Implementation of Performance Support Approaches in Central America and Uganda

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LIST OF ACRONYMS

MOH	Ministry of Health
NGO	Nongovernmental Organization
NUMAT	Northern Uganda Malaria, AIDS and Tuberculosis
PMTCT	Prevention of Mother-to-Child Transmission
PS	Performance Support
UPMB	Uganda Protestant Medical Bureau

EXECUTIVE SUMMARY

The Capacity Project worked with governments and partners in Central America and Uganda to test approaches for strengthening supervision systems in the health sector, as one component of the Project's workforce performance support strengthening. These experiences demonstrate that supervision makes sense when it follows the local performance improvement processes, and when supervisors pay attention to the needs derived from local action plans to close identified performance gaps. Local health workers feel more connected to the organization; they feel that the organization is finally responsive to their needs, and their feelings of invisibility, isolation and abandonment are reduced. Supervisors feel that their visits are useful and appreciated by local staff; they feel that performance support creates a link among the different levels of the organization. All of them find themselves playing different and complementary roles of a common task: improving performance and quality of service delivery.

Evidence collected from the performance support approach test sites shows that in addition to improving adherence to good practices and performance standards, the intervention was strong enough to produce changes in the structure and behavior of the participating organizations.

The following are the most important lessons learned during the Project's eight performance support implementation experiences and that will guide future implementation.

1. Performance support helps make supervision both supportive and effective. Supervision works best when supervisors are supported to understand how they can help local teams by following the local performance improvement processes.
2. Highly bureaucratic organizations with rigid structures make the implementation of performance support more challenging. Implementers should be prepared to deal with unexpected obstacles that may emerge.
3. Learning organizations that are willing to innovate and rapidly incorporate promising practices can help to facilitate performance support implementation. Strong and dedicated leaders who serve as champions on the intervention side can expedite the implementation.
4. Selecting only one service delivery or management issue helps to focus performance support efforts. It may be difficult to address the whole supervision system or activities in an organization.
5. Framing visiting supervision as a professional development opportunity may reduce resistance to change.
6. Performance support efforts improve efficiency and effectiveness by offering managers a district-wide perspective of common issues that cannot be solved by local health teams on their own.
7. Managers implementing performance support should find an initial niche to implement the approach and defend it, keeping a low profile, avoiding direct confrontation and delaying any scale-up attempt until they have strong evidence of the benefits of performance support.

BACKGROUND

Traditional Supervision Systems

Supervision is one of the most relevant tasks in health systems management (Iles, 1997). This is because access to quality health services depends on the performance of skilled personnel (Dussault and Franceschini, 2006). Health services are not delivered by machines—rather, they are part of a system of people who take care of people. Consequently, improving the effectiveness and efficiency of health services requires continuous support and reinforcement to allow those in the frontline of service delivery to perform as expected.

In many countries, however, health workers struggle with low salaries, excessive workload and unsafe workplaces. Health workers lack proper training, recognition and rewards; thus their performance, productivity and morale usually dwindle, and job dissatisfaction is rampant. A report on Uganda's human resources for health confirmed the existence of a "combination of exhaustion, being overworked, and working without adequate facilities or equipment over time [that] diminish and eventually can destroy the wish to serve, the ability to care" (Morehouse, 2007).

Health managers commonly neglect supervision. Usually, supervisors have many responsibilities, combining service delivery and management; thus, for most of them supervision is an extra task. Since job expectations are unclear, managers may lack the knowledge, skills and tools for effective supervision. An assessment in Zimbabwe revealed that supervisors failed in helping local teams to solve problems and in following up; in this case, supervisors' performance did not meet local teams' expectations (Tavrow et al., 2002).

Supervision is included in organizational charts and budgets of most ministries of health; however, in many cases the related systems, structures or activities are not working effectively. Traditional supervision methods demand many resources for their implementation, including skilled full-time supervisors, travel allowances and vehicles (with drivers) for contacting health establishments regularly. Since resources are often limited, supervisors from ministries of health and health organizations can visit a limited number of units, usually only those more accessible to the management team, neglecting the units scattered in remote settings. Also, the number of visits to each unit over a time period is limited; in the best case scenario, health units receive only one or two visits per year. Finally, the time dedicated to each unit is insufficient, ranging from just minutes to a few hours.

The global shortage of skilled health workers also affects the availability of supervisors. Understandably, countries may prefer to use their limited number of health workers for service delivery rather than for management positions. A performance needs assessment of supervision in two Bangladesh districts found that vacancies in supervisory positions increased the number of health facilities assigned to each supervisor. Thus, supervisors decreased the number of visits and the time allocated to each health establishment (Directorate of Family Planning, Ministry of Health and Family Welfare Bangladesh, 2005).

When visits do happen, they are often performed perfunctorily; supervisors spend most of the time collecting epidemiological and administrative data, and focus their attention on the most

visible problems. There is evidence suggesting that low-quality supervision visits are even worse than no visits at all (Luoma, 2005).

Supervisors generally focus attention on what is wrong; when the local staff reports problems, supervisors and authorities usually engage in "reward for the few, blame for the many, and a search for the guilty" (Spitzer, 2007). This is a global issue; from Central America to sub-Saharan Africa, health workers feel threatened by supervisors. It is not uncommon for supervisors to misuse their authority. In Uganda, for example, one out of four interviewed health workers reported physical, verbal or emotional abuse from their supervisors (McQuide et al., 2008).

