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Guidelines for Implementing Supportive Supervision

A step-by-step guide with tools to support immunization

path
Program for Appropriate Technology in Health

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Program for Appropriate Technology in Health (PATH) is an international, nonprofit, nongovernmental organization whose mission is to find and implement solutions to critical health problems, especially those affecting women and children. PATH is widely recognized for its collaborative work with local and international partners and its success in building and sustaining public- and private-sector partnerships. PATH shares knowledge, skills, and technologies with governments and nongovernmental partners in low-resource settings around the world. For PATH, "appropriate" technologies and interventions are those that meet critical health needs in an affordable and culturally acceptable manner.

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Please contact the Children's Vaccine Program at PATH for questions or requests for additional copies.

Children's Vaccine Program
PATH
1455 NW Leary Way
Seattle, WA 98107
USA

Tel: 206-285-3500
Fax: 206-285-6619
Email: info@ChildrensVaccine.org
Website: **www.ChildrensVaccine.org**

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Acronym list

AD	Auto-disable
AED	Academy for Educational Development
AEFI	Adverse Events Following Immunization
ANM	Auxiliary Nurse Midwife
AP	Andhra Pradesh
ASHONPLAFA	Asociatión Hondureña de Planification de la Familia
BCG	Bacillus of Calmette and Guerin
COPE®	Client-Oriented, Provider-Efficient
CVP	Children's Vaccine Program
DHMT	District Health Management Team
DFID	Department for International Development
DTP	Diphtheria, Tetanus, and Pertussis
EPI	Expanded Programme on Immunization
GAVI	Global Alliance for Vaccines and Immunization
ICC	Interagency Coordinating Committee
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
JICA	Japanese International Cooperation Agency
MAQ	Maximizing Quality in Health
MCH	Maternal and Child Health
MIS	Management Information System
MOF	Ministry of Finance
MOH	Ministry of Health
MNT	Maternal and Neonatal Tetanus
MSH	Management Sciences for Health
MV	Measles Vaccine
NGO	Nongovernmental organization
NIP	National Immunization Program
OPV	Oral Polio Vaccine
PAHO	Pan American Health Organization
PATH	Program for Appropriate Technology in Health
PNA	Performance Needs Assessment
QAP	Quality Assurance Project
QI	Quality Improvement
RED	Reaching Every District
TBA	Traditional Birth Attendant
TNA	Training Needs Assessment
TOT	Training of Trainers
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VVM	Vaccine Vial Monitor
WHO	World Health Organization

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Primary Reviewers: Jhilmil Bahl, WHO/Vaccines and Biologicals; Stanley Foster, Emory's Rollins School of Public Health; Evariste Mutarabuka, WHO-African Regional Office (WHO/AFRO); Modibo Dicko, WHO/AFRO; Erin Mielke, EngenderHealth; Alasdair Wylie, Immunization Management Consultant; James Cheyne, Willow Gerber, Scott Wittet, and Heidi Lasher, PATH.

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Foreword

In order to provide safe and cost-effective immunizations to people at risk, health workers need to be well trained on immunization practices and management. Training and capacity building are key elements to improve access to sustainable, high-quality immunization services. Four main steps are involved to develop this capacity:

- Conducting training needs assessments.
- Providing pre- and in-service education.
- Conducting supportive supervision, including continuing education.
- Monitoring and evaluating training programs.

The Global Alliance for Vaccines and Immunization (GAVI) partners have identified supportive supervision as a high priority and a critical gap in immunization training. Supportive supervision is also one of the five key elements of the "Reaching Every District"[1] strategy to accelerate progress toward GAVI's goal of reaching 80 percent DTP3 coverage in 80 percent of developing country districts (WHO 2002). The following guidelines have been compiled in response to this need. They are designed to be adapted for local context to help national managers and country staff understand and include supportive supervision methodologies as part of routine immunization management. The purpose of these guidelines is to:

1. Define supportive supervision and show how it can improve immunization programs.

2. Outline major steps that should be considered when introducing and implementing supportive supervision.

3. Provide country examples of supportive supervision, highlighting different approaches and lessons learned.

4. Identify and disseminate available tools that can be used for supportive supervision.

These guidelines are designed to be adapted for local context. Checklists and tools are included as possible models for immunization programs. Because supportive supervision is a lesson "in progress," we encourage readers to send feedback, questions, and other examples of tools and case studies to the Immunization Training Partnership website (www.who.int/vaccines-diseases/epitraining) to share with others.

