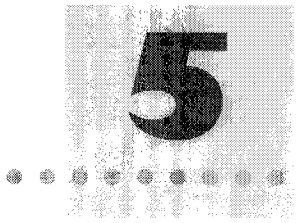


Applications

How do you apply facilitative supervision to real-world situations? How does facilitative supervision help you address training needs and supply, logistics, and infrastructure problems in the sites you supervise? How does it help staff determine and fill the needs they can address themselves?

This chapter focuses on applying what we have learned about facilitative supervision to the important areas of training and supplies, logistics, and infrastructure.

Objectives:

This chapter will give you the information you need on:

- How to help site staff identify learning needs and develop a training plan
- How to enable staff to identify the supply, logistics, and infrastructure problems that they can solve themselves

Information and Training

As a supervisor, why is training important to you? Training is an integral part of quality. Staff cannot deliver quality services if they don't know how to do their jobs properly. Also, training and supervision are closely linked. As supervisors help staff to improve quality, it is inevitable that training will play a part in this process. Supervisors must, therefore, understand how to use training most effectively as a quality improvement tool.

As a supervisor, you are aware that people want to do a good job. Site staff want to deliver quality services and contribute to the health of their clients. When they don't do a good job, it is usually the fault of the system or processes. And sometimes the system has not provided them with the information and training they need.

Poor training also costs money.

Exercise

The Costs of Poor Training

Can you think of any examples of poor training in your facility that cost money?

_____

_____

_____

For example, what happens if staff at your clinic are not trained properly in preparing lab smears?

What are three consequences?

1._____

2._____

3._____

Possible answers:

1. *When the laboratory cannot read the smears, they have to be done over. This means that equipment, supplies and staff time are wasted.*
2. *Such duplication of effort costs extra money.*
3. *The client has to wait longer for the results, which lowers client satisfaction.*

Drawbacks to Traditional Training Approaches

In many places, training has traditionally been done by sending staff to an off-site location. While there are advantages to such centralized training, it also has many drawbacks. For an example, let's look at the case of Dr. González

- **Follow-up is lacking.**
  Trainers in centralized systems often lack the resources to stay in contact with distant trainees and thus cannot evaluate their skills. Since training and supervision are not linked, qualified supervisors are not part of the training team and do not follow up.
- **Trainees often cannot apply new knowledge to their work.**
  Trainees often receive instruction in a work environment unlike their own and may feel that they are unable to apply the training to their site. Trainees may return to an unsupportive environment (e.g., other staff are not trained to participate with the trainee in the new skill or knowledge).

- **Trainees are often selected inappropriately.**
  When training courses involve a trip away from the site, managers may choose trainees as a reward or because it is their turn to travel, rather than on the basis of the needs of the site or the qualifications of the trainee.
- **Expanded needs for training cannot be met.**
  Because off-site training is expensive and trainee slots are limited, this type of training cannot meet all the learning needs of the site.

Thus, in many cases centralized training is ineffective and does not justify the high costs of trainee travel, per diems, and time away from regular duties.

Can we do training better? Yes!

Case Study: Dr. González

A decision is made at higher levels that no-scalpel vasectomy should be introduced at all the clinics in a certain region. Dr. González is chosen to go to the capital city for technical training in this procedure. He goes away for a week, is trained, and returns to his clinic. Months go by and he does not use his new skills. Why? Mainly because there is no demand for the service. This is because there has been no effort to provide information on no-scalpel vasectomy to the community and there are no educational materials on no-scalpel vasectomy in the clinic itself. In addition, few staff in the clinic have been informed that this service is now available, so they do not refer potential clients. Consequently, when the supervisor arrives six months after the training, he finds that not only is Dr. González not using his new skills, but also that he has lost some of his proficiency in the technique.

The following situations are typical in traditional training:

- One or two people go to the capital or a large city for training.
- The trainees return and do not find support systems needed to use new skills, e.g., equipment, trained support staff, and educational materials.
- Other levels of staff have not been involved so they may not even be aware of the new service or expertise at the site.
- Ongoing technical assistance and supervision are often not available.

Traditional training has its strengths. It provides the trainee with the opportunity to: learn a skill, often under optimal conditions (e.g., with sufficient cases for practice and excellent equipment and facilities); exchange views with colleagues; and observe how services are delivered in another environment.

However, there are weaknesses as well:

- **Training and supervision are not linked.**
  Supervisors are not involved in identifying training needs or in planning training. This decreases the likelihood that the training will meet local needs.

Whole-Site Training (WST)

EngenderHealth proposes a new approach to training that is based on the learning needs of the site. This approach:

- Is carried out on site as much as possible
- Involves all levels of staff at the site
- Includes an ongoing supervision component

What Is *Whole-Site Training?*

Whole-site training is an approach to training that meets the learning needs of all the staff at a service-delivery site within the context of organizational development. WST has the following characteristics:

- Needs are identified through self-assessment approaches, such as COPE
- Needs are met through different levels of training (skills training, updates, and orientations), with instruction at the service site whenever possible.
- Emphasis is placed on the development and training of teams at the service-delivery site so that services can continue when individuals are on leave.

Traditional training is often limited to initial skills training. Whole-site training recognizes the fact that many auxiliary staff can benefit from an orientation and that previously trained staff need periodic updates. When all the staff at a site are oriented or trained in a skill or service, there is a better chance that the skill or service will be effectively utilized at the site.

- *Orientation* creates awareness and provides basic information to staff so that they can support other staff who are receiving either skills training or updates.
- *Update (refresher)* adds or upgrades information, knowledge, or skills related to advancements and changes in knowledge or technology.
- *Skills training* teaches skills that enable trainees to perform specific new tasks.

Example: WST for the Case of Dr. González:

Instead of going to another city for no-scalpel vasectomy (NSV) training, a trainer goes to Dr. González's clinic, or a skilled practitioner at the site transfers the necessary skills. This means that the site has to prepare a place for performing NSV, has to have the instruments necessary, has to recruit and prepare clients, and has to arrange for follow-up of clients. As a result, the stage is already set for the eventual delivery of the service after training, and Dr. González has a practical impression of how he will actually provide the new service.