Improving Supervision

While traditional supervision systems are often problematic, there is evidence that ineffective supervision can be changed. A field experience in Kenya showed that properly trained and supported external and on-site supervisors were able to support local health teams' performance in district hospitals and health centers (Lynam and Takuom, 2005). Field experiences in business and development suggest that appropriate supervision empowers local teams to identify and face their own challenges in a continuous improvement loop (Thomsen, 2005; Galer, 2005). This contributes to aligning the entire workforce with common goals and clients' needs, improving staff motivation and satisfaction when linked to rewards, recognition and opportunities for career development. It can also lighten the burden for supervisors as trust grows and problems are brought to attention in a more timely way.

Supervision has revealed the potential for improving quality of care when its design supports the efforts of local health teams. A recent literature review found that supervision produced positive effects on staff performance, especially when self-assessment was in place (Rowe et al., 2005). Also, the use of reproductive health services increased when supportive supervision was one of the key staff-related interventions (Atherton et al., 1999). When supervision supported performance improvement the results were also positive (Lynam and Takuom, 2005; Benavides, 2003). Supportive supervision and self-assessment can reinforce communication and counseling, reflection and learning, especially among inexperienced health workers, helping them to improve their communication skills (Kim et al., 2002).

Performance Improvement and Performance Support

Performance improvement refers to an internal process in a given health facility to bridge gaps between expected and actual performance. Performance support (PS) is a broader concept; it consists of aligning district/provincial/regional/national management to support several simultaneous performance improvement processes. Therefore, performance improvement is a component of PS.

Performance improvement focuses on strengthening existing good practices and implementing needed practices that are not in place. Examples include actions to keep encouraging hand-washing practices that are already in place, and actions to improve information to clients on side-effects of contraceptive pills.

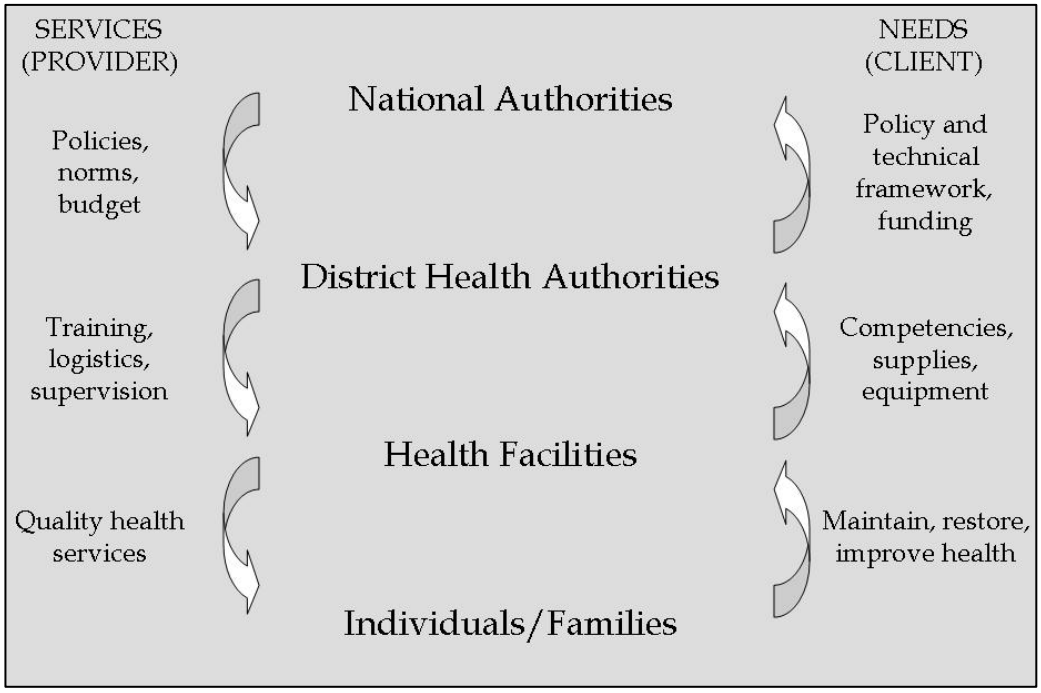
PS focuses on common issues affecting several local teams or addressing issues where the local team has weak or no control—for example, training activities for improving neonatal resuscitation, which was found to be poor in eight out of ten district health centers; and improving a district logistics system that is preventing health facilities from having required drugs.

THE CAPACITY PROJECT'S APPROACH TO SUPPORTIVE SUPERVISION

The Capacity Project designed and tested the PS approach to help local health teams improve supervision activities. The PS approach ensures that three basic human resources management rules are in place: 1) the staff know and understand the organization's expectations for their work performance; 2) staff have the competencies, tools and equipment necessary to perform their duties; and 3) staff receive continuous positive feedback about their performance (Iles, 1997). These three rules are also the basis of performance improvement. As such, they can stand alone. The PS approach goes further, however, to improve the capacity of local health teams to carry out actions to close the gap between expected and actual performance.

The PS approach proposes a realignment of the different levels of the health system to facilitate the delivery of quality health services. While performance improvement can be implemented as a stand-alone intervention for individual health facilities, PS implies systemic changes in the way the different levels of the health system interact. This becomes an arrangement of continuous client-provider interactions, where each level of the health system is simultaneously a client and a provider.

Figure 1. Client-Provider Interactions in a Health System



The Capacity Project recommends five steps for implementing PS interventions. These steps consider the extensive experience of Project partners (Bossemeyer and Necochea, 2005; IntraHealth International, 2005) and successful international experiences on improving supervision systems with similar approaches (Davids and Loveday, 2005). The Project's own experience in helping countries to carry out PS in HIV and reproductive health services has also influenced these steps.

