Leadership and Innovation** (from R.K. Sood, Epidemiologist, District AIDS Programme Officer, Dharamshala, Himachal Pradesh)

The staff of the seven Integrated Counseling Testing Centres in the Kangra district underwent an organizational development workshop consisting of brainstorming sessions on roles and relevance to organizational goals. The workshop came out with an objective appraisal system for the staff so that they can plan their performance accordingly and addressed some of the other concerns of the staff. Read More

**Haryana**

**Institute of Rural Research and Development (IRRAD) successfully trains Village Health and Sanitation Committee on Sanitation issues, Mewat District** (from Lalit Mohan Sharma, Institute of Rural Research and Development, Gurgaon)

IRRAD initiated training of defunct Village Health and Sanitation Committee (VHSC) and linking these with the larger communities. Women of the villages felt empowered and started taking interest in the development of the villages particularly on sanitation being the worst sufferers. Now there are many villages where all the domestic waste water is disposed safely at household or cluster levels and people use latrines.

**International**

**Cameroon**

**Facilitative Supervision initiated under the Client-Oriented-Provider-Efficient (COPE) Services model proves successful** (from Amungwa Athanasius Nche, Health and Development Certified Training Professional, Cameroon)

The project followed the COPE model through which a team of National Trainers was recruited, trained and their capacities built in facilitative supervision, training skills, monitoring and evaluation management. This multi-tasked team would go to the field to supervise service providers and give them technical support during their work and identify performance gaps that need training solutions. The trainers were kept motivated by short courses in and out of the country and service providers also had frequent refreshers with some financial benefits.

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**Related Resources**

**Recommended Documentation**

**Report of the Participatory Planning Workshop of District AIDS Control Programme of District Kangra, HP** (from R.K. Sood, Epidemiologist, District AIDS Programme Officer, Dharamshala, Himachal Pradesh)

Report; by Rajeev Ahal and Vijay Kumar; National AIDS Control Programme; Kangra, Himachal Pradesh; September 2011;
Available at ftp://ftp.solutionexchange.net.in/public/wes/cr/res10081201.pdf (PDF; Size: 1.2 MB)
Report on the workshop held to address the issues related to organizational development and enhance quality of interventions being undertaken by the staff at the Integrated Counseling Testing Centres.

**Poster - “Supportive Supervision At Scale - Experiences from Uttar Pradesh” (from Ashok Kumar Singh, Vistaar Project, IntraHealth International, Lucknow, Uttar Pradesh)**
By Vistaar Project; March 2010
Available at ftp://ftp.solutionexchange.net.in/public/mch/cr/res10081204.jpg
The poster depicts the interventions undertaken by the Vistaar Project to improve Supportive Supervision in two Government systems i.e the ICDS and the Health and Family Welfare.

**“RAPID” Implementation - Using a Supportive Supervision Approach at Scale in India**
(from Karan Singh Sagar, Maternal and Child Health Integrated Program (MCHIP), New Delhi)
Report; by Maternal and Child Health Integrated Program; Uttar Pradesh;
Available at ftp://ftp.solutionexchange.net.in/public/mch/cr/res10081202.pdf (PDF; Size: 214 KB)
Describes the MCHIP strategy of providing supportive supervision at systems level, which looks at elements of programme planning, implementation and monitoring.

**Supportive Supervision and Immunization Coverage: Evidence from India**
(from Giridhara R Babu, Indian Institute of Public Health, PHFI, Hyderabad)
Article; by Giridhara R Babu, Vivek V Singh and Siddhartha Nandy, et al; The Internet Journal of Epidemiology; USA; 2011;
Available at ftp://ftp.solutionexchange.net.in/public/mch/cr/res10081203.pdf (PDF; Size: 1.2 MB)
The paper infers that supportive supervision improves immunization coverage and serves an efficient tool to strengthen the local health systems.

**Meeting the Health Information Needs of Health Workers: What Have We Learned?**
(from Leila Caleb Varkey, Independent Public Health Researcher)
Paper; by Margaret D'Adamoa, Madeleine Short Fabica and Saori Ohkubob; Journal of Health Communication: International Perspectives; USA; June 2012; Permission Required: Paid publication, order online.
Available at http://www.tandfonline.com/doi/abs/10.1080/10810730.2012.666626
Presents results that confirm that health workers’ information needs differ on the basis of the level of the health system in which a health worker is located, regardless of country.

**Understanding Health Information Needs and Gaps in the Health Care System in Uttar Pradesh, India**
(from Nandita Kapadia-Kundu, John Hopkins University/Center for Communication)
Paper; by Nandita Kapadia-Kundu, Tara M. Sullivan, Basil Safi, Geetali Trivedi and Sanjanthi Velu; Journal of Health Communication: International Perspectives; USA; June 2012; Permission Required: Paid publication, order online
Available at http://www.tandfonline.com/doi/pdf/10.1080/10810730.2012.666625
Describes how providing actionable information across all levels is a key means to strengthen the health system and improve the quality of services.

**Enhancing Impact of Food Fortification Program - Program Design, Quality, Monitoring and Evaluation**
(from Shubhada Kanani; NETNAA (Network for Nutrition Awareness and Advocacy); Former Professor at Department of Foods and Nutrition; M.S. University of Baroda, Vadodara; Gujarat)
Presentation; by Shubhada Kanani; Presented at Micronutrient Fortification of Foods: Science, Application and Management; ILSI - India, Jan 7-8, 2011, New Delhi
The presentation depicts that admin work/records/reports, review meetings and other meetings take up bulk of the time of the ICDS supervisors with negligible community outreach.

From Krishnamurthy, Sukshema project, Karnataka Health Promotion Trust, Bangalore

**Quality Assurance for RCH Services: The Karnataka Experience**

Paper; by Krishna M. C.; National Rural Health Mission, Government of Karnataka; Karnataka; 

Describes how in order to institutionalize improvement in RCH services, an attempt is being made to set up a functioning district quality assurance mechanism.

**The Sukshema Project**

Report; by Karnataka Health Promotion Trust; Bangalore; 
Available at [http://www.khpt.org/sukshema.html](http://www.khpt.org/sukshema.html)

Report on the Sukshema project which focuses on improving the availability, accessibility, quality, utilization and coverage of maternal newborn and child health services.

From Shyam Singhal, WHO-India, NPSP, Madhya Pradesh

**Managerial Supervision to Improve Primary Health Care in Low- and Middle-income Countries**

Paper; by Bosch-Capblanch X, Liaqat S, Garner P; US National Library of Medicine, National Institutes of Health; USA; September 2011; Permission Required: Paid publication, order online. 