All staff receive orientation, update, or training as follows:

- *Guard, doorman, receptionist, cleaners:* where, when, by whom NSV is delivered; general information about the procedure (orientation)
- *Supplies, maintenance staff:* the above, plus the instruments/supplies needed and how to care for them (orientation, plus update)
- *Counselors, educators:* the above, except care of instruments, plus mode of action, effectiveness, advantages, disadvantages, side effects, and how to counsel clients interested in NSV and document informed consent (update and skills training)
- *Nurses:* the above, plus how to assist in NSV (skills training)
- *Dr. Gonzáles:* the above, plus how to perform the procedure and follow-up clients. (skills training)

Since 1993, whole-site training has been used in many locations around the world to meet a variety of training needs. In Mexico, WST was used to improve the availability and use of vasectomy service in a national health system. Training doctors to provide vasectomy was only a part of the training strategy. It also involved staff who provide vasectomy clients with related services (such as medical examinations, postoperative instructions, follow-up examinations and treatment of complications), staff who provide family planning information and counsel vasectomy clients, and other personnel such as managers, medical directors, supervisors, and social workers. As a result, the number of vasectomies performed increased substantially.

In Alexandria, Egypt, nurses, doctors, and cleaners came together to learn and discuss how they could function better as a team to prevent infection. Initially, the doctors were resistant and the nurses were shy, but gradually barriers were broken down and staff began to appreciate the need to learn and act together.

Exercise

Whole-Site Training

If a site decides to provide training in infection prevention, what kind of orientation, updates, or training would be provided to the following levels of staff?

Guard, doorman, receptionist: _____

Cleaners: _____

Supplies staff: _____

Maintenance staff: _____

Counselors, educators: _____

Nurses: _____

Doctors: _____

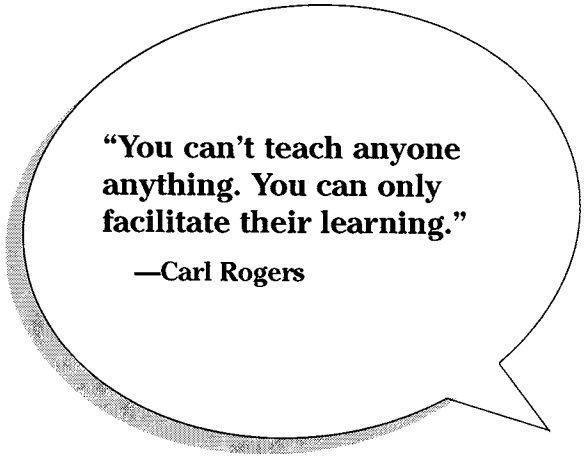
Answer: *All would need to know about the importance of infection prevention; the cleaners, how to dispose properly of waste; supplies staff, the importance of a constant supply of disinfectants; maintenance staff, why sterilization equipment must be kept functioning and how to do so; counselors and educators, what to tell clients; clinicians, how to protect themselves and clients from infection.*

Facilitating the Whole-Site Training Approach

As a supervisor, your role will be to introduce this new approach by helping the site identify its learning needs and then by helping staff to fill those needs

- On site, whenever possible
- With local resources when available
- In a horizontal, integrated fashion

so that the training will be cost-efficient, effective, and sustainable.



This approach can be effective at a single site, or on a local or regional level. Even with only one site, you can accomplish a great deal to improve quality through training. It is important to note that the purpose of whole-site training is to meet the learning needs of the entire site. This can be accomplished by sending one or more staff members to train elsewhere if no one on site has the necessary skills and knowledge. The selected staff should agree to share what they learn with colleagues when they return from training.

Steps in Facilitating Training

Step 1 Help staff identify their learning needs.

The first step in facilitating training is to help the site staff identify their learning needs. You can use many of the same methods of problem identification introduced in Chapter 4 to define a site's learning needs. All of the methods of problem identification apply here, but some special considerations also apply.

Self-Assessment. One of the problems with traditional training is that it does not always meet the needs of the site. Having staff and supervisors identify their learning needs through self-assessment increases the likelihood that any training undertaken will be appropriate. This is important because adults learn better when they understand that the training will help them in some way, and when they have some say in the training they receive.

The self-assessment guides included in EngenderHealth's COPE process are excellent tools for this purpose. Using this series of questionnaires or "trigger questions," staff evaluate the quality of the services they provide. The guide on training is specifically designed to help staff identify learning needs. The self-assessment questions include:

- Do clinical staff know how to perform examinations required for the services they provide (e.g., breast, pelvic, scrotal examinations)?
- Do staff regularly participate in training events in order to acquire new skills or to maintain or improve existing skills?
- Do enough staff in the facility have the skills necessary for counseling clients, including groups with special needs (for example, men and postpartum and postabortion women)?
- Do staff feel competent to do STD screening by asking questions about exposure to risk of contracting STDs and by clinical screening?

How Adults Learn

It is important for you to know what motivates adults to learn.

Adults

- **Decide for themselves what is important to be learned.**
- **Need to validate the information based on their beliefs and experiences.**
- **Expect what they learn to be immediately useful.**
- **Have much past experience upon which to draw—may have fixed viewpoints.**
- **Significant ability to serve as a knowledgeable resource to the trainer and fellow learners.**

Children

- **Rely on others to decide what is important to be learned.**
- **Accept the information being presented at face value.**
- **Expect what they are learning to be useful in their long-term future.**
- **Have little or no experience on which to draw—are relatively "clean slates."**
- **Little ability to serve as a knowledgeable resource to teacher or fellow classmates.**

Consequently, when arranging for training, you'll want to ensure that the learning experience:

- Is highly interactive, involving participants fully
- Takes into account the participants' knowledge and experience
- Is related to the person's job and will help him or her provide quality reproductive health services
- Is considered beneficial by the participant

(Ittner and Douds 1988)

Staff Performance Reviews. During staff performance reviews, individual staff members may indicate a lack of proficiency in a certain area—or managers may identify such a lack. The more staff members with a particular performance gap, the higher the priority for training in that area. Supervisors should take this source of information into account when planning training activities.