We hope that these guidelines serve as a useful resource for you.

[1] The five key elements of the "Reaching Every District" strategy are: reestablishing outreach vaccination; supportive supervision; links between community and service; monitoring for action; and planning and management of resources.

Guidelines for Implementing Supportive Supervision

I. Introduction

Many institutions' response to poor performance is to provide in-service training. Long-term capacity building takes time and planning, and should include a needs assessment, in-service training based on results of the assessment, supervision, and continuing education. Supervision is an excellent opportunity to provide follow-up training, improve performance, and solve other systemic problems that contribute to poor immunization coverage. Though there are many examples and case studies where supportive supervision has been used to improve health worker performance and immunization coverage, long-term and sustainable results have not been thoroughly documented. The following guidelines focus on supportive supervision—a process that promotes sustainable and efficient program management by encouraging effective two-way communication, as well as performance planning and monitoring.

Ongoing supervision is an important, often overlooked, step to ensuring quality immunization services. While supervision can be a very participatory process, traditional supervisory visits focus more on inspection and fault finding rather than on problem solving to improve performance. Health workers often receive little guidance or mentoring on how to improve their performance. They are frequently left undirected, with few or no milestones to help assess their performance, until the next supervisory visit. Motivation is hard to maintain in such an atmosphere.

Supervisors often lack the technical, managerial, or supervisory skills needed to effectively evaluate health facilities across the many sectors for which they are responsible. In addition to assessing performance, supervisors are also expected to monitor services, evaluate management, and ensure that the health facility supply chains are working properly—all in a short period of time. Consequently, they are unable to provide adequate technical guidance and feedback to improve service delivery.

Supportive supervision requires staff time, costs for per diem, and travel to remote sites. Health budgets frequently do not allocate sufficient funds or personnel to conduct supportive supervision, making regular visits difficult to finance and coordinate. Furthermore, supervisors need support and authority from the central or district level to implement supervision or make changes to improve services at a health facility.

II. Moving toward supportive supervision

Supportive supervision is "a process that promotes quality at all levels of the health system by strengthening relationships within the system, focusing on the identification and resolution of problems, and helping to optimize the allocation of resources—promoting high standards, teamwork, and better two-way communication." (Marquez and Kean 2002)

A cornerstone of supportive supervision is working with health staff to establish goals, monitor performance, identify and correct problems, and proactively improve the quality of service. Together, the supervisor and health workers identify and address weaknesses on the spot, thus

preventing poor practices from becoming routine. Supervisory visits are also an opportunity to recognize good practices and help health workers to maintain their high-level of performance. (See Table 1 for a comparison of traditional supervision and supportive supervision.)

Table 1: **Comparison of traditional and supportive supervision** (Marquez and Kean, 2002)

Action	Traditional supervision	Supportive supervision
Who performs supervision	External supervisors designated by the service delivery organization	External supervisors designated by the service delivery organization; staff from other facilities; colleagues from the same facility (internal supervision); community health committees; staff themselves through self-assessment
When supervision happens	During periodic visits by external supervisors	Continuously: during routine work; team meetings; and visits by external supervisors
What happens during supervision encounters	Inspection of facility; review of records and supplies; supervisor makes most of the decisions; reactive problem-solving by supervisor; little feedback or discussion of supervisor observations	Observation of performance and comparison to standards; provision of corrective and supportive feedback on performance; discussion with clients; provision of technical updates or guidelines; onsite training; use of data and client input to identify opportunities for improvement; joint problem-solving; follow-up on previously identified problems
What happens after supervision encounters	No or irregular follow-up	Actions and decisions recorded; ongoing monitoring of weak areas and improvements; follow-up on prior visits and problems

Moving from traditional, hierarchical supervision systems to more supportive ones requires innovative thinking, national buy-in, and time to change attitudes, perceptions, and practices. This document is the result of recommendations from various partners who recognize the importance of supportive supervision and who are implementing it in their programs. Program managers should adapt these guidelines to their local situation and share their results with others.

A. Understand the country context and mobilize appropriate national support

Before implementing supportive supervision, it is important to understand the supervisory systems that have already been established, including knowing who makes the decisions on supervision and how it is funded.

1. Find out what supervision policies currently exist and assess whether they allow for supportive supervision. If there is a policy in place, determine how effectively it is being

implemented; assess the number of supervision visits scheduled; and determine the number of visits actually carried out.