*It reviews the effects of managerial supervision of health workers to improve the quality of PHC in low- and middle-income countries.*

**Supervision in Primary Health Care – Can it carried out effectively in developing countries?**


*The paper supported by field observations in Papua New Guinea, concluded that supervision and its failure should be understood in a social and cultural context, being a far more complex activity than has so far been acknowledged.*

From Meenakshi Aggarwal, MCH Community

**Guidelines for Implementing Supportive Supervision: A step-by-step guide with tools to support immunization**

Guidelines; by PATH; December 2003 
Available at [http://www.path.org/vaccineresources/files/Guidelines_for_Supportive_Supervision.pdf](http://www.path.org/vaccineresources/files/Guidelines_for_Supportive_Supervision.pdf) (PDF, Size: 798 KB)

*Designed to be adapted for local context to help national managers and country staff understand and include supportive supervision methodologies as part of routine immunization management and includes a case study from Andhra Pradesh, India.*

**Supportive Supervision to Improve Integrated Primary Health Care**

Paper; by Rhode J; Management Sciences for Health; NO. 2; 2006 
Paper explores common problems with supervision of PHC; briefly examines approaches to supervision of PHC and identifies the critical elements of a policy to underpin a sustainable system of support to improve the quality of PHC as well as the competence and satisfaction of staff.

Related Portal

Management of Health Services Delivery: Supportive Supervision of Staff
The portal provides a range of articles related to supportive supervision of frontline managers and for higher level managers.

Responses in Full

R.K. Sood, Epidemiologist, District AIDS Programme Officer, Dharamshala, Himachal Pradesh

I would like to share a case study of team building of staff of Integrated Counseling Testing Centres (ICTC) in reference to this query. In Kangra District of Himachal Pradesh, there are seven standalone ICTCs, which have been performing quite well and demonstrating proactive leadership and innovation, and evolved into new additional roles keeping pace with the organizational goals. I would like to address the following sub queries:

- What were the challenges related to operationalizing effective supportive supervision mechanisms for staff/workers?

  1. **Lack of Role Clarity and Ownership:**
     The front-line staff is faced with a variety of tasks in addition to their job, often there is lack of prioritization and clarity on understanding on what is needed to be done to achieve organizational goals. There is a lack of ownership of the targets allotted, and staff perceives it as burden. Hence the performance is often not directed towards the organizational goals. Further, in absence of clear vision, the work is limited to tasks for which repeated reminders are received, rather than initiative/ self-driven. Even during supervision, we limit ourselves to checklists of performance, rather than looking deeper into the reasons.

  2. **Lack of Objective Appraisal Systems:**
     Lack of accountability, leads to poor performance and vague systems of appraisal are partly responsible for this.

  3. **Inability to Comprehend Letters in Letter and Spirit:**
     Often we found that staff did not respond timely to letters, they communicated within themselves and did not call us for clarifications, in the absence of clarity, just kept the matter pending.

  4. **Inter-Staff Conflicts, Lack of Understanding of Each Other’s Perspective:**
     Team output is adversely affected by Not Me Syndrome, and whenever any team member feels that it’s not his job and other person is responsible for whatever is not done- the results are poor.

- What effective steps were taken to address the challenges?
1. **Ownership and Clarity**

We conducted an organizational development workshop for the staff. This consisted of brainstorming on the roles and relevance to organizational goal. This self-clarification of chain of tasks to be performed at the ICTC level helped give a macro over-view of program responsibilities to the counselors and the Laboratory Technician's – providing information as a basis for seeking shared responsibility and interchangeable co-working.

This was followed by group work on responsibilities and problems. This session was very evocative in naming the issues that had been lying under the surface, both at level of technical specialization (counsellors vs Laboratory Technicians) as well as inter-personal differences and multiple realities and took almost two hours. The facilitators supported in the plenary, a process of 'naming without shaming' which led to a healthy dealing with various existing perceptions, assumptions and consequent positions. This helped team members to air their fears and concerns and also take responsibility for dealing with them.

This eventually led to a participatory plan, and two of the good centers developed a checklist of tasks and displayed it in their center. We rarely need to send reminders to these centers. In subsequent reviews, the presentation of achievements v/s self-committed targets was done with review by peers. However, other areas where results have not been sustained as well - staff needs to be given repeated group learning opportunities and with proper facilitation, can address the underlying issues. A copy of the report is available here - ftp://ftp.solutionexchange.net.in/public/wes/cr/res10081201.pdf

2. **Objective Appraisal Systems:**

We graded each item into what exactly would constitute Ranking A, Ranking B/ C/ D and shared the same with all staff, so that they could plan their performance accordingly. Initially grace points were given to poor performers, at time of introducing the system, but it enabled self-appraisal and accountability with transparency.

3. **Hand Holding to Support What is Expected and How To Do It:**

On telephonic follow-up with the staff, it was found that they did not understand how to implement the directions, often there was low motivation level. We discussed one-to-one with them, as weak team members were hesitant to ask in front of peers in meetings. The tasks were completed after the personalized calls. Follow up, and individualized hand holding is crucial part of supervision. Often staff was not comfortable with creating MS excel sheets - we created and sent templates for facilitating the job. Initially we even created email ids for the teams which were less computer friendly.

4. **Conflict Management:**

Conflict Management is a continuous process - Encouraging communication, and responsible conduct, as well as shared responsibility is. However there are individual personality traits and individual capacity levels which have to be dealt on case to case basis.

I would like to suggest Organization Development specialist Mr. Rajeev Ahal as expert on the issues. His contact details are in the report shared above.

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**Brijendra Singh**, Ex. General Manager, Public Sector, SIPSA, Retired Director Family Welfare, Uttar Pradesh
Supervisory structure in primary health care is non-functional due to lack of institutional vision, role clarity, lack of purpose, skills and capacity of supervision and absence of conducive environment. Most supervisory posts are created as part of career promotion without blueprint of changed responsibility. As a result, supervisors continue to perform duties of subordinates in a competitive environment without attaining attitude, skills and stature of motivational leaders and responding to grass root workers need for support and direction. Higher up superior tiers are themselves ignorant about need to inculcate and utilize supervisors towards improving access and quality issues related to health care services and responding to community needs of health care. There is no chain of command and entire system is based on generating service reports not reflecting ground realities.

Under USAID funded IFPS project phase I (1992-2004) in Uttar Pradesh, measures were undertaken to improve supportive supervision in project interventions of clinical training and institutional up-gradation projects with inputs on capacity building of supervisors, support for field visits, on site validation of skills and availability of quality services, improved coordination of available workforce and improved local problem solving. It worked in the short run but in absence of an integrated institutional mechanism, rapidly expanding new focus areas and campaign approach for initiatives like Pulse Polio Immunization, could not be integrated into institutional memory and supportive supervision remained a potential and an opportunity to be explored in future.