Medical Monitoring. All supervisors have a responsibility to identify learning needs through medical monitoring and observation. Supervisors should continue to observe the delivery of services, review medical records, interview staff and clients, and monitor compliance with national standards. If the site staff do not themselves identify problem areas noted by the supervisor, the supervisor must tactfully lead the staff in identification of the deficiencies, especially if they compromise client safety. *The supervisor must never abdicate this role.*

Using a combination of methods, supervisors can help staff uncover a variety of learning needs. For example, below is a list of problems that were revealed by a COPE exercise:

1. Staff are not explaining side effects of family planning methods to clients.
2. There is an unmet demand for injectables because of a lack of trained staff.
3. Staff do not disinfect instruments properly.
4. Clinicians do not fill out client records completely.

In this example:

- Problem #1 was identified through client interviews.
- Problem #2 was identified through community meetings.
- Problem #3 was identified through staff self-assessment.
- Problem #4 was identified through supervisor's observation.

Step 2 Help staff keep current with new services and procedures.

When staff are unaware of new services or procedures, they will not be able to identify their own deficiency in these areas. As a facilitative supervisor, you are responsible for keeping staff informed and providing orientation or training as needed. Consider the following example.

Example: Keeping Staff Current

In a regional hospital in Africa, the supervisor noticed that staff were not decontaminating instruments properly before sterilization. However, during a self-assessment exercise, infection prevention was not identified as a problem area. When the supervisor carefully raised the issue, staff replied that they were following the procedure they had been taught in medical and nursing schools. But new infections had come on the scene since most of the staff underwent initial training, and, as some of the infections were life-threatening (e.g., HIV), more stringent procedures were considered necessary. Consequently, the supervisor suggested an infection prevention review, and staff agreed. Staff selected ward representatives to attend the training, at which they received written infection prevention protocols. After training, the ward representatives in turn trained the staff and approached the hospital administration regarding the supplies they would need for more effective decontamination.

What new services or procedures are being introduced in your area? What training needs do you foresee?

_____

_____

_____

Step 3 Ensure that training is the appropriate solution to the problem.

It is important to know that:

- Training is not always appropriate.
- Training will not solve all your problems.
- Training cannot compensate for poor supervision.
- Training cannot help an employee who is unsuited for or unwilling to perform a task.

Another way of looking at a performance problem is to consider why people don't do what they are expected to do. For example, staff members may not perform a task well because:

- They don't know how to do it.
- They are unclear on their role.
- They are not authorized to do it.
- They don't get regular feedback on their performance.
- Their sources of information are inadequate.
- They don't have job aids to cue correct performance.
- Their work environment provides obstacles to desired performance.
- The organizational structure makes performance difficult.
- They're penalized for performing correctly.
- They're praised for performing incorrectly.
- No one pays attention to whether they perform correctly or not.

(Mager 1992.)

Which of the above situations can be solved by training?

_____

_____

Most of these problems are a result of inadequate supervision, poor work environment, inappropriate organizational structure, and lack of adequate documentation. Training will not solve them and any attempt to fix them with training will be a waste of resources. The only problems that can be solved by training are the first two on the list. Managers must solve the rest of these problems through other interventions.

Sometimes staff need training in order to provide quality services, for various reasons:

- They are performing tasks in a way that compromises quality.
- They are not performing tasks according to national guidelines.
- There is new information that they are unaware of.
- There are new procedures or techniques in which they are unskilled.

In order to decide if training will solve a problem, it is important to identify the basic cause. Asking the question "why?" several times can help identify the root of the problem.

Exercise

Is Training the Answer?

Can training solve this problem? Explain why or why not

1. The receptionist is not polite to clients.

Why? Because she is not motivated to be polite.

Why? Because her salary hasn't been paid in two months.

2. The surgeon is doing a poor job of removing Norplant implants.

Why? Because he has never removed Norplant implants before.

Why? Because when he was trained, there were no cases for him to practice on.

3. Staff are not doing Pap smears.

Why? Because there are no reagents.

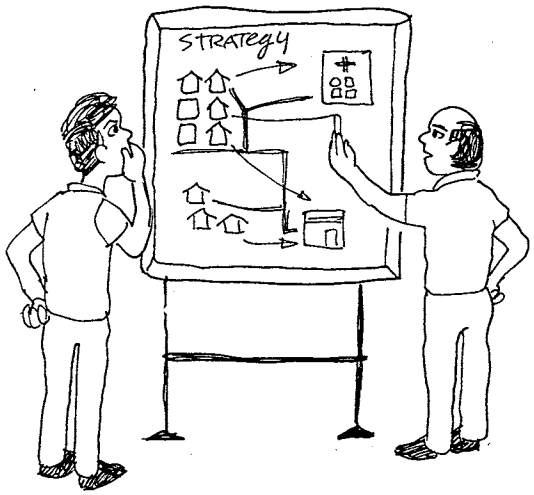
Why? Because the reagents were not ordered in time.

Why? Because the person responsible resigned and management didn't appoint anyone else to do this job.

The answers appear on page 16.

Step 4 Help staff develop a written plan to meet the learning needs of the site.

Once you have helped staff identify their problems and decide which ones can be solved through training, the next step is to help them develop a plan to meet those training needs. The sample chart below shows one approach that can be used to do this.