2. If supervision is part of integrated health services, find out whether supervisors will be responsible for integrated health care systems or for immunization services alone. Take this into account when budgeting for supervision. (*See Case Study 1 on integrated supervision.*)

3. Find out **who** does the supervision and the other responsibilities of these supervisors. Also find out how much time they have to commit to supportive supervision.

4. Build on successful supervision currently in place in other health sectors. Use the same standards, approaches, and vocabulary to ensure consistency. (*See Case Studies 1-4 for different approaches to supervision.*)

5. If there is no policy or it needs to be updated, participate in its development and/or revision and advocate for appropriate ministries and other stakeholders to be involved in the process.

6. Advocate for financial support to implement supportive supervision by:

   - Using district-level microplanning to estimate what resources are needed for effective supportive supervision.

   - Preparing a budget with actual costs of conducting supportive supervision for Interagency Coordinating Committee (ICC) and Ministry of Health (MOH) review. Costs should include funding for supervisor training, per diem for supervisory visits, transportation costs, purchase of vehicles, etc. (*See Annex B for a sample budget.*)

   - Investigating local resources within the community such as community health committees and local governments.

   - Preparing a persuasive argument using available data to advocate to decision makers on the benefits of supportive supervision.

   - Mobilizing senior-level managers to lobby for adequate funding for supervision costs within the ICC, the MOH, and Ministry of Finance (MOF).

7. Advocate for supportive supervision with the ICC, MOH, and MOF to ensure that adequate funds are made available and that these funds are not reduced during the budgeting process.

8. Incorporate supportive supervision into annual health budgets, national work plans, and financial sustainability plans.

9. Galvanize institutional support for supportive supervision. Supervisors need standard procedures, authority to make decisions, training, and sufficient funds to carry out their jobs effectively.

10. Involve senior-level managers to help make all levels of supervision a priority and ensure that all supervisors are held accountable. (*See Annex C on different supervision responsibilities at the national and subnational levels, developed by WHO/AFRO.*)

B. Make supervisors part of the training process

Supervisors can play a very important role in the training process and their involvement in a training program is critical for buy-in. They can also help ensure that the training needs of the health workers are addressed. Below are suggestions on how to involve supervisors in training:

1. Update supervisors on current policies, new immunization practices, techniques, and management skills.[2]

2. Train supervisors on how to coach, mentor, effectively communicate, and conduct performance planning. This will build their supervisory skills to better guide service providers to improve performance and solve problems at the health facility level.

3. Involve supervisors in the training process—conducting training needs assessments, building training-of-trainers (TOT) skills, and carrying out workshops. Because they know the issues at the health facility level, supervisors can help identify training needs and performance gaps, and develop training priorities for vaccinators.

4. Train supervisors on adult learning and training techniques. This will strengthen their capacity to deliver effective on-site instruction and follow-up.

5. Involve supervisors in the development of training curricula and job aids. This ensures buy-in and builds the capacity of the supervisor to effectively transfer skills and knowledge to health workers.

6. Help supervisors build a receptive environment for new techniques by updating all staff on new practices. For example, if a nurse at the health center is going to be trained in new waste disposal practices, the supervisor can brief the health center staff on the new technique and how to support this practice.

C. Work with supervisors to plan and conduct supportive supervision

Many program managers use the following steps to implement supportive supervision in their health programs.

[2] *Immunization Essentials* is a useful guide for EPI managers developed by USAID. Information will be available soon on the Immunization Training Partnership website (www.who.int/vaccines-diseases/epitrainig).

1. Prepare in advance for supervisory visits

   - Plan to conduct **regular** supervisory visits. When supervisory visits are made routinely, supervisors are better able to monitor performance and can identify and address problems before they negatively impact service delivery.

   - Arrange visits when supervisors can observe an immunization session, interview clients, and arrange for staff meetings **without** adding extra burden to the staff. Some institutions recommend monthly supervisory visits, others quarterly. Lesser performing health facilities should receive more frequent visits.

   - Organize the supervisory visit by:
     – Reviewing objectives of annual and multi-year plans.
     – Developing clear objectives for the visits.
     – Following up on recommendations made during previous visits.
     – Collecting helpful publications, materials, and supplies for the health facility.
     – Preparing updates and/or refresher training to present during the visit.