Role clarity, institutional mechanism for supervision, will help to improve quality of care in pragmatic manner, mechanism to continuously find gaps and weakness creeping in workforce, information and monitoring system proving feedback and analyzing impact of supervisory system and documentation of successes and failures will be the way forward.

S.K. Chaturvedi; Former Unicef Representative for NE/NW states

The goal of supportive supervision is to promote efficient, effective, and equitable health care. Checklists help organize the work of supervisors to make it regular and reliable. Supervisees find this objective process motivating, because it helps them identify and address the highest-priority problems. They know what is expected of them and when they have met those expectations.

One of the problems that is commonly encountered is that the supervisor has to provide support for various vertical programs. The supervisor himself/herself may be equipped for one or two such programs. Other problems constantly seen are lack of guidance, erratic and irregular visits, depending more on the availability of transport than on any regular schedule.

Developing clear cut guidelines and checklists and training the supervisors for use of these can be a useful. This will help:

- Supervisors organize their work;
- Focus on the critical inputs and processes required to deliver the essential PHC services;
- Provide basic information about each clinical service to enable objective review of all the required elements;
- Summarize, for review with staff, important aspects of clinic administration, financial management, staff motivation and performance, and the usefulness of the particular information system used for collecting routine data in the facility;
- Assess the extent of and actively encourage community involvement in clinic activities;
- Appointment of a single generalist supervisor to oversee the work of each facility. Facility staff know the one person to whom they are accountable and who carries their concerns to higher levels;
- Regular scheduled visits with adequate time to cover the facility’s PHC functions. A fixed and reliable schedule of visits is essential to enable facility staff to plan their work and to interact with the supervisor during her visits;
- Reliable transport, either dedicated to supervisors or through preferred allocation of district vehicles in accordance with the supervisory schedule;
- An assured mechanism of information sharing with higher level functionaries;
- Authority to mobilize support to address high priority problems.

**Deepika Anand, Independent Consultant, New Delhi**

Nice query. Are there any examples of supportive supervision by supervisors or CDPO’s under the ICDS programme?. It would be interesting to know if members can share studies or experiences on what do supervisors or CDPOS focus on during their supervisory visits?.

Thanks in advance!

**Ravishwar Sinha, Independent Consultant, New Delhi**

Thank you for the compact and lucid response. There is no doubt that this is the vital and mostly the weakest link. The work design has very unclear guidelines and needs improvement.

Supervision of quality of supervisor’s inputs is essential and a gradation within the program with inbuilt recognition is required.

**Shubhada Kanani; NETNAA (Network for Nutrition Awareness and Advocacy); Former Professor at Department of Foods and Nutrition; M.S. University of Baroda, Vadodara Gujarat**

Yes, supervision is one of the weakest link compromising quality of health-nutrition and other services. I suggest that a time-activity pattern audit may be done in action research /rapid appraisal surveys to assess how much time of supervisors goes in which activity - and the results will be enlightening!

For example, we asked supervisors of ICDS in our district to fill up a time and activity log for a month and compiled the data. Assuming some errors and inaccurate reporting, the trends were very clear - admin work /records/ reports, review meetings/other meetings and other tasks (not serving the purpose of ICDS) took up a bulk of the time; and community outreach was negligible (two slides from a presentation made by me at an ILSI conference last year is available here to illustrate this). Yes, we know this from field experience and anecdotal information, but documenting hard data and facts tells the story more effectively and can be good advocacy tool.

Secondly, at a workshop organized by me and my colleague Dr. H. Gandhi in 2010-11 in Food and Nutrition Department, M.S University only for supervisors - we gave them several tools to enhance the quality of their supervision (in Gujarati); explained the tools (eg supervision checklist when they go to AWC or for field visits; how to more effectively conduct seja (cluster) meetings and so on). No new task was added; this was simply to make their job more effective. Their
CDPOs endorsed these tools - they too were present. But, as is common experience for many of us, these tools were rarely used; and if and when used, we got no feedback despite follow up.

So the message seems to be: Unless the government seriously wants to improve quality of supervision, monitoring and implementation, and integrates into its system some of the 'good practices' known to work from good operations research studies or large scale projects; and follows up with objective evaluations to decide what it wants to keep... chances of lasting change are dim.

Anil Kumar Sukumaran; Independent Consultant; New Delhi

Supportive Supervision is a practice worth discussing; the query was initiated on 10th August and two more days are left. However, I find only few responses. It shows the severity of the practical aspect of Supportive Supervision. It clearly infers that this is limited to Capacity Building workshops.

My experience with WCD and Health in EAG states reveal:

- The coordinating departments working on MDGs still work using the term ‘Supervision’ which is done as policing with authoritative roles. The new changes are hardly imbibed;
- Majority of CMOs, BMOs, DPOs and CDPOs still believe/ practice punitive methods for irregularities;
- Short comings are addressed with warnings, threats rather than Corrective Action (emphasizes root cause analysis) and Preventive Action;
- Supportive Supervision as ‘Good Practice’ emphasizes documentation. However in practice, CMHO/ DPO visits the field but their field notes are mostly done by subordinates who scribbles something for name sake to complete the formality of ‘documentation’;
- Apart from this, I find that most of the current ICDS Supervisors are promoted AWWs who have least spirit of learning 'good practices' and/or 50% are awaiting trainings.

Supportive Supervision is important that it need to be practiced right from Central/State ministry departments to Village-level workers. Therefore, this should be practiced by all Administrative Officers (IAS, IPS etc) to be followed by subordinates. Lastly, various training centres like ANM/Nursing Training Centres, MLTCs, Administrative Training Colleges should inculcate Supportive Supervision in their syllabi. ‘Old practices die hard’ – one should have mock sessions to enact Supportive Supervision.

Supportive Supervision empowers the team members and builds confidence to achieve common goal; it is a practice of empowering fellow colleagues with on-site correction, necessary education/training along with an emphasis on a system of feedback, suggestions for improvement to track progress against timeline.

Krishnamurthy, Sukshema project, Karnataka Health Promotion Trust, Bangalore

I congratulate UNICEF for initiating a very important discussion in relation to supportive supervision, an area that we all know can make a difference in a team’s performance and thereby on the quality of care offered, yet this is the area that is often not recognised enough or not invested adequately for a number of reasons. It is more relevant to discuss this in the context of the scale-up of interventions that we have in our country as costs and the implementation challenges do come across as limiting factors.
NRHM’s District Quality Assurance (DQA) was a good initiative to address issues related to quality of care in the facilities. Some initial evaluations in certain states including Karnataka (http://kshsrc.org/quality-assurance-for-rch-services-the-karnataka-experience/) have shown positive changes in certain inputs and some process indicators, but not satisfactory in changes related to outcome indicators. The report concludes that there is a need to augment supportive supervision in order to change behaviours and practices that directly affect outcome indicators. The realization of this fact and efforts by the Government of Karnataka (GoK) to bridge the quality gaps is commendable. Supporting ASHAs with ASHA mentors and involving medical colleges to improve Routine Immunization in the districts are other examples.