1. **Foster agreements and commitments among stakeholders**
   The most important condition for improving supervision is that leaders from different levels of a health organization must have identified the need for its improvement. During this early stage, the organization's leaders should understand the concepts, procedures, tools and implications of PS. They should analyze and decide whether PS meets their needs and aligns with the organization's strategic directions. At this stage, it is critical to commit the organization's leadership to obligate and reallocate existing human and financial resources to implement learning experiences and their eventual scale-up. At this time, the leadership should define how it will recognize successful local staff, health teams and district experiences. Announcing recognition in advance has proven to be a powerful incentive for garnering staff commitment and enthusiasm (Benavides, 2003).
2. **Determine the expected performance of local health teams**
   Expected performance is simply implementing good practices to achieve health outcomes by delivering effective, safe and acceptable health services. The sources for selecting good practices for service delivery could be, among others, national and international clinical guidelines, management procedures, expert advice, client preferences and provider expertise. Good practices organized as performance standards state clearly *what* the local health team must do; after identifying performance standards, they should be broken down into the necessary tasks—*indicators* or *verification criteria*—needed for having the good practices in place. In other words, verification criteria state *how* local staff should perform the good practice.
3. **Assist local health teams to carry out performance improvement**
   Carrying out PS is a complex task. Organizational culture, balance of power, social mores and personal beliefs and practices condition staff performance. PS realigns the power balance inside the organization and redefines roles and goals. It empowers health workers and teams to bridge performance gaps. The role of higher levels in the organization is to support lower ones to carry out their own decisions. Authorities facilitate the process, ensuring proper regulations, a positive environment and financial support. District-level managers are ready to respond to local teams' needs, promoting coordination and providing technical support; local teams provide quality health services and are eager to incorporate innovations into their daily work.
4. **Manage change and PS efforts**
   When projects that have successfully implemented performance improvement end, too often the performance improvement process declines or disappears entirely (Marquez and Kean, 2002). To address this issue, PS implementation combines bottom-up and top-down movements. The core of the approach is improving the capacity of the local health team to bridge identified performance gaps. This is the engine for a powerful bottom-up movement; this movement needs, however, to be complemented and

supported from the district and national levels. Without this, local advances could be easily wiped out by staff turnover or changes at the national, district or local levels. PS must be orchestrated by the district-level health management team, with strong commitment and leadership from its members. Organization and maintenance of networking among health workers and teams is particularly important, and can contribute to breaking isolation, facilitating horizontal communication and exchanging experiences and good practices.

5. **Celebrate progress**
   When local teams achieve even small advances in carrying out their performance improvement action plans, district health authorities should celebrate the success. A combination of positive feedback, social and material recognition and branding should be used (Bossemeyer and Necochea, 2005). Recognition will help local staff remain motivated in their jobs and committed to continuing progress toward further performance improvement goals.

However, managers often react to local staff achievements with indifference. Managers may think, "Why should they be rewarded? They are doing exactly what they were hired for." In the private sector, recognizing workers is an increasingly common practice; pictures of outstanding employees are published in newsletters, the "employee of the month" is clearly displayed on the company's walls and a salary bonus is given at the end of the year—these are just some of the usual incentives to engage staff in a cycle of increased productivity and quality. "Employees want to know that they have done a good job—and that [employers] noticed. Employees want to be thanked and appreciated" (Heathfield, n.d.).

Table 1. Performance Support Testing Locations and Purpose

Region or Country	Scope	Purpose
Central America	36 hospitals in six countries: Belize, Costa Rica, El Salvador, Guatemala, Nicaragua, Panama	Improve performance and quality of decentralized HIV services
Uganda (Ministry of Health)	104 health facilities in nine districts: Amuru, Amolatar, Apac, Dokolo, Gulu, Kitgum, Lira, Oyam, Pader	Improve performance and quality of prevention of mother-to-child transmission services
Uganda (Uganda Protestant Medical Bureau)	Nationwide	Improve performance of health management information system

CONTEXT AND CHARACTERISTICS OF THE CENTRAL AMERICA INTERVENTION

Context

USAID's Central America Regional Program (G-CAP) requested the Capacity Project to support decentralization of HIV services in six countries. Given the increasing demand for HIV services, the ministries of health (and Social Security in Costa Rica) decided to increase the number of hospitals providing HIV services. In the past, only a few highly specialized hospitals in each country provided these services under direct responsibility of infectious disease specialists.

G-CAP had previously supported important efforts to train health workers on HIV diagnosis, treatment and prevention in partnership with in-country universities; the program also supported communications efforts to raise awareness in the communities and advocacy to incorporate changes in the legislation mainly against stigma and discrimination, and assisted countries to improve their laboratory and testing capacity.

Despite advances, the provision of HIV services was a neglected area. A technical report showed that quality of care was a serious issue in the entire region, especially the persistence of stigma and discrimination, the lack of nutritional management and the increasing difficulties for accessing services given the centralization of services (Mendizabal, 2006).

Characteristics of the Intervention

- The Project assembled a team of two regional consultants, who had previous experience in implementing performance improvement, and one in-country consultant for each country (except Guatemala), for whom it was the first exposure to the these type of methods and tools. This team was trained in the concepts, methods, implementing steps and tools. A chief of party coordinated and facilitated their efforts, while a Project senior staff member provided guidance and technical backup.
- The chief of party presented the methodology and obtained buy-in from all the national HIV programs; in Costa Rica the counterpart was the Directorate of Health Service Development of Social Security[1].
- The Project team adapted and developed draft performance standards based on existing ones, and revised the Salvadoran norms and guidelines, which were the most advanced and detailed in the region.
- Multidisciplinary teams in each country revised and modified the draft set of standards, making them fully compatible with the national policies and guidelines. These teams included professionals from the hospitals where HIV services were being decentralized. The teams were trained in the PS implementation steps, methods and tools.
- The Project team completed a baseline assessment in all the hospitals of the region. They identified local performance gaps as well as three cross-cutting issues in all the hospitals: 1) persistence of stigma and discrimination practices; 2) poor nutritional care; 3) dangerously weak infection prevention practices.
- Following the PS methodology, the national counterparts supported the design and implementation of local action plans, including locally designed solutions, for bridging identified performance gaps. Simultaneously, they identified common issues to organize system-wide interventions. Since the above-mentioned issues affected the entire region, the Project facilitated general interventions for improving nutritional care and infection prevention practices. Stigma and discrimination practices were addressed by creating and strengthening partnerships with local nongovernmental organizations (NGOs) working on advocacy and human rights.

[1] In Costa Rica the Ministry of Health is in charge of policy-making, while Social Security manages health service delivery.

Changes Associated with the Intervention

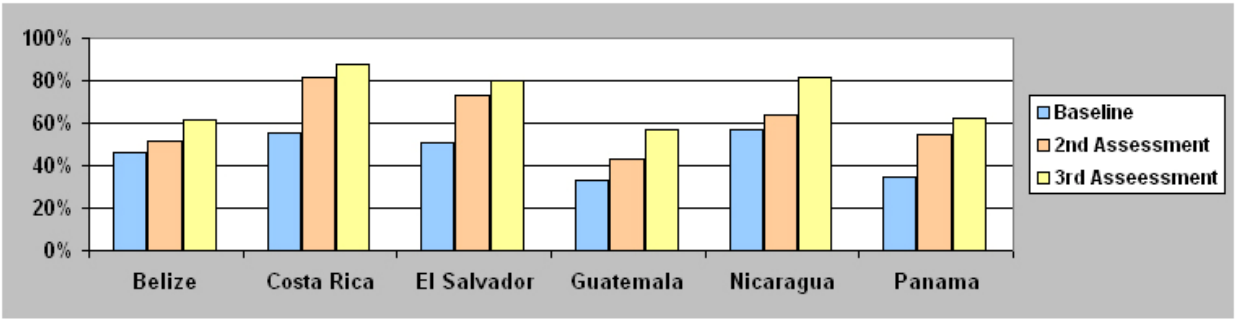
Local teams across the region became empowered during the process by selecting their own priorities and making decisions. Follow-up performance assessments carried out six months and one year after the baseline showed that several deficiencies were solved, including: incorporating infection prevention supplies into the regular procurement lists; acquiring basic missing equipment; addressing stigma and discrimination practices; and training cleaning staff to improve their performance. Listed below are the changes by country:

- **Belize**: Karl Heusen Hospital's basic pediatric unit purchased equipment they had lacked for several years; Cleopatra White Health Center built hand-washing facilities in each consultancy room, acquired basic equipment and trained cleaning staff on good practices; Orange Walk Health Center trained most of the local staff in infection prevention and patients' rights.
- **Costa Rica**: Hospital de Mujeres extended performance improvement beyond HIV services, and the lab took the national lead for improving infection prevention practices based on the performance standards; the nutrition care services designed algorithms and protocols to comply with the performance standards; the hospital addressed human resources shortages by relocating existing staff (psychologists), hiring new staff (pharmacists) or through task redistribution (incorporating general doctors in HIV care and treatment).
- **El Salvador**: HIV clinics incorporated odontologists and local teams addressed issues such as improving infection prevention practices and reducing stigma and discrimination, among others.
- **Guatemala**: In Quetzaltenango the team relocated human resources, equipment and supplies to address deficiencies; in Escuintla the central pharmacy moved to a new location to solve structural issues identified in the performance assessment; in Coatepeque the team incorporated key infection prevention supplies into the procurement plan list.
- **Nicaragua**: In Masaya the process boosted the position of the hospital to become a model of pre-service learning; in Leon the administrative team fully engaged in improving the logistics and management issues for quality HIV service delivery; in Masaya and Leon, the team redeployed and hired human resources to address workforce shortages.
- **Panama**: Local teams coped with issues identified during the performance assessment, mostly in terms of training and motivating staff; in Santo Tomas the team led an aggressive intervention to address infection prevention issues, including training, continuous supervision, competition among services, recognition of the best teams and partnership with the private sector; also the team eliminated use of yellow sheets to identify HIV patients.

The national and regional management teams reorganized supervision activities. Participating national and regional units adjusted their usual supervision approach in such a way that their own plans are aligned with the actual hospital needs. These bodies have provided continuous support to hospitals for implementing local action plans:

- **Belize**: The national HIV program organized its supervision and support activities around the local action plans.
- **Guatemala**: A national-level supportive supervision multidisciplinary team assembled to provide technical assistance to hospital teams on the implementation of local action plans; the national HIV program incorporated supportive supervision activities into its regular annual plan.
- **Nicaragua**: Officers of the decentralized health management units (SILAIS) developed skills for implementing and supporting performance improvement; in Leon, human resources shortages were solved; the SILAIS included support to local action plans into their supervision plans; the National Directorate of Health Services incorporated PS into its annual and quarterly plans.
- **Panama**: The national HIV program incorporated local management-related verification criteria into its supervision plan; in Colon, the team assembled a bilateral commission of the Ministry of Health (MOH) and Social Security to address integration issues that were obstructing the quality of service delivery; in Chiriqui, the team integrated MOH and Social Security services to facilitate performance and quality improvement.

Figure 2. Average Compliance with Performance Standards in Central American Hospitals



Moving toward sustainability, key actions have been made in numerous countries. For example, in Costa Rica Social Security is using PS as the key intervention to facilitate the decentralization of HIV services. Social Security developed and implemented national guidelines for nutritional care, and incorporated PS into the Directorate of Heath Services Development and the Department of Environmental Health's management plans. The national HIV program in El Salvador incorporated PS as one of its management responsibilities, designated officers to lead the implementation and follow-up of this intervention and created a budget line item to support these activities. Guatemala's national HIV program and the Vice-Ministry of Hospitals incorporated PS into their plans and agendas; designated central-level officers to lead PS and follow up; and allowed for partnerships with the Global Fund, Fundacion Barcelona, UNICEF and UNFPA to gain additional funding for procurement of key equipment and hiring of human resources. Nicaragua's general directorate of health incorporated PS into its plans and regular activities; partnerships and trust have been built with NGOs providing HIV services, and these organizations have adopted and implemented PS in their own clinics in Masaya and Xochiquetzal; PS was incorporated into the national prevention of mother-to-child transmission (PMTCT) guidelines; the MOH adopted the performance standards for HIV treatment and care;

the MOH has plans for expanding the use of PS beyond HIV services, including maternal and child health programs. And in Panama, the MOH led the intervention and funded PS activities and local plans; performance assessment results unveiled education and training issues, triggering a series of actions to improve pre-service education and in-service training.

CONTEXT AND CHARACTERISTICS OF THE INTERVENTION IN THE UGANDA MOH

Context

The Project approached the Uganda MOH about improving PMTCT services as part of the Northern Uganda Malaria, AIDS and Tuberculosis (NUMAT) Program. As part of the complementary efforts to improve human resources management, the Project proposed to implement the PS approach. This was a challenging effort considering the complexity and highly structured organization of the MOH. Besides challenges related to communication and overlapping plans and activities among vertical programs, the MOH already had well established supervision and quality improvement initiatives. However, after several months of negotiations, it became possible to assemble a task force of central-level officers, with participation of the reproductive health and HIV programs and the Infection Control unit, with the leadership of the Human Resources Development unit; NUMAT officers and a local Project consultant were also part of this team. This task force was in charge of the design, implementation and follow-up of the intervention in nine districts of Northern Uganda. The Project was responsible for the design and implementation up to the district level, while NUMAT was in charge of implementing the approach at the health facility level.

Characteristics of the Intervention

During the first six months:

- The central-level task force was trained on the PS concepts, methods and tools. Since there is a significant shortage of human resources in the participating districts, task force members considered it unrealistic to address all the PMTCT aspects simultaneously. They chose to use a step-wise approach, selecting antenatal care services as the target during the first year of intervention. They also decided that based on experiences during the first year, adjustments should be incorporated into the methods at the time of expanding to other PMTCT-related services.
- The task force developed performance standards with the Project's technical assistance, used existing standards developed by the reproductive health unit and revised others from Ghana, Afghanistan, Tanzania, Kenya and Central America developed by Jhpiego. The task force developed and tested corresponding performance assessment tools.

During the following year:

- The task force organized and implemented workshops to train the district health management teams from the nine districts.
- These district teams trained health facility staff from health centers and hospitals that provide antenatal care services. Training focused on the performance improvement

- The task force conducted a performance assessment at the health facility level; according to the initial agreement, they would design the local plans and district health management teams would support those plans.
- In addition to the complex relationship between the different units of the MOH, we faced other challenges in implementing the strategy: district teams lacked sufficient leadership and management capacity; some key central-level members of the task force decided not to continue because they were expecting higher travel allowances; and finding synchronized availability of the remaining task force members and district health teams became increasingly difficult. Insufficient effort was focused on strengthening leadership and management capacity as well as on appropriate incentives to foster sustained interest. All of these conditions significantly slowed the pace of the intervention.
- Task force members made the decision to skip the local planning step in the methodology and only drafted district plans. Because the intervention's effectiveness depends on following all steps in the methodology, the decision to skip the local planning had a negative effect on the intervention results. Local teams were not motivated to engage in the process and lacked ownership. Consequently, the intervention did not achieve the expected bottom-up movement that should follow the initial top-down movement. In addition, the design of the district plans lacked adequate specificity; thus, plans were difficult to follow-up and assess.
- It was planned that after six months of implementing the local and district plans, a new performance assessment would measure progress, which would allow for adjusting/ renewing the local and district action planning. However, the unexpected slow implementation pace and the above-mentioned changes in the original methodology did not allow for this expected follow-up assessment on progress.

Changes Associated with the Intervention

- Empowerment of local teams did not happen as expected. The task force's decision to skip the local action planning had a significant effect on the process. Final assessment visits showed that performance improvement processes were not in place at local health facilities. Staff members were not aware that the intervention was taking place; some remembered remotely that the district health management team had completed a performance assessment months ago. Basic and visible deficiencies were still present, meaning that improvements associated with PS did not take place. It was not clear to district officers and local staff who was in charge of delivering results to the health facilities.
- According to task force testimonies, district and local teams very much appreciated the advantages of using PS. Partial changes took place: district plans were affected by the performance assessment findings, meaning that to some extent the district health management teams were sensitive to the findings, prioritized important local issues and dealt with some of them. In other words, performance assessment provided evidence for decision-making at the district level. However, there was no evidence that

- NUMAT, a strategic partner in this experience, found the PS approach useful. Its officers participated in all stages of the implementation process and were critical of the lack of engagement of the local-level teams. NUMAT seems to have embraced the approach and is ready for continuing its application after adjusting the deficiencies in its implementation process.
- No quantitative results could be established since there was no follow-up performance assessment.

CONTEXT AND CHARACTERISTICS OF THE INTERVENTION IN THE UGANDA PROTESTANT MEDICAL BUREAU

Context

The Uganda Protestant Medical Bureau (UPMB) is the coordinating body for Protestant health services in Uganda. UPMB is a network of over 256 faith-based health institutions. Founded in 1957 to serve as a liaison between the Government of Uganda, donors and member hospitals, UPMB now serves as a national umbrella organization with a wider mandate and membership from all over the country. UPMB members provide promotional, preventive, curative and rehabilitative health care to Ugandan people regardless of ethnicity, religious creed, gender and socio economic status (Uganda Protestant Medical Bureau, 2009).

UPMB's leadership asked the Capacity Project to assist in implementing the PS approach after attending a dissemination workshop in Kampala. UPMB wanted to improve its health management information system (HMIS). HMIS encompasses a routine reporting system that involves accurate and timely record-keeping on all the health services provided across the network. These include drugs, staffing, inventory, income and expenditures. UPMB's leaders were worried because the organization did not have reliable and timely information; this situation was undermining the organization's capacity to make informed strategic decisions. They had focused their attention on training registrars on what, how and when to collect and send reports, and believed that after having trained staff, the main reason behind the poor performance of the HMIS was that local-level registrars were struggling with lack of forms, pens, calculators and even computers. UPMB leadership was open-minded and was persuaded to follow the PS approach's methodological steps.

UPMB has a simple and decentralized structure. Health facilities are organized in 32 dioceses. They are coordinated by a relatively small central secretariat.

Characteristics of the Intervention

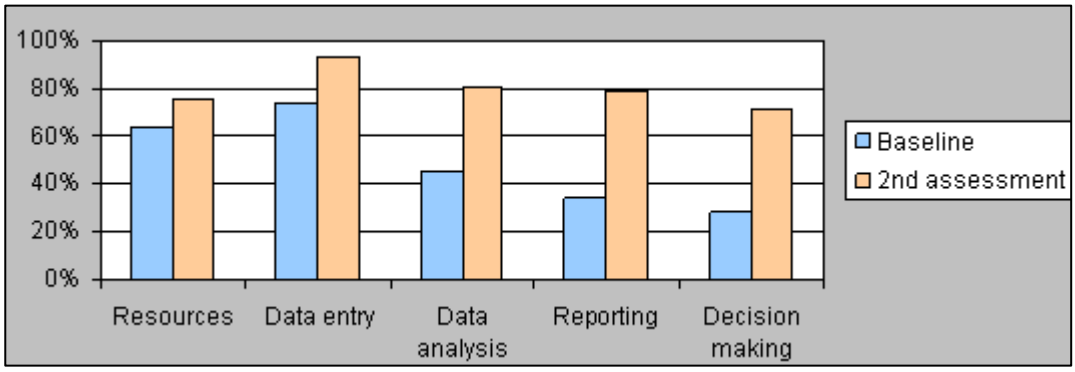
- UPMB brought on board all officers involved in the management of HMIS, and they engaged in rigorous planning and training in HMIS performance improvement strategies.
- Dioceses in charge of the system designed the HMIS performance standards, after a detailed task analysis completed in a national workshop. The standards enlisted good practices that the local team must put in place to register, compile, analyze, report and use HMIS information for proper decision-making in the management of health units.
- The team designed performance assessment tools based on the approved standards.
- Health facility managers, diocesan health coordinators and records assistants assessed 72 health facilities. The exercise was carried out nationally while bringing on board all the levels of health establishments.
- The performance results revealed that the UPMB secretariat's perception was inaccurate; there was a fair availability of resources, but the system was not functioning well due to deficiencies in analyzing and reporting data and making decisions based on that information.
- Local health teams designed and implemented action plans to fix identified performance gaps under their control.
- The UPMB secretariat decided to address the difficulties in data analysis and reporting by designing a tool that would make analysis automatic and report in real time. The team developed a web-based Open Source tool for this purpose. Diocesan health coordinators and records assistants are accessing the web-based HMIS system from Internet cafes in their nearest township. UPMB dioceses provide the budget for Internet access. This approach is cost-effective given that it does not require procuring computers and subscribing to Internet access.
- Nine months after the baseline, the team completed a follow-up performance assessment to measure progress.

Changes Associated with the Intervention

- The PS methodology allowed local teams to identify and solve HMIS problems. Local action plans fostered mobilization of local resources and initiatives to solve deficiencies such as ensuring the availability of forms, making sure data collection is complete, matching reporting forms with existing data in the original data collection tools, complying with deadlines for report filing and preparing and displaying graphs about key indicators.
- Local staff, diocese officers and secretariat leaders realized that complaining about lack of resources had become an excuse that affected the organization's culture, veiling the existence of several easy-to-solve issues that did not require additional resources or funding, but rather changes in attitude. Local staffs' perception of HMIS has started to change from something belonging to the secretariat and ultimately to the MOH, to a tool that is primarily useful for the local level.

- The UPMB secretariat had a dramatic change of attitude. Before the intervention its members were focused on external issues such as lack of resources or local staff skills; during the intervention the secretariat realized that it could play a more proactive role in such a way that it should be supportive to local performance improvement initiatives and action plans. Designing a web-based tool for reporting and automatic data analysis was very well received by local teams that were able to send reports on time and receive analyzed information on key indicators, which paved the road for local informed decision-making.
- UPMB has already made the decision to institutionalize the use of PS not only for HMIS but for other management and service delivery areas as well.