   - Plan to spend sufficient time (from several hours, to a full day or more) to conduct the supervisory visit. The amount of time of a supervisory visit varies depending on the needs of the health facility. For example, in some cases a two-day visit would be more effective than just one day. It allows the supervisor enough time for meeting with the health worker to discuss performance goals, meeting with the community, assessing the facility's cold chain, and traveling.

   - Stick to the schedule and respect the health workers' time. Always schedule a return visit before leaving the site.

2. Set expectations for performance

   - Develop job descriptions, expectations, and standards of performance. Supervisors should prepare these together with the staff being supervised.

   - Determine measurable performance goals together with staff. Make sure that the goals are realistic and attainable.

   - Develop measurable indicators, milestones, and tools so that staff can monitor their progress toward goals. (*See Annex D for a sample workplan.*)

   - Develop a supervisory team within the health facility that can provide day-to-day support and supervision.

   - Introduce a self-assessment/feedback system.

3. Monitor and assess performance of the health facility

   - Observe immunization sessions and note strengths and weaknesses. *(See Annex E for observation worksheet.)*
   - Talk to clients about the quality of services, preferably away from the health facility—you will be more likely to receive honest answers.
   - Involve the community in the evaluation process. Ask community members how they are treated when they visit the facility. Do they know about reactions to immunization? Do they know what to do about them? Do they know when to return? Meet with designated community leaders during the visit to get their feedback.
   - Check the availability of stock and the condition of equipment.
   - Check cold chain and vaccine quality.
   - Review health facility records, including coverage and dropout rate monitoring charts. (*See Annex G for a sample dropout rate-monitoring chart.*)
   - Meet with the supervision team within the facility and ask for additional feedback on service delivery.
   - Use information gathered during the visit to discuss progress with the health facility team.
   - Always start out by presenting the health staff and facility's positive attributes.
   - Review indicators, milestones, and performance with staff. (*See Annex H for a list of GAVI core immunization program indicators that can be adapted to the local context.*)
   - Assess performance goals and make adjustments as needed.
   - Both the supervisor and supervisee should keep a written log/record of items discussed, including strengths and weaknesses, and actions to be taken (by whom and by when).

4. Identify gaps and solve problems in positive ways

   - Praise health workers in public for good performance and for practices that meet quality standards. **Correct performance only in private**.
   - Provide staff with informational updates on policies or new recommended practices.

- Discuss findings and recommendations with the health facility team:
  - Ask the staff to identify areas of strength and weakness. A supervisor can serve as a facilitator and help the staff develop strategies for solving problems.
  - Give constructive feedback.
  - Find causes and reasons for poor performance—is it a capacity issue? An equipment or supply issue? Motivation?
  - Discuss, listen, give feedback, and solve problems together.
  - Review coverage data and drop-out rates. Work with the team to identify reasons for drop-out rates and strategies for improvement.
  - Set target coverage rates for improvement.

5. Provide support and strengthen capacity of health care providers to meet performance goals

- Identify information/training needs together with staff.

- Work with health facility and district- or central-level authorities to set priorities.

- Provide on-site updates and training.

- Develop job aids according to priorities. Be prepared to leave job aids at the health facility, but consider leaving behind only the job aids related to priorities.

- Follow up on equipment and supply problems in a timely manner with the district or central level authorities.

- Work on ways to improve the delivery system with the district- or central-level authorities.

D. Stay motivated

Staying motivated to use supportive supervision can be a challenge. Motivation can decline when supervisors and health workers are poorly paid or transferred, and when results are hard to see. Staff can become discouraged when performance planning is burdensome. The following suggestions may help:

- Give praise and recognition to health workers for what they are doing right. Even if monetary recognition is not possible, recognition can come in other forms. Health workers can be recognized in official letters, newspapers, newsletters, by awarding certificates acknowledging good work, and by receiving new uniforms, pins, bags, or prizes for a job well done.

- Identify career growth or leadership opportunities and provide guidance and training needed for advancement.

- Involve health workers in the planning process and encourage supervisors to work together with health facility staff and the community to develop checklists, job aids, monitoring tools, etc.

- Act on feedback from the health workers. For example, if a health center needs a new refrigerator and a supervisor is able to lobby the central-level authorities to procure one, health workers will feel valued and that they have an impact.

- Establish regular monthly meetings with **all** health facilities within a district. The meetings could coincide with when health workers collect their pay. This provides an