As a part of Sukshema project, we undertook assessments to understand the quality of maternal and neonatal services in northern Karnataka. The Sukshema Project is working in 8 districts of northern Karnataka on maternal and neonatal health, within the framework of the NRHM. The quality assessment revealed that knowledge levels among providers across facilities were satisfactory, but the skills and practices pertaining to critical MNCH services were inadequate (http://www.khpt.org/sukshema.html). We were keen on understanding the mechanisms for improving quality and through our interactions with providers and program officers, identified that one time trainings need to be followed up with supportive supervision and mentorship; there was a need to create more opportunities for hands on experience and a need to simultaneously address systems issues alongside clinical competencies, etc.

For this to materialize in a systematic way, the following aspects have to be considered:

- “Quality of care” needs critical attention, if we have to make a difference in outcome / impact level indicators. It is worthwhile in investing in a supervisory cadre that is completely dedicated to the cause of quality. Currently, the DQA responsibilities are entrusted to the program officers as an additional responsibility and may not get the focus that it should need.
- These supervisors needs to stay focused on a set of facilities / supervisees that are manageable and realistic. What makes supervision work is the rapport between the supervisor and supervisee and this rapport builds over few visits and through high quality interactions. Currently the ASHA mentor has a very high number of ASHAs to manage and this ratio poses a challenge.
- Specific to the context of ASHAs or AWWs that are high in number and offer unique challenges to supervision, research and demonstrations in use of technology for effective supervision should be considered.
- The supervisors need to focus on a package of services that is critical and can influence mortality indicators. This offers gains in the long run and optimizes costs incurred.
- The supervisors need to be provided with checklists and tools to stay focus on the critical package. And the supervision itself is not complete without provision of mentorship to the staff around the gaps identified. The supervisory visit should accommodate time for adequate mentorship.
- Specific to addressing clinical competencies (as in MNCH care), the supervisor should have a strong clinical background so as to be able to provide on the job training during the visits. Hence the supervisor should continue to be in touch with clinical practice and the system should create opportunities for these supervisors to balance field visits and clinical practice.

The providers’ skills strengthening should be complemented with timely response to addressing systems issues (supply chain, referrals systems, etc) from district officials and hence the supervisor should liaise between facilities and program officers.
Lalit Mohan Sharma, Institute of Rural Research and Development, Gurgaon

We at Institute of Rural Research and Development (an initiative of SM Sehgal Foundation) are working actively in District of Mewat, Haryana since year 2001. The villagers here did not have good opinion about the immunization program resulting in very poor immunization results. Few community meetings and follow-ups at household level by our field team changed the situation to 100% coverage. NGO supporting the work of health worker particularly in the field of maternal and child health brings wonderful results. I feel the main reasons of this is the trust with the community and zeal to work for the society, which is not that effective in case of the public system.

Similarly, in the field of sanitation we started with the training of defunct Village Health and Sanitation Committee (VHSC) and linking these with the larger communities. Women of the villages felt empowered and started taking interest in the development of village particularly on sanitation as they suffer the most. Now there are many villages where all the domestic waste water is disposed safely at household or cluster levels and people use latrines. Many more are on the way.

I feel trust building, empowerment and participation is the key to bring change and this is lacking in the public system. Whereas NGOs are capable of doing this to a large extent. So if NGOs supplement this need of public system, change is bound to come. But for this, the public system also need to realize the need and start working together.

Shiv Chandra Mathur, Public Health and Education Specialist, EU-Institution and Technical Support, New Delhi

Lady Supervisors are directly responsible to supervise the Anganwadi Centres; CDPO's in turn supervise the work of Lady Supervisors. On the basis of my observations in the state of Rajasthan, I can share that a fairly good number of CDPO come to the Women and Child Department on deputation. Eventually their mindset is not sensitively oriented to the type of support which ICDS machinery requires. More often their bureaucratic approach sends the signals of indifference to the Supervisors and Anganwadi workers. Exceptions are always there and individual's attitude does matters.

My personal experience as ICDS Consultant from Medical College for a division convinced me that supervisory personnel devotes most of their time in material management at the cost of educating and persuading the AWW in weighing the children, and counseling the mothers. If Women and Child Department could handle this challenge at cutting-edge, the prevalence of malnutrition would have been substantially low then what it is.

Ashok Kumar Singh, Vistaar Project, Intrahealth International, Lucknow, Uttar Pradesh

I agree with Shubhada Kanani but would like add few more details and experiences/evidences generated in this context. First of all I would like to share a poster on "Supportive Supervision At Scale - Experiences from Uttar Pradesh" which was presented by us in March 2010 in Bangkok. Available here - ftp://ftp.solutionexchange.net.in/public/mch/cr/res10081204.jpg. There are key elements of supportive supervision which needs to be addressed adequately in the process of operationalizing supportive supervision -
1. Clear job expectation among workers (Expected role Vs actual role)
2. Appropriate knowledge and skills (Gaps between existing and required skills/knowledge)
3. Appropriate physical environment and tools (quality and regularity in supplies, job aids/tools)
4. Immediate performance feedback mechanism (Onsite support, regular monitoring & feedback, problem solving and action planning)
5. Motivation through reward and recognition (Clear performance factors/indicators and provision for financial/non-financial reward and recognition)

Results of supportive supervision are very encouraging. Few highlights of SS interventions are as follows –

- Review of records by supervisors gone up from 22% to 90%.
- Attendance of FLWs in monthly meeting meetings increased by 7%.
- Grey area of the program like joint home visit by AWW and supervisor has also significantly increase from 12% to 75%.
- Demonstration of counseling skills by supervisor during home visit increased from 37% to 89%.
- Majority of FLWs considered that their supervisor has now changed from “Dhamki Devi” to “Shanti Devi”.

Supervision and proper monitoring are the areas which need to addressed at scale to bring qualitative and quantitative change of large program like ICDS and NRHM.