Sample Training Plan, March 20

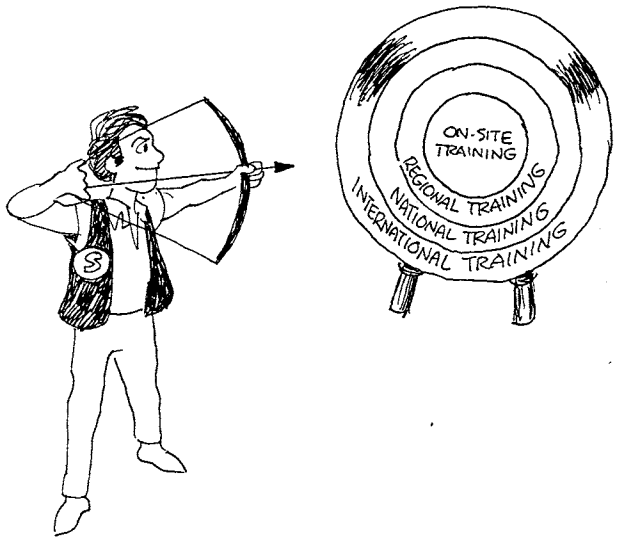
Problem and cause	Recommendation	Type of training	Where	By whom	By when	Materials needed
Practitioner cannot remove Norplant implants properly because of lack of training	Provide training in removal of Norplant implants	Skills training in removal of Norplant implants	At the trainee's site	Dr. X (from nearby clinic)	June 15	Norplant implants operator's manual; removal instruments
Infection rate too high because staff need refresher training	Provide refresher in infection prevention to all staff	Whole-site training in infection prevention practices	At the site	Medical director of site	March 31	National guidelines, posters
Unmet demand for vasectomy because no trained practitioner is available	Train a clinician in no-scalpel vasectomy	Skills training followed by whole-site training	At regional training center; then at site	Regional trainers (NSV, counseling, etc.)	Oct. 15	Curricula, protocols, etc.

Answers: Is Training the Answer? from page 14

Only the second situation can be solved by training—training the surgeon in Norplant implant removal. In the first case, the receptionist knows how to treat clients well but is refusing to do. In the third case, there is no one assigned to do a certain job and staff must be either identified or hired before training would be appropriate.

Below are some important elements to consider when developing a training plan.

- **Problem and cause**—Make sure that the problem is expressed in its root cause. Ask Why? several times in order to get at the root of the problem.
- **Recommendation**—Make sure that training will solve the problem and address the true cause. If the deficiency is due to organizational problems, lack of facilities, or lack of supervision, training will have no impact. For example, "infection rate too high" is a vague statement. Why is the infection rate too high? Are disinfectants lacking? Are staff unaware of the protocols? Is sterilization equipment in need of repair? If the problem is that staff lack knowledge or expertise, training can solve it.
- **Type of training**—Identify the kind of training envisioned, for example, orientation, update, skills training. Staff who are not directly involved in service delivery but who need to know that the service is going to be offered at their facility and how to promote it would receive an orientation. If the service already exists but staff do not have recent information or are not applying the most advanced procedures, an update would be the answer. If the service does not yet exist at the facility, those who are going to be offering the service to clients would need skills training. Skills training could include both clinical and counseling skills.
- **Where**—To the extent possible, arrange for training to take place at the trainee's site or nearby. As we have seen, decentralized training can be more cost efficient and effective.



Try to hit the bull's eye as often as possible!

- **By whom**—The order of preference is:
  - ***Training conducted by one of the site staff***
    This is most feasible when the content area is not a new skill (e.g., infection prevention). Training by qualified site staff can be both more cost effective and easier to arrange than training by outside experts.
  - ***Nearby trainer comes to site***
    If the content area requires external expertise, try to find someone nearby or in the region who is proficient in the skill and has training ability and experience. Arrange for this person to come to the site. Again, this is cost efficient.
  - ***Distant trainer***
    Sometimes it is not possible to find a skilled practitioner in the region who can lead the training, and the services of a distant or international trainer are required.

If you locate a site staff person or an expert practicing nearby who is not a trainer, you will need to coach them in how to lead a training session that will allow them to transfer their skills (see Chapter 3).

- **By when**—Realistic deadlines are important. You will need to help the site staff weigh such factors as the availability of the trainer and trainee(s), the availability of training materials, the availability of clients, and the readiness of the training site, wherever it may be.
- **Materials needed**—Make sure the site staff understand what materials will be needed, whether they are already available or must be developed or obtained.
- **Training priorities**—It is also important to help the staff prioritize training needs. In the sample training plan above, which of the trainings should they try to do first? The most urgent training is in infection prevention, because the safety of the client, the most important customer, is in jeopardy. Consequently, training should be scheduled not only according to availability of the trainers and other logistical factors, but also according to its importance in terms of quality, keeping in mind the customer perspective.

Step 3 Help staff recognize the validity and value of decentralized or local training.

As much as possible, learning needs should be met by training conducted at the site and that involves all staff levels. This is a departure from centralized training, the old way of doing things. One of your challenges as a supervisor is to help staff understand that on-site or local training is beneficial to them and is just as valid.

What are some of the reasons why staff would be in favor of decentralized training?

- _____
- _____
- _____

People prefer decentralized training because:

- More levels of staff have the opportunity to learn something new.
- Staff who are unable to travel do not miss training opportunities.
- Staff feel that they are important because someone is paying attention to their needs.
- More staff feel that they can contribute more to quality improvement (this also promotes teamwork and motivation).
- There is less jealousy than if only the privileged few receive training (this also promotes teamwork).

Generally, those who oppose decentralized or local training are those who would have been the most likely candidates to travel somewhere to receive centralized training. But even these staff can be won over to the camp of decentralized training once they understand these benefits:

- Decentralized training will help them use their new skills immediately.
- Decentralized training will help them understand how to use their skills in their own setting.
- Decentralized training will make it quicker for them to identify and solve problems related to using their new skills.
- Decentralized training is more efficient in meeting the expanded training needs of the site.