Figure 3. Average Compliance with HMIS Performance Standards at UPMB



DISCUSSION AND LESSONS LEARNED

PS Works

Evidence collected from the PS approach test sites shows that in addition to improving adherence to good practices and performance standards, the intervention is strong enough to produce changes in the structure and behavior of the participating organizations. Even in Uganda, where the intervention faced more challenges, there is evidence of some change at the district management level. Changes in performance are important, and it was expected that they would take place since performance improvement is a widely proven approach. These experiences show that supervision structures and practices can be aligned to support the local performance improvement initiatives.

Many times supervisors do not have a clear idea about what they are going to do during supervision visits, or how they can support local teams. During a workshop in Lira, Uganda, a district health officer summarized his perception of PS after completing a training field experience: "This is the first time in my career that I knew very clearly what the staff in the visited health center needed; it has been the first time that I was able to support them. The performance assessment tool allowed me to see beyond the appearance. PS is the key for making supervision supportive."

These experiences demonstrate that supervision makes sense when it follows the local performance improvement processes, and when supervisors pay attention to the needs derived

from local action plans to close identified performance gaps. Local health workers feel more connected to the organization; they feel that the organization is finally responsive to their needs, and their feelings of invisibility, isolation and abandonment are reduced. Supervisors feel that their visits are useful and appreciated by local staff; they feel that PS creates a link among the different levels of the organization. All of them find themselves playing different and complementary roles of a common task: improving performance and quality of service delivery.

Promising Practices in Implementing PS

1. Select a single service delivery or management issue to start
2. Use a very low profile and avoid looking threatening
3. Identify innovators in the organization who can become champions
4. Make an actual demonstration of the methods and tools
5. Provide continuous support to avoid "business as usual" responses to challenges.

Facilitators and Obstacles for PS Implementation

The PS approach interacted differently with the existing systems and structures in the eight implementation experiences.

While different in many ways, UPMB and Costa Rican Social Security are both learning organizations. They are willing to innovate and rapidly incorporate promising and successful experiences into their regular functioning. It is important to highlight that the technical competencies of the leadership and local teams were completely different in UPMB and Costa Rican Social Security; however, these differences did not play a significant role in the results of the experience. In both organizations, the implementation was led by strong and dedicated leaders who became champions of the PS approach. Local teams already had a considerable degree of autonomy for local decision-making. Committed local, district and national leaders were a key factor for success. Having them on the intervention side permitted them to expedite the implementation, make decisions when required, motivate local teams, mobilize additional resources and remove unexpected obstacles.

Having a single service delivery or management issue—HIV, PMTCT services or HMIS—helped to focus efforts and energy. During the experience with the Uganda MOH we learned that it may be difficult to address the entire supervision system or activities in an organization, especially those with complex and rigid structures, where power distribution has an established balance and where existing systems—even those that may be inefficient or ineffective—have strong roots in the organizational culture.

Since PS introduces new concepts, methods and tools, it was important to present them at the very beginning using a hands-on field application experience where managers and decision-makers could grasp the innovation and embrace it. During workshops participants had the opportunity to make an actual performance assessment, using real tools, in a real health service. Then they analyzed the data, found performance gaps and assisted local staff to design action plans to bridge them. After that they also analyzed data from various health establishments, thus positioning themselves to suggest an agenda for an upper-level plan to support the local plans.

During the implementation activities we struggled with the prevalent mindset of many health managers that training is their first and main option to face issues. While training is needed to empower health staff with the required competencies for organizing and delivering quality health services, it cannot solve all the issues that prevent a local team from performing as expected. Poor leadership, conflicting team climate, or management, logistics and financial issues could be the leading cause behind most of the performance gaps faced by local teams. However, many resources are allocated to train staff, often times unnecessarily, which in turn can make problems worse. A common side-effect of this approach is the creation of structures, procedures and habits around training. Training has become a routine activity in many health organizations, and its results are usually not assessed. As a consequence, sometimes staff perceive training as a benefit—a source of allowances, days off and traveling. Programs include training in their planning without a clear understanding of its role and expected outcomes, and many times agencies compete to support this type of training.

Consequently, we had to overcome the temptation of using training unnecessarily. Leaders and managers interested in PS implementation must be ready to face a competition for resources and organizational commitment that are usually already assigned to training. In other words, under the usual resource-constrained conditions where health organizations work, implementing PS means taking some of the scarce resources from training and other well established activities. It may represent a conflicting scenario with leaders and managers whose power rests on these activities; PS could also affect some established indirect benefits of local staff who take part in routine training activities, like having access to travel and allowances.

It is important to keep in mind that the PS approach is actually competing with other existing systems and structures and, sometimes, well established approaches for organizing and delivering health services. Implementing PS means incorporating changes in the way a budget is allocated and power is distributed across the organization. At this stage, it is clear that an offensive tactic is needed; however, it is important to map the players and decide on the best tactical approach. As with any other innovation, PS can face skepticism and scrutiny from stakeholders, particularly those in charge of supervision, training and planning. Even the local staff may initially perceive PS as extra work and be resistant to implement it.

An important lesson learned is that managers implementing PS should find an initial niche to implement the approach and defend it, keeping a low profile during this stage (Reis and Trout, 1986). Changing well-established practices like visiting supervision may be difficult; any direct confrontation should be avoided. Identify a specific health program, district or activity whose leaders are concerned about the poor results of current service delivery or supervision systems. Managers should delay any scale-up attempt until they have strong evidence of the benefits of PS.

When G-CAP asked the Project to provide technical assistance to improve the delivery of decentralized HIV services, this was an opportunity to apply what was learned in Uganda. The Project deliberately approached national HIV programs with a low-profile proposal for testing the PS approach in a very limited number of health establishments in each country. Most of the authorities and officers were open-minded and accepted the proposal, although with

reservations. At the beginning, we made strong efforts to transform concerned, and even resistant, leaders into champions of PS in their organizations. Some basic steps included sharing the cumulated evidence that supported the technical reliability, simplicity, low cost and potential benefits of PS and its components. The effort also included the dissemination of successful results of previous experiences. It was important to demonstrate that most of the time PS required no significant additional investment, resources or staff time. Stakeholders, especially those at the health establishment level, progressively changed from skeptics to enthusiastic allies.

REFERENCES

Atherton F, Mbekem G, Nyalusi I. Improving service quality: experience from the Tanzania Family Health Project. *International Journal for Quality in Health Care*. 1999;11:353-356. Available at:
http://intqhc.oxfordjournals.org/cgi/content/abstract/11/4/353

Benavides B. Project 2000: a project of innovations in health. Lima, Peru: Pathfinder International, 2003.

Bossemeyer D, Necochea E. Standard-based management and recognition—a field guide: a practical approach for improving the performance and quality of health services. Baltimore, MD: Jhpiego, 2005.

Davids S, Loveday M. The nine step guide to implementing clinic supervision. Durban, South Africa: Health System Trust, 2005.

Directorate of Family Planning, Ministry of Health and Family Welfare Bangladesh. Results of the performance improvement needs assessment (PINA-2) to strengthen the supervision system. New York, NY: ACQUIRE/EngenderHealth, 2005.

Dussault G, Franceschini M. Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce. *Human Resources for Health*. 2006:4(12). Available at:
http://www.human-resources-health.com/content/4/1/12

Galer J. Leadership for performance improvement: a new approach for supervision. Presented at Beyond the Visiting Supervisor: What Works, What's Next?; 25 Oct 2005; Washington, DC. Available at:
http://www.capacityproject.org/supervision/presentations.html

Heathfield SM. Employee recognition rocks: kick employee recognition up a notch [website], n.d. Accessed 12 Jul 2009 at:
http://humanresources.about.com/od/rewardrecognition/a/recognition_emp.htm

Iles V. *Really Managing Health Care*. Buckingham, UK: Open University Press, 1997.

IntraHealth International. Performance improvement: stages, steps and tools. Chapel Hill, NC: IntraHealth International, 2005. Available at:
http://www.intrahealth.org/sst/tools.html

Kim Y, Figueroa ME, Martin A, et al. Impact of supervision and self-assessment on doctor-patient communication in rural Mexico. *International Journal for Quality in Health Care*. 2002; 14:359-367. Available at:
http://intqhc.oxfordjournals.org/cgi/content/abstract/14/5/359

Luoma M. The visiting supervision model—what's the evidence? Presented at Beyond the Visiting Supervisor: What works, What's Next?; 25 Oct 2005; Washington, DC. Available at: http://www.capacityproject.org/supervision/presentations.html

Lynam P, Takuom C. Supervision training: some lessons from Kenya. Presented at Beyond the Visiting Supervisor: What Works, What's Next?; 25 Oct 2005; Washington, DC. Available at: http://www.capacityproject.org/supervision/presentations.html

Marquez L, Kean L. Making supervision supportive and sustainable: new approaches to old problems. MAQ Paper No. 4. Baltimore, MD: Management Science for Health, 2002. Available at: http://www.maqweb.org/maqdoc/MAQno4final.pdf

McQuide P, Kiwanuka-Mukiibi P, Zuyerduin A, Isabiryie C. Uganda health workforce study: satisfaction and intent to stay among health workers in public and PFNP facilities. Presented at First Global Forum on Human Resources for Health; 2-7 Mar 2008; Kampala, Uganda. Available at: http://www.who.int/workforcealliance/forum/presentations/Pamela_Mc_QuideA.pdf

Mendizabal M. Análisis de situación y respuesta ante el VIH/SIDA en Centroamérica. PASCA-Acción SIDA de Centroamérica, 2006 (unpublished).

Reis A, Trout J. *Marketing Warfare*. New York, NY: McGraw-Hill, 1986.

Rowe A, de Savingny D, Lanata C, Victora C. How can we achieve and maintain high-quality performance of health workers in low-resource settings? *Lancet*. 2005; 366:1026-35. Available at: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(05)67028-6/abstract

Spitzer DR. Transforming performance measurement: rethinking the way we measure and drive organizational success. New York, NY: AMACOM, 2007.

Tavrow P, Kim Y, Malianga L. Measuring the quality of supervisor-provider interactions in health care facilities in Zimbabwe. *International Journal for Quality of Care*. 2002;14:1:57-66.

Thomsen M. Focus on supervision: guiding principles for supervising success. Presented at Beyond the Visiting Supervisor: What Works, What's Next?; 25 Oct 2005; Washington, DC. Available at: http://www.capacityproject.org/supervision/presentations.html

Uganda Protestant Medical Bureau (UPMB). Who we are [website]. Uganda: UPMB, 2009. Accessed 7 Jul 2009 at: http://www.upmb.co.ug/index.php?option=displaypageand Itemid=50and op=pageand SubMenu=

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- Improving workforce planning and leadership
- Developing better education and training programs for the workforce
- Strengthening systems to support workforce performance.

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