**Amungwa Athanasius Nche, Health and Development Certified Training Professional, Cameroon**

I thank you wholeheartedly for the rich theory on supportive supervision. I wish to share with the group an experience we had in Cameroon with supportive supervision within the framework of family planning and reproductive health, it was called facilitative supervision which I believe should be synonymous with supportive supervision. All we did had to fit within the COPE model, that is Client-Oriented- Provider-Efficient Services. Family planning service delivery actually started full scale in Cameroon in 1990 and operated within the USAID package. This package demanded that a team of National Trainers be recruited and trained and their capacities built in infection prevention, contraceptive technology, facilitative supervision, training skills, monitoring and evaluation and logistics management. Thus these polyvalent, multi-tasked team would go to the field to supervise service providers. They themselves trained to provide performance and technical support during their work and identify performance gaps that need training solutions and plan for refreshers to close such gaps. A quality assurance initiative was integrated in the program and trainers as supervisors use monitoring and evaluation tools to collect data which is later analyzed to come out with best practice health units to win the Circlel Awards for excellent Family Practice. This award promoted health competition among the health centres providing family planning. The trainers were kept motivated by short courses, in and out of the country within the JHPIEGO career development ladder as far as reproductive health is concerned. On the other hand service providers also had frequent refreshers with some financial benefits.

During the period that this lasted, from 1992-2002, quality family planning was well assured to the population with unmet needs and the service providers became more motivated at their sites. The problem with the program was that after USAID could no longer fund it, the tempo slowed down or even stopped in some areas.
Now the G8 has come in to re-launch family planning in Cameroon and the NGO SAILD won the contract but it would be only after a long term that the outcomes could be measured to those realized with USAID funds.

There is therefore a budgetary problem nationally for the nation to be able to provide family planning within the COPE framework as this would demand a lot of money to keep providers motivated enough to be able to provide quality outcomes. The training and supervision components coupled with appropriate resource allocations and regular supervision keep performance in top form and this is what kept our program alive while it lasted.

_Pankaj Kumar Singh; District Health Society; Siwan, Bihar_

I am the new member of group and first time writing with a lot of hesitation. Novice, so do not know how to write but hope you will extend your support. It is a good query to discuss. I have been working under NRHM at district level for last six years and since there are several programs under NRHM are running with close support of ICDS, I am in good position to discuss the existing supervisory practices in the ICDS at block and district levels. There are two supervisory personnel CDPOs and Lady Supervisors at block level and DPO at district level who monitor the implementation and ongoing activities in the ICDS programme.

**Geographical Area distribution among supervisory personnel** -

<table>
<thead>
<tr>
<th>Role</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lady Supervisors</td>
<td>One at every 25 AWCs</td>
</tr>
<tr>
<td>CDPOs</td>
<td>Entire Block</td>
</tr>
<tr>
<td>DPO</td>
<td>Entire District</td>
</tr>
</tbody>
</table>

**Role and Responsibilities of supervisory personnel** -

- **CDPOs** - A CDPO is an overall in charge of an ICDS Project and is responsible for planning and implementation of the Project. A CDPO is supported by a team of 4-5 Lady Supervisors who guide and supervise AWWs.
- **Lady Supervisors** - A Lady Supervisor has the responsibility of supervising 20, 25 and 17 Anganwadi Workers in rural, urban and tribal projects respectively. A Supervisor guides an AWW in planning and organizing delivery of ICDS services at AWC and also gives on the spot guidance and training as and when required.

**Supervisory/Monitorable Issues**

**Location** -

- Is easily accessible?
- Is away from congested or traffic areas?
- Does not have ponds or rivers or other dangerous places nearby?
- Is near the locality of weaker sections of the society?

**Building** -

- Is there well ventilated room to accommodate 40 children for sitting as well as indoor activities?
- Is there space for storage of play equipment & material?
- Is there space for cooking and storage of kitchen equipment & food?
- Is there arrangement for safe drinking water supply and toilet facilities?
- Is there sufficient open space for outdoor activities?
Equipment -
- Availability of general use items - small mat, close shelf, wooden rack, chair, table, weighing machine, first aid box, national flag, files, registers, records, immunization card etc.?
- Availability of kitchen equipment - tumblers, plates, spoon, vessels, stove, kerosene etc.?
- Availability of Bathroom equipment - Buckets, mug, soap, brush, broom, etc.?
- Availability of Indoor play equipment - counting frame, paint, brush, colour chalk etc.?

Supplies and Material
- Availability of playing materials, preschool education kit, medicine kit etc.

Apart from these supervisor needs to monitor activities and performance of AWC that includes following -
- Timing of AWC
- Open & close time
- Daily Attendance
- Cleaning of the Anganwadi center
- Supply of drinking water
- Making arrangements for PSE activities
- Cooking supplementary food or keeping the food ready for distribution

Health Issues -
- Health check-up of children and mothers
- Immunization (as per the schedule)
- Weighing children and Growth Monitoring
- Distribution of Vitamin A and Iron Folic Acid tablets
- Organizing mother’s meeting
- Family Survey Register

And so on......

The ICDS supervisor must monitor the above mentioned indicators during their field visit but big question is - "do they do?" - The answer is almost No.

Suggestions -
- Need to supervise the activities of supervisors as well;
- Need to develop reporting formats for all indicators;
- Make it compulsory to carry these formats during their visit and fill it with full sincerity;
- Analyze the reports and take curative (not punitive) steps;
- Provide protection to supervisors from local politicians as well PRI representatives;
- Fair monitoring without biasness;
- Control/prevent corruption.

Karan Singh Sagar, Maternal and Child Health Integrated Program (MCHIP), New Delhi

I am sharing the experience that MCHIP project has in implementing a slightly different strategy from the regular one to one supervision, but based on premise of supportive supervision. This strategy is primarily for providing supportive supervision at systems level, wherein we look at
critical elements of program planning, implementation and monitoring for any thematic area at district and sub-district level. The exercise identifies gaps, promotes on site correction, capacity building and regular follow up to ensure that the system improves and delivers what it intends to.

We have tried this for 2 thematic areas (immunization and newborn health) in our focus states of UP and Jharkhand. I am sharing an example from immunization. Please access the document for more details - "RAPID" Implementation - Using a Supportive Supervision Approach at Scale in India - [ftp://ftp.solutionexchange.net.in/public/mch/cr/res10081202.pdf](ftp://ftp.solutionexchange.net.in/public/mch/cr/res10081202.pdf) (215 kb)

**Giridhara R Babu, Indian Institute of Public Health, PHFI, Hyderabad**

I would like to share an article we published in 2011 on trying to quantify the role of supportive supervision in improving Immunization Coverage. It is not methodologically perfect and we look forward to improve study design issues in future studies.

We concluded in the paper that supportive supervision is often consistent missing link in efficient implementation of public health programs in India. Our paper attempted to demonstrate that supportive supervision has an independent role and might be a significant contributor for overall immunization program strengthening. Despite limitations, our paper contributes to the fact that supportive supervision not only improves immunization coverage immediately but also serves as an efficient tool to strengthen the local health system to deliver services.