Nevertheless, given that there might be some resistance to decentralized training, it is important that all staff see it as a valid alternative to centralized training. You as supervisor can promote this mindset by ensuring the existence of the critical element: a certification process. The process has three levels:

1. Identification of qualified on-site or local trainers by regional or headquarters supervisors
2. Availability of traditional training materials
3. Certification of trainees

Identification of Designated On-Site or Local Trainers/Skilled Practitioners
You will need to help the site by:

- Identifying which of their staff are proficient in the procedure/skill/information to be taught and have training ability and experience
- Identifying skilled practitioners/trainers in the area who could be brought in to provide training at the site
- Helping skilled practitioners transfer their skills to other staff

Example: Identifying Local Trainees

In 1994, staff from an African mission hospital wanted to train four doctors to insert Norplant implants, but found that centralized training had ceased due to financial constraints. The supervisor identified a local physician who had been trained to insert the implants, had training experience, and was willing to come to the hospital to provide on-the-job training. He trained all four doctors one day a week over a four-week period. While he was at the hospital, staff mentioned to him that some clients were interested in the post-partum IUD. Since he was also qualified to do this type of training, he offered to train maternity ward nurses in IUD insertion in the postplacental period. In addition to Norplant implants sessions with the doctors, he was able to provide IUD training to the nurses
(Bradley et al.1998).

A chart of skilled clinicians will help. Try to fill out this chart as completely as you can. If you are a site supervisor, you can prepare this information for each of the sites with the assistance of site staff. If you are a regional supervisor, you can help other supervisors fill out the chart or you can complete it for the region. This information will be useful in enabling a site to meet its training needs on premises or through local resources.

Sample Trainer Chart

Content/skill	Skilled practitioner	Trained (when/where)	Years of experience	Capable of training others (Y/N)	Comments
Counseling					
Cancer screening/ treatment					
STD screening/ treatment					
IUD insertion					
Male reproductive health services					
AIDS awareness					
Other area:					
Other area:					
Other area:					

If skilled practitioners have no experience in training, your role is to help them transfer their skills to others. This is best done by coaching, which is explained in Chapter 3.

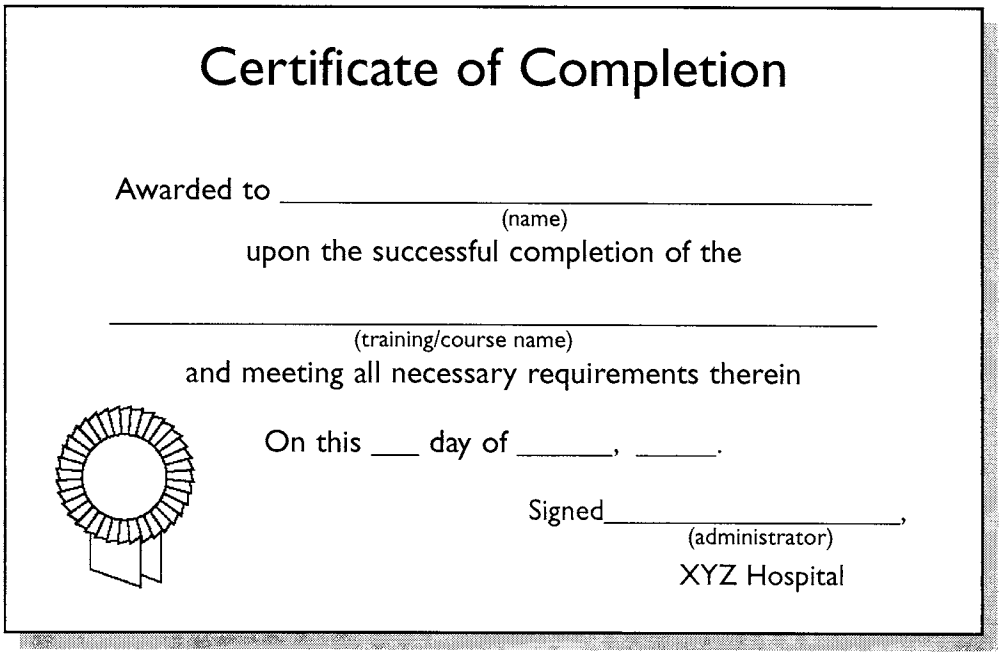
Availability of Traditional Training Materials

In order to ensure that ongoing, on-site training is possible, it is important to have essential training materials on hand at the facility. These include:

- Training curricula (including didactic and practical training) in all areas in which training will be provided
- Handouts, manuals, or other reference materials for trainees
- Equipment (e.g., audio-visual equipment, anatomical models)
- Training evaluation guides (competency based)

Certification of Trainees

Just as with centralized training, any on-site training course should end with a "graduation" ceremony and the distribution of certificates to all the trainees who have successfully completed the course. Such a ceremony is important not only for the self-esteem of the trainees but also to impress upon all staff the importance and validity of the training. Below is a sample certificate that you can use at your site:



Certificate of Completion

Awarded to _____
(name)

upon the successful completion of the

_____
(training/course name)

and meeting all necessary requirements therein

On this ___ day of _____, _____.

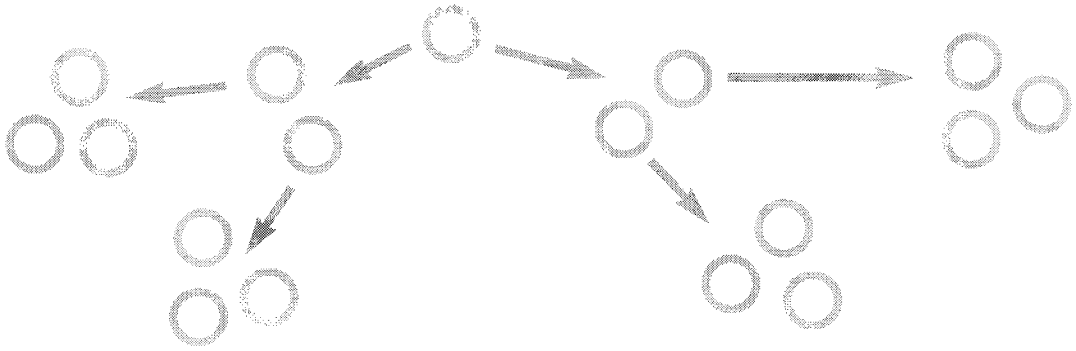
Signed_____,
(administrator)

XYZ Hospital

Of course, the certificate must be sanctioned and recognized by the institution if it is to have validity beyond the site.

Cascade Training

Once a cadre of staff has been trained, they should continuously transfer their knowledge and skills to colleagues within the system. This is known as cascade training.



Those who receive the training first (first-generation trainees) train one or more staff (second-generation trainees), who in turn train one or more staff (third-generation trainees), and so on (Organizational Dynamics 1993). It is a good idea for the original trainer, in conjunction with the facilitative supervisor, to review the process from time to time in order to ensure the quality of the training, especially as it moves beyond the second generation. Reviewing the process means periodic observation and evaluation of the training efforts, including the training materials (design, curriculum or guides, and handouts) and the actual training sessions.

Cascade training may be conducted within a region, within a system, or within a single site. When used in a region or system, the original trainees receive training at a regional site or flagship facility. Then they are expected to organize and hold courses at other facilities in the region or system. When cascade training is employed at a single site, the first-generation trainee transfers the skills to specific site staff. They are expected to transfer the skills to other staff and to new staff as needed, and also to conduct refresher courses from time to time. If the cascade is to continue to the third generation, second-generation trainees must also have instruction in training skills. This continuous sharing of knowledge and skills fosters team spirit at the site.

Cascade training has distinct advantages:

- It allows capacity to be built locally much more rapidly than other types of training.
- It promotes sustainability, as staff start to make information sharing and training part of their daily work.

(Bradley 1998.)

Example: Cascade Training

In Tanzania, regional supervisors helped sites to develop training programs and themselves conducted much of the initial training. Now site staff are working on their own to develop training strategies and are using local skilled practitioners to build capacity (Bradley et al. 1998).

Supplies, Logistics, and Infrastructure

Many supervisors agree that problems related to supplies, logistics, and infrastructure are the most difficult to solve. Supervisors the world over are all struggling with ways to provide more space, to solve the problem of stock-outs of essential supplies, and, probably the most difficult problem of all, to fill the need for transportation.

The good news is that facilitative supervision can lighten the burden on supervisors because it helps mobilize the site staff to find ways to solve some of their own problems. This leaves fewer problems for you, the supervisor, to solve.

Note: Many of the examples found in this chapter are from Tanzania and Kenya because organizations in these countries were AVSC's earliest partners in implementing facilitative supervision. Therefore, our longest history and greatest experience with facilitative supervision are in these countries.

Examples: Supplies, Logistics, Infrastructure

- Supervisors in one African country had oriented staff to proper infection prevention (IP) practices, including the use of chlorine for decontamination. Although staff were committed to improving IP practices, shortages of chlorine for disinfection was a chronic problem in many sites. Chlorine was expensive (USD $2 for one liter on average). In addition, some vendors diluted it, so that staff could not rely on the strength of the solution. This compromised both staff and client safety. After an international donor agency provided a sample of chlorinated lime powder and instructions for mixing the solution, hospital pharmacists learned to mix the chlorine solution for use in disinfection, decontamination, and sterilization. Previously they had only used the powder to prepare a skin antiseptic applied before surgery. One hospital found that the chlorinated lime powder available from the MOH at the rate of 4 kilos for USD $5 made 6,000 liters of chlorine. This solution was enormously cheaper than buying chlorine and allowed the staff to control the strength of the solution. The next step will be to ensure sufficient supplies of chlorinated lime powder to meet the demand at all sites.
- Facilitative supervision requires that supervisors make more frequent and longer visits. However, lack of transportation has remained a problem in many sites. To solve the problem, the MOH and nongovernmental organizations in one African country are committed to sharing vehicles and performing joint supervision. If an MOH vehicle is being used to provide outreach services, the MOH supervisor and NGO representative will share the vehicle to visit another site and thus are able to fulfill their duties.

Question:

What intractable problems are you facing now as a supervisor in terms of supplies, logistics, infrastructure? What creative solutions can you suggest?

_____

_____

_____

Example: Action Plan

Take a moment to review this sample action plan and think about what might be problematic about it:

Site Action Plan, Developed by Site Staff on June 1

Problem	Recommendation	By whom	By when
1. Stock-out of Depo	Order from MOH	Medical director	Immediately
2. Beds in ward need to be replaced	Request new beds from MOH	Clinic director	June 15
3. Shortage of nursing staff	Request budget from MOH; hire new staff	Clinic director	June 30
4. No space for client education sessions	Prepare proposal for international donor agency	Proposal team	July 30
5. Lack of means of transporting patients	Ask MOH for vehicle	Clinic director	July 15
6. Shortage of expendable supplies	Request from MOH	Clinic director	June 15

Question:

This plan has little chance of being accomplished. Can you suggest some reasons?

_____

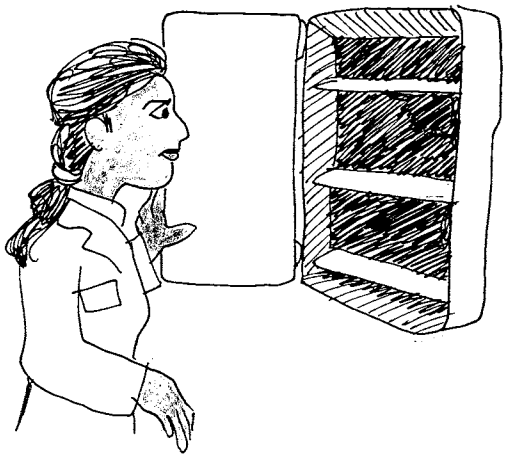
_____

Example: Finding Local Solutions

In the example above, all the solutions depend on external resources, the time frame is too short or does not show a specific date, no specific names are recorded, and in four of the six areas the same person is responsible for the solution. In this example, let's reexamine this plan and see if there are ways to achieve local solutions for the problems identified.

Consider item 1 from the sample action plan, the problem of the stock-out of Depo-Provera.

Problem	Recommendation	By whom	By when
1. Stock-out of Depo	Order from MOH	Medical director	Immediately



While helping staff find the root of the problem by asking "why?" three times, you discover the following:

Why did you run out of Depo?

Answer: Because we didn't get our resupply from the MOH.

Why didn't you get your resupply?

Answer: Because we didn't place our order in time.

Why didn't you place your order in time?

Answer: Because we ran out of order forms.

So the root cause of the problem does not lie with the Ministry of Health, but with the site's system for ordering supplies. Consequently, there should be two actions: 1) order supplies of Depo from the MOH, and 2) obtain order forms (perhaps by getting a form from another clinic and making photocopies).

The revised item on the action plan would now look like this:

Problem and cause	Recommendation	By whom	By when
1. Stock-out of Depo because of lack of order forms	Order from MOH	Kim Lee (supplies person)	June 1
	Copy sufficient supply of order forms	George Veracruz (secretary)	June 1

Consider item 2, the problem of the beds.

Problem	Recommendation	By whom	By when
2. Beds in ward need to be replaced	Request new beds from MOH	Clinic director	June 15

Again, the problem might not necessarily require staff to order new beds. Take a look at the following example:

Example: Finding Local Solutions

In an African hospital, beds were sagging so badly that patients were putting their mattresses on the floor. The supervisor asked, "What can you do to solve this problem yourselves?" Staff noticed the wire mesh that protected the windows of the clinic and suggested that, since this commodity was available in the community and relatively inexpensive, they could weld it to the bed frames. This was accomplished and solved the problem.

This item in the new action plan would read as follows (note that the time frame has also been made more realistic):

Problem and cause	Recommendation	By whom	By when
2. Beds are sagging because of broken springs	Buy wire mesh Replace bed springs with wire mesh	Kim Lee (supplies person) Sam Ochoa (maintenance person)	June 15 December 15

Consider item 3, the shortage of nursing staff.

Problem	Recommendation	By whom	By when
3. Shortage of nursing staff	Request budget from MOH; hire new staff	Clinic director	June 30

To make sure that there really is a shortage, the supervisor should ask, Can the shortage be proven statistically?

Help staff calculate the workload per nurse and judge whether it is reasonable (see data collection information in Chapter 4), or conduct a client-flow analysis to calculate staff utilization. If the shortage cannot be proven statistically, the supervisor should help staff find out why they feel there is a shortage. This perception may really be due to other factors, as in the example here.

Example: Finding the Root Cause

In a clinic in Thika, Kenya, clients were complaining that they had to wait too long for services. Staff at first felt that this delay was caused by a shortage of nurses. However, an analysis revealed that no clients were being seen during the lunch and tea periods because all of the staff took lunch and tea at the same time. The staff solved this problem by staggering their own lunch and tea periods. As a result, client waiting times decreased.

This item and time frame in the new action plan would now read:

Problem and cause	Recommendation	By whom	By when
3. Long waiting times because all staff take lunch and tea at same time	Stagger lunch/tea schedule	L. Karisa, J. Samanda (clinic staff)	June 1

Consider item 4, the lack of space for educational sessions.

Problem	Recommendation	By whom	By when
4. No space for client education sessions	Prepare proposal for international donor agency	Proposal team	July 30

Renovation and construction are typically beyond the scope of site staff because of their high cost. Nevertheless, first try to solve the problem locally by asking staff: What can you do to solve this problem? Is all available space fully utilized? Can space that is not used all day be shared? Can existing space be used for more than one purpose at a time?

If staff are unable to find usable space, encourage them to consider local community resources. What about local churches/mosques? Community groups or clubs? Remind them that the community is their customer and benefits from their services. The community, therefore, may be a willing partner in the solution of the site's problems.

Example: Using Community Resources

A hospital in an African country did not have a space for client-education sessions. The hospital had land, but no funds. Hospital managers approached a local church that had funds, but no land. Together they built a chapel on the hospital grounds. It is used six days per week for client education and one day per week for religious services.

This item and time frame in the new action plan would now read:

Problem and cause	Recommendation	By whom	By when
4. Low level of client knowledge because no space for client education sessions	Meet with community leaders to discuss renovation or construction of space	Dr. Navotnik (hospital director)	June 15
	Prepare proposal for community leaders	N. Sharif (clinical officer), J. Mbanga (supervisor)	September 1

Consider item 5, the lack of transport.

Problem	Recommendation	By whom	By when
5. Lack of means of transporting patients	Ask MOH for vehicle	Clinic director	July 15

Ask the staff: "What can you do to solve this problem?" Give examples of what other sites have done, such as:

- In rural Tanzania, staff places a red flag on the road as a signal that a patient needs transport to the hospital. The community has been educated to recognize this signal.
- In some clinics, staff use their own vehicles to transport patients.

Transportation is a difficult problem, often beyond the scope of staff. In such cases, an interim solution and a long-term solution involving external assistance are both necessary.

This item in our action plan might then read:

Problem and cause	Recommendation	By whom	By when
5. Lack of means of transporting patients	Canvass staff and community for available vehicles	Dr. Ware (clinic director)	August 15
	Prepare proposal to MOH for vehicle	Dr. Ware (clinic director)	November 15

Consider item 6, the shortage of expendable supplies. This is a chronic problem in many areas.

Problem	Recommendation	By whom	By when
6. Shortage of expendable supplies	Request from MOH	Clinic director	June 15

The supervisor should ask, "What can you do about it?" and give examples of creative solutions, such as those in the following example box.

Examples: Creative Solutions

- Through self-assessment, staff at a regional hospital in Africa identified a lack of supplies, especially beds, linens, and mosquito nets. Hospital staff approached the churches in the community. Three churches joined forces and held a fundraiser for the hospital. They raised enough money to buy mosquito nets for the beds and rubber sheets.
- At a district hospital, staff approached a member of Parliament with a list of supplies that the hospital budget could not cover. Realizing that the hospital protected the health and welfare of his constituents, he arranged for part of the Ministry of Health's budget to cover the hospital's supply needs.
- Some hospitals with chronic shortages ask prenatal clients to donate a package of supplies (gauze, alcohol, sutures, etc.), called the "maternity packet." Pharmacies have the list of contents and have the packets already prepared. Whatever is not used for the client is kept by the hospital and used for others, assuring that those who cannot provide their own packet are cared for.

This item in our action plan might now read:

Problem and cause	Recommendation	By whom	By when
6. Shortage of expendable supplies because of inadequate budget	Ask pharmacy to prepackage maternity supplies	Dr. Ware (clinic director)	July 1
	Ask clients to bring maternity supplies	L. Karisa (clinic nurse)	July 1

Now consider the revised action plan in its entirety:

Problem and cause	Recommendation	By whom	By when
1. Stock-out of Depo because of lack of order forms	Order from MOH	Kim Lee (supplies person)	June 1
	Copy sufficient supply of order forms	George Veracruz (secretary)	June 1
2. Beds are sagging because of broken springs	Buy wire mesh	Kim Lee (supplies person)	June 15
	Replace bed springs with wire mesh	Sam Ochoa (maintenance person)	December 15
3. Long client waiting times because all staff take lunch and tea at same time	Stagger lunch/tea schedule	L. Karisa, J. Samanda (clinic staff)	June 1
4. Low level of client knowledge because no space for client education sessions	Meet with community leaders to discuss renovation or construction of space	Dr. Navotnik (hospital director)	June 15
	Prepare proposal for community leaders	N. Sharif (clinical officer), J. Mbanga (supervisor)	September 1
5. Lack of means of transporting patients	Canvass staff and community for available vehicles	Dr. Ware (clinic director)	August 15
	Proposal to MOH for a vehicle	Dr. Ware (clinic director)	November 15
6. Shortage of expendable supplies because of inadequate budget	Ask clients to bring supplies	L. Karisa (clinic nurse)	July 1
	Ask pharmacy to prepackage maternity supplies	Dr. Ware (clinic director)	July 1

This action plan now has a much higher chance of being accomplished because many of the solutions are in the hands of the staff themselves. Other problems will be solved through local resources, which are more immediate and more responsive to the site's needs than are international donors.

Bibliography

AVSC International. 1995. *COPE: Client-oriented, provider-efficient services.* New York.

AVSC International. 1996. AVSC medical monitoring handbook. Unpublished draft. New York.

AVSC International. 1997. Training desk reference: Guidelines and resources. Unpublished draft. New York.

Ben Salem, B., and Beattie, K. J. 1996. Facilitative supervision: A vital link in quality reproductive health service delivery. *AVSC Working Paper* No. 10. New York.

Berwick, D. M.; Godfrey, A. B.; and Roessner, J. 1990. *Curing health care: New strategies for quality improvement.* San Francisco: Jossey-Bass.

Bradley, J., et al. 1998. Whole-site training: A new approach to the organization of training. *AVSC Working Paper* No. 11. New York.

Buzzotta, V. R. 1998. Restoring trust in the workplace. *Performance in Practice* (spring): 13-14.

Dohlie, M., and Satia, J., eds. 1997. *Population manager: Improving quality of care.* Population Manager, vol. 5. Kuala Lumpur, Malaysia: The International Council on Management of Population Programmes (ICOMP).

Family Planning Management Development. 1993. *The Family Planning Manager* 2(1). Newton, Massachusetts.

Harper, A., and Harper, B. 1996. *Team barriers: Actions for overcoming the blocks to empowerment, involvement, and high performance.* New York: MW Corporation.

Harrington-Mackin, D. 1994. *The team building tool kit: Tips, tactics, and rules for effective workplace teams.* New York: American Management Association.

Holy Cross Hospital. 1998. *Holy Cross Hospital Service Excellence Institute.* Chicago.

Interaction Associates. 1997. *Facilitative leadership: Tapping the power of participation.* San Francisco: Interaction Associates.

Ittner, P. L., and Douds, A. F. 1988. *Train-the-trainer: Practical skills that work.* Amherst, MA: HRD Press.

Jayakaran, R. I. 1996. *Participatory learning and action: User guide and manual.* Madras, India: World Vision of India.

Katzenbach, J. R., and Smith, D. K. *The wisdom of teams: Creating the high-performance organization.* Boston: Harvard Business School Press, 1993. Reprint, New York: HarperBusiness, 1994.

Kinlaw, D. C. 1996. *Coaching: The ASTD trainer's sourcebook.* New York: McGraw-Hill.

Landsberg, M. 1997. *The tao of coaching: Boost your effectiveness by inspiring those around you.* Santa Monica, California: The Knowledge Exchange.

Mager, R. F. 1992. *What every manager should know about training.* Atlanta: The Center for Effective Performance.

Minor, M. 1996. *Coaching and counseling: A practical guide for managers and team leaders.* Revised edition. Menlo Park, California: Crisp Publications.

Muhondwa, E., and Rutenberg, N. 1997. Effects of the Vasectomy Promotion Project on knowledge, attitudes, and behaviour among men in Dar es Salaam, Tanzania. Report. New York: The Population Council.

Organizational Dynamics. 1993. *Making teams work: A guide to creating and managing teams.* Burlington, Massachusetts.

Vera, H. 1993. The client's view of high-quality care in Santiago, Chile. *Studies in Family Planning* 24(1): 40-49.

Wilson, G. L. 1996. *Groups in context: Leadership and participation in small groups.* Fourth edition. New York: McGraw-Hill.

Zenger Miller. *Giving and receiving constructive feedback: Instructor's unit guide.* 1995. West Conshohocken, Pennsylvania.