

Minutes of QI in Focus Phone call

Date: 03/20/08

Time: 8:30-10:00 AM EST

Topic of the call: Dee Dee Yates and Lucy Steinitz from FHI/Namibia presented on their experiences in supportive supervision and coaching for OVC care providers.

Due to the small size of the group, the call was conducted as an informal discussion facilitated by Lori DiPrete Brown.

Participants:

Lucy Steinitz (Presenter), Senior Technical Officer, FHI Namibia

Dee Dee Yates (Presenter), FHI Namibia

Lori DiPrete Brown (Facilitator), Assistant Director, Center for Global Health, U. of Wisconsin

Marie-Eve Hammink, QA Advisor, URC

Samantha Dovey (Note taker) Project Coordinator, URC

William Flemming, CCF

Sandy Dalebout, Project Hope

Ochi Ibe, USAID/Nigeria

Philomena Irene, USAID/Nigeria

Dee Dee Yates:

In Namibia, FHI in collaboration with the MOH are working with a group of about 70 people to develop community and home-based care standards.

They held a 3-day workshop in February, with clients, providers, policy-makers, and MOH officials to draft the standards. Standards are comprehensive and focused on what is really required by the volunteers.

Supportive supervision falls under their supportive management of CHBC providers' standards. It is listed as one of the seven critical minimum requirements, it is included as part of the whole package, instead of being listed separately.

Standard for Supportive supervision:

- Each CHBC provider shall receive quality supportive supervision monthly, including: technical, emotional, spiritual and administrative components.
- Each CHBC provider shall be managed, supported, supervised and evaluated by a permanent staff member, trained in supportive supervision.
- Each supervisor shall accompany each CHBC provider on a home visit at least once per year.
- The supervision shall keep written records of supervision meetings.
- Recommended duties of the supervisor should include to:
 1. Determine compliance w/quality standards of each CHBC provider
 2. Provide on the job skills transfer and learning.
 3. Listen to the CHBC providers

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4. Recognize signs of burn out in self and others.
5. Care for the carer through strategies such as adjusting the pace or approach of work and having a support network. Ensure groups of CHBC providers are working together and that group or peer counseling takes place.
6. Facilitate regular support group or network meetings to be held.
7. Ensure groups use stress management techniques and other coping strategies.
8. Encourage group members to stay in good health.
9. Arrange quarterly network meetings with other local partners, if not organized by the MoHSS clinic nurse.
10. Adjust the case load of individual CHBC providers when a client's situation changes.
11. Encourage success stories to be shared.
12. Discuss challenges and give appropriate advice or take appropriate action.
13. Monitor that HBC kits are being used properly and benefiting the clients.
14. Reinforce the importance of taking universal precautions.
15. Collect Reports.

For monthly supervision, supervisor would make home visits with the volunteer; it was felt that more than monthly visits would be too much.

In Ethiopia, Marie-Eve commented that volunteers didn't feel comfortable being accompanied on home visits. However, it is important that supervisor's accompany volunteers to be able to understand better the issues the volunteers face. In Ethiopia they are looking into a few options: monthly visits, meetings that are one on one with the volunteers.

Recognize the importance of supervisors meeting clients in order to better understand their situation and also to be able to monitor quality.

Age of volunteers was brought up as an issue, is it necessary that they be 18 in order to be a volunteer? Other issues highlighted were possible compensation for the volunteer and changing their titles from 'volunteers,' to being care providers.

Standards should be adapted appropriately for the environment.

FHI will be starting a QI collaborative on home-based care in Namibia.

Another issue that was brought up in the discussion was how to count the number of people served? Does only the child get counted, or the child and one family member, or the entire family? This remains to be a determined based on what is felt appropriate for the care provided.

Lucy Steinitz:

Lucy began with a brief background on the past history of Namibia to give light to the current political and social situation of the country, explaining the affects of colonialism and apartheid and it's creation of the current environment of fear.

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Due to the current situation, FHI has tried to create a different environment—one where they provide support and comfort. Have created a packet for volunteer providers of tips on how to be able to create this different working environment.

Supervisors need to help to reorient volunteers—to be able to provide supportive care, they need to be encouraged and motivated and feel good about the success they have achieved.

Sharing of experiences by supervisors is still a challenge. There exists a fear about what other people will think and also a there is fear to take the risks that they need to in order to grow.

Training for supervisors needs to be dynamic, include role-playing—they will learn best by experience and through personal growth. There needs to be an emphasis on the things that they are doing right in order to encourage and motivate them and to not feel bad about the things that they've been doing wrong.

Training is very important because many of the people in supervision roles have never been trained in supervision.

Discussion on the differences between coaches and supervisors: Coaches are fundamental to keeping people motivated, constantly supported and continuously learning. Coaching can be among peers, whereas the supervisor role is inevitably hierarchical and requires taking both a disciplinary and regulatory role.

Other issues that were raised at the end of the call:

There was a short discussion regarding the feasibility of engaging volunteers, low literacy caregivers in assessing the quality of services. The discussion centered on how feasible is it to engage volunteers in using the CSI as a tool to assess children's well being. One of the proposed strategies is to review existing low-literacy materials and use them to develop and test possibly an assessment tool that can be used at the community level. Project Hope would be very interested in reviewing other types of low-literacy tools as it is trying to develop some assessment tools that can be used by volunteers. Project Hope would appreciate anyone that has examples of low literacy data collection tools to send them to sdalebout@projecthope.org. In addition, there was a request to circulate to all on the call such tools.

Data collection- There needs to be a feedback loop to get information back to the volunteer/family/community built in as part of the process. Will help volunteers and families understand why they are gathering the data.