**K. Suresh, Public (Child) Health Consultant, New Delhi**

I have been following the discussion on Supportive Supervision since it started. I believe the questions were to share experiences of supportive supervision (SS) within the health system constraints. The responses so far have been theoretical justification of SS or academic explanation of its utility or suggestions as to how to do. Other set of responses like that of PHFI Hyderabad and MCHIP brought out the special efforts done for a short duration.

Indian Immunization history (since 1967 as I know) have many such trials (though very few documented) or exceptional excellence, which did become a part of the existing health system. Even in the present health system in every district one can identify such excellent worker, work culture (call any term you want). Exceptions cannot be cloned.

I am sure even if each of the Public Health teaching institute makes an effort (planning, implementation, SS outcome monitoring) to make SS a part of Health system approach and demonstrates success as assessed by some independent agency will pave way for the system to buy the idea.

Research papers claiming success over a short duration or the islands of excellence (one village, one SC etc) are not going to do much good to the massive programming needs of the health system. The need is to demonstrate the success in at least one full district and sustenance of the same after the supporting agency withdraws for a reasonable time period is the need of the time.
Nirmal Kumar Pradhan, PATH - Sure Start Project, Lucknow, Uttar Pradesh

I would like to share the experience of supportive supervision/mentoring for Accredited Social Health Activists (ASHA), done under the Sure Start project of PATH in Uttar Pradesh. Sure Start reached 7450 ASHAs, 2811 Village Health and Sanitation Committees (VHSC) and more than 23 million population in seven intervention districts; Baharaich, Balarampur, Barabanki, Basti, Gorakhpur, Hardoi and Raebareli of Uttar Pradesh. The objectives of the project were:

- To increase individual, household, and community actions that directly and indirectly improve maternal and newborn health (MNH)
- To enhance systems and institutional capabilities for sustained improvement in maternal and newborn care and health status

Now the project is being implemented in Sant Kabir Nagar and Raebareli with the objective of sharing knowledge and experiences with the government health department and other stakeholders.

As we all know, one of the core strategies of NRHM includes activating and empowering a community based cadre of ASHAs. ASHAs have become the key link between the health department and the community. Promoting behavior change is one of her key roles. As a consequence of this it is important to develop the ASHAs’ interpersonal and persuasive communication skills so that they are better able to conduct home visits and group meetings in order to improve the health seeking behavior of the community. Besides being trained intensively under NRHM for effective interpersonal communication and behavior, supportive supervision/mentoring of ASHAs were identified as an important component, which needed to be addressed.

Sure Start’s focus was to engage in ASHA mentoring and VHSC strengthening. There are two phases to the ASHA mentoring work that has been accomplished (i) 2007 – 2011 and (ii) 2011 till date. During the first phase from 2007 till end 2010, Sure Start deployed NGO supervisors of its sub-consortia partners at block level. The supervisors at the Block level had approximately twenty ASHAs in different gram panchayats. The supervisor had to do, one on one counseling with the ASHA, teaching her appropriate use of IEC tools (flip books, flip cards and games), storytelling techniques, counseling for birth preparedness and danger sign recognition, support with village level planning at the VHSC Meetings and help with maintaining systematic information as well as record keeping. The supervisors helped ASHAs maintain the Village Health Indicator Register. They also supported the ASHAs in availing health care services at block level, while accompanying a family for institutional delivery. Initially, the ASHA shadowed the Supervisor as he or she facilitated mother groups’ meetings or home visits. As the ASHAs skills and capacities improved, the mothers group meetings were gradually left completely to her. This process brought about a gradual yet steady improvement in recognizing and removing bottlenecks to the ASHAs work and provided the needed mentoring support to her. To do the mentoring of ASHAs, NGO supervisors were trained on the mentoring skills in various in-house trainings.

During the current phase from 2011 till date, PATH is engaged with the district health department of Sant Kabir Nagar district in Uttar Pradesh, to train ANMs on the ASHA mentoring training curriculum. The first phase of the trainings has been done, in which 184 ANMs were trained in eight batches till July 2012. A core group of 10 trainers who would function as a sustainable resource pool for the UP Government were identified and trained. The training experts from State Institute for Health and Family Welfare, Lucknow visited and participated in one batch of the trainings. They found the training curriculum effective for training ANM/ASHA supervisors on mentoring ASHAs.
During this endeavor a systematic six days training curriculum to be imparted in two phases of three days each has been developed for ANMs/ASHA supervisors on ASHA mentoring. The goal of the curriculum is to equip ANMs/ASHA supervisors with the requisite capacity for mentoring ASHAs to effectively deliver maternal and newborn health information to the community. The objectives of the training are to develop the capacity of the participants to -

1) Define roles and responsibilities of ANMs and ASHAs for better coordination.
2) Understand and realize the importance of mentoring in improving ASHA performance to conduct effective home visits and mothers’ group meetings.
3) Develop a detailed mentoring plan for the ASHAs they supervise.
4) Understand roles and responsibilities of VHSCs in facilitating village health planning.
5) Gain a clear understanding of information that ASHAs need to impart to improve maternal and newborn health.
6) Effectively utilize mentoring skills and tools for enhancing ASHAs efficiency.

The curriculum can be used at scale, in any part of the country with requisite modifications according to regional needs. The training curriculum provides scope for experiential learning and will enable ANMs overcome their prejudices as well as problems they face in applying their knowledge in the field. It aims at developing the knowledge, awareness and skills of ANMs particularly regarding importance of mentoring ASHAs, group meetings, home visits, capturing data for review and planning and developing a mentoring plan for ASHAs. Evidence based approaches have been incorporated in the curriculum and it has been prepared keeping in mind that ANMs will be mentoring ASHAs for their personal and professional growth. It is hoped that the curriculum on ASHA mentoring will complement the efforts made under NRHM and that it can be used on a large scale. An ASHA tool-kit has also been developed to enable ASHAs conduct effective mothers groups meetings.

**Abrar Ahmad Khan, The Vistaar Project, Intrahealth International Inc., New Delhi**

I am sharing experiences of institutionalizing supportive supervision though our work in the Vistaar Project.

The USAID-supported Vistaar Project (2006-2012) works with the Government of India and State Governments of Uttar Pradesh and Jharkhand to improve maternal, newborn and child health and nutrition by:

- Providing strategic technical assistance
- Generating needed evidence about effective, efficient and expandable MNCHN approaches
- Advocating for scale-up of successful MNCHN approaches

Improving health and nutrition outcomes are very dependent on performance of frontline workers including ANMs, AWWs and ASHAs. However, the systems that support them are often weak. Programs often focus on one-time training but other performance factors such as supportive supervision, clear performance expectations, motivation and recognition are neglected. Supervisors play a key role in helping frontline workers perform to expected standards and ensure better quality of services.

Based on systematic performance needs assessment, the Vistaar Project with ownership and support of the state and district level Health and ICDS systems initiated interventions for capacity building of frontline workers and strengthening systems for supervision. The project provided Technical Assistance in 8 districts of UP and 14 districts of Jharkhand. The key TA areas where
supportive supervision was strengthened include expanding the reach and number of services at Village Health and Nutrition Days, improving home visits and counselling for newborn care and nutrition by ASHAs/AWWs and improving skilled attendance at birth (Jharkhand only).

The intervention design for strengthening supportive supervision included a multi-pronged approach consisting of capacity building of supervisors in knowledge, skills and attitudes for effective supervision, supervisors training for technical competence in critical areas of work to support frontline workers and system level measures to facilitate more effective supervision.

For example, in the case of Medical Officers supervising Skilled Birth Attendants, three day training was conducted to cover -
- Job tasks and performance expectations from SBAs
- Role and responsibilities of supervisors as mandated in the government guidelines
- Plotting of partograph to recognize danger signs early and make timely referrals, active management of third stage of labor, Magnesium Sulphate injection for managing eclampsia etc.
- Positive attitude and characteristics of supervisors, what to do and what not to do in supportive supervision
- Communication skills, including listening, asking questions, paraphrasing, providing positive and corrective feedback
- Use of supervisor checklists for making the process of supervision more in-depth and systematic
- Problem solving skills and preparing action plans with frontline workers and
- Continuity between supervisory field visits and monthly meetings and using monthly meetings as additional platforms for supervisory guidance.

Government orders were issued to strengthen the practice of supervision encouraging supervisors to do the following –
- Visit trained SBAs at least once every month
- Review SBA performance using the supervisor checklist to know what to observe, what to ask and which records to review.
- Appreciate what is working well to motivate SBAs to improve performance.
- Identify problems and assist SBAs in solving problems. Work with SBAs to prepare a plan for action for areas that need improvement and follow up on the action taken in subsequent visits.
- In case the problem needs attention and action at a higher level for example, problems related to equipment and supplies ensure it is conveyed to the appropriate level.
- Based on findings using the checklist, provide on-the-job mentoring and coaching to reinforce SBA knowledge and skills.
- Discuss common problems at monthly meetings.
- To the extent possible make use of supervisory observations and data to guide activities for program improvements. Also consolidate data from the checklists to observe trends over time.
- Institute recognition and non-financial reward schemes for motivating good performers.

On similar lines, capacity building and other facilitating measures were also initiated to strengthen supervision in ICDS by Mukhya Sewikas and for strengthening the skills of ANMs/LHVs to offer support and guidance to ASHAs.

End line evaluation of the project conducted by external agencies has shown some increase in the frequency of interaction between the supervisors and supervisees. Frontline workers reported that the quality of interactions is more supportive, encouraging and oriented towards problem solving.
Challenges have been –

- High number of vacancies in some districts for supervisory positions in ICDS is very high, which makes regular supervisory visits difficult.
- Mobility support for supervisory visits is low and supervisory visits could entail out of pocket expenses. Advocacy with the Jharkhand government resulted in enhanced mobility funds being requested in the PIP. To address mobility issues, reorganization and clustering of sectors overseen by a supervisor also resulted in reduced travel time for the supervisor who would otherwise tend to neglect far flung sectors.

Furthermore for sustainability of systems, improvement at district level ownership and support at state and national level is essential. The Project achieved this by providing technical assistance for block, district and state level review of compiled data. Thus the observations from supervisory visits are used not just for providing feedback to individual workers but program review at higher levels. Because the data from supervisory visits has uses at every level of the health system, the Project has reason to conclude that systematic supervisory support has been institutionalized in project-supported districts.

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**Leila Caleb Varkey**, Independent Public Health Researcher

A useful recent open access publication would be helpful. **Meeting the Health Information Needs of Health Workers: What Have We Learned?**

http://www.tandfonline.com/doi/abs/10.1080/10810730.2012.666626

The issue presents three studies of health information needs in India, Senegal, and Malawi that demonstrate these information challenges, provide additional insight, and describe innovative strategies to improve knowledge and information sharing. Results confirm that health workers' information needs differ on the basis of the level of the health system in which a health worker is located, regardless of country or cultural context.

My advice from long term work in this area (Manual for Supervisors of ANMs in ANE OR/TA Project and QA Manual for PHC CHC in FRONTIERS/UNFPA projects of Population Council 2000-2005 and various others) is to **follow basic management principles.** Authority, autonomy and accountability must be balanced - you can't make someone a supervisor but give them no autonomy for action nor accountability for the work of their subordinates.

Hence my work on Supervision is with that long term framework in mind where the:

1. Promotion is based on merit - i.e. the worker looks up to the Supervisor as an example.
2. The career path is well defined and greater autonomy is permitted - i.e. the same professional category supervisor is essential. Doctors supervising all other Public Health workers is not a good practice, they can be good managers and mentors but must get formal training in supervision too if that is to be their role.
3. Build in accountability of the work - Supervision is a two way process, the workers must see their supervisors as accountable also for their work.

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**Nandita Kapadia-Kundu**, John Hopkins University/Center for Communication

I would like to add to **Leila's** comments. I am enclosing the India paper of the study she's referred to - **Understanding Health Information Needs and Gaps in the Health Care**
We learnt a few things while understanding the health information needs of health officials and workers across the health system (state, district, block, sub-centre, village) in Lucknow district, UP. We learnt that the **most important source of information is the immediate supervisor**. The information chain goes from state to village, but the barriers begin district level downwards (refer paper). The need at the grassroots is for "practical" information which can aid implementation. The need at the block level is for "government guidelines" which often reach too late. The district officials were more focused on "coverage" information.

So the question remains, how to fulfill diverse and dynamic (constantly changing) information needs of different health care workers and officials within the health system? The paper outlines five criteria for "actionable information". Actionable information ties into the concept of supportive supervision in assisting in problem solving, on field demonstration and training, assistance in planning etc. Timeliness of information is also a key factor and the study indicated that programme implementation was often delayed or incomplete due to a break in the information flow.

The main lesson that the paper provides is that ICTs can be a good tool for transmitting information but at the end of the day, it will be worthwhile only if the information is "actionable" i.e. relevant, simple, timely and of adequate quantity (not too much).

**Shyam Singhal, WHO-India, NPSP, Madhya Pradesh**

Thanks for raising a very pertinent query. I am sharing my experiences regarding supportive supervision in the state of Bihar, UP & Madhya Pradesh.

While supportive supervision is undoubtedly an improvement on the traditional top-down colonial model, even this version will not succeed to any great extent until there is a better understanding of the human interactions involved in supervision\(^1\).

Supportive supervision improves the services by focusing on staff needs. The staff needs might be related to their competency, commitment and logistics support. Needs related to competency can be fulfill by various kind of trainings. Similarly, adequate logistics support can be provided by proper maintenance of supply chain. **But the needs related to commitment are most difficult to deal with.** Without addressing this need, even the most competent staff, with all resources, will not be able to perform well. On the other hand if there is commitment for the work the staff itself may takes the initiatives to learn the skills and manage within available resources.

In a Cochrane systematic review while studying the effects of managerial supervision of health workers to improve the quality of primary health care in low- and middle-income countries authors concluded that "It is uncertain whether supervision has a substantive, positive effect on the quality of primary health care in low- and middle-income countries. The long term effectiveness of supervision is unknown\(^2\)."

If we look around, plenty of evidences are there showing that despite repeated trainings and hands on support most of the field staff is still not performing well in poor performing states. Just for an example, while organizing immunization sessions even senior ANMs are still not following the basic guidelines regarding tracking of mother and children, duelist preparations, infection prevention and waste disposal etc. Support by external agencies brings the
improvement but it is unsustainable. The wrongful practices return after withdrawal of the support.

Therefore, staff motivation to enhance commitment is the key component of supportive supervision. "If there’s will, there’s a way". But this important factor is often overlooked at all the levels. During filed visits the focus of supervision is mostly on fault findings (not to mention the further implications of it). Similarly, during review meetings the focus remains on the output & performance indicators. Problems faced by staff are often ignored and not allowed to be discussed.

**Why supervisors are unable to motivate the staff? Why they do not want to listen to them?**

The basic problem lies in the fact that we have been conditioned to think in a hierarchal model best represented by a pyramid in which departmental head is at the top and workers are at bottom. In between there are several levels of supervisors.

![Pyramid Diagram]

In this model assumption is that everyone works for the person above them on the organizational ladder. As a result, supervisors are thought to be responsible for planning, organizing, and evaluating everything while their people are supposed to be responsive to the directives of supervisor. This way the persons at the base (workers) are supposed to do most of the work and supporting the entire system. Still the supervisors are not responsive to their need.

If we turn the same pyramid upside down so that the top managers come at the bottom, there is a powerful twist in who is responsible and who should be responsive to whom.

![Pyramid Diagram]

If worker is responsible and job of the supervisors is to be responsive, the supervisors should really work hard to provide the workers with the resources and working conditions they need to perform well. The supervisor’s job is not to do all the work himself or to sit back and wait to ‘catch them doing something wrong,’ but to roll up the sleeves and help the workers to win. If they win, everyone win³.

"The days of command and control when less stress and more perks awaited those who made it to the top are long gone. Today, the key to success is understanding that leadership isn’t about lording it over people, but serving them by helping them discover who they are and how they can
creatively contribute. That’s why the "higher” you go in the organization, the more people you have to serve. Here’s how to meet the challenge.4.

References:


Bindu Singhal, Divisional Maternal Health Consultant, UNFPA, Gwalior

Since almost two years, I am working at Gwalior division and trying to upgrade the skills of health workers by good supportive supervision services at various maternity wings of Gwalior. To my experience I realized that supportive supervision and motivational support to the health staff should go hand in hand. To exemplify this, if one is giving on-sight support and finds that abdominal pressure has been given at the time of delivery, the behavior of the staff should be changed by giving education about its hazards but at the same time praise the staff for giving injection oxytocin for active management of third stage of labor.

It is also very important to keep in mind that district officers should be sensitized regularly about the regular supply of simple but important logistic like injection Oxytocin. Otherwise at the time of Nil stocks of oxytocin the health worker will very soon forget the importance of using injection Oxytocin for active management of third stage of labor.

Thus supportive supervision can show best results if given at regular basis. Good practice of supportive supervision is praising the staff to boost morale of ANM/LHV and staff nurses, ASHAs and Anganwadi workers. This will build a good rapport of the health supervisor among the health staff.

Regular use of supportive supervision checklist help to demarcate the areas in which critical attention has to be given. For example if newborn corner of a facility is not functional and on checking the records the rate of newborn deaths is also high, corrective action can be taken easily. Senior officers shall also implement the required things immediately.

**Challenges**-

- The store rooms attached to the maternity wings are seldom opened to check the logistics. A good supervisor should always visit the stores. For example, to my wonder, many a time it is found that whole lot of labor room registers/ referral registers will be lying in plenty and on the other hand the ANM or staff nurse will be running around to make a hand-made register for entering the delivery records.
Due to mismanagement and ignorance, Skilled Birth attendants are working in places other than maternity wings.

Gynaecologists adhering to the treatments which they thought was the best and not following the Government of India norms.

Best way to overcome the challenges are to always keep regular touch with higher district officers for feedback and necessary corrective actions.

Follow up visits should be regular and focused.

Hope this useful.

Ravi Nitesh, Mission Bhartiyam, New Delhi

Supportive supervision itself is a broad subject to work that includes a scope of continuous upgradation and innovation. Supervising a process is a difficult task, however it is the most required thing for proper implementation and for making the process more effective.

There are various challenges that sometimes never comes in theoretical versions of feasibility and policy framing of supervision, but it comes during practical implementation phase and it can be associated with various factors. As per my view, these challenges can be of:

- Predictable - such as barriers from the side of staff members itself, literacy and understanding level, behavioral skills, adaptation of community culture/language/standards, inclusion of all stakeholders, groupism, individual benefits and interests etc).

- Non predictable - can be of anything where one must be able to modify/change/stop on ongoing work and can start another alternate plan).

Effective steps that can be taken to meet the challenges may include specific portion of policy framing that must attend specific location where the supervision process has to be implemented. It must say that for the same supervision of similar nature, a policy at one place may require some change from another place in view of the difference between nature, climate, culture of these places. Apart from this, experience of past implementation (evaluation based) must be included. Situation reaction training can also be a part of training and supervision for effective participation and implementation.

Suneela Garg, Maulana Azad Medical College, New Delhi

Supportive Supervision is core to get optimum functioning of any program. I have had this experience in monitoring of RTI/STI control program. This is a very challenging area and where correct information is very important and vital. Supportive supervision helps us in identifying the barriers and challenges in accomplishing the task.

The use of check list is very important and must be taught to the workers. Issues like regular supplies of logistics the problems encountered can only be elicited if supervision is not punitive. All the staff has to be sensitized to techniques of supervision and in return they have to sensitized also to supportive supervision.
Many thanks to all who contributed to this query!

If you have further information to share on this topic, please send it to Solution Exchange for the Maternal and Child Health Community in India at se-mch@solutionexchange-un.net.in with the subject heading "Re: [se-mch][se-watr] QUERY: Supportive Supervision - Good Practices. Additional Reply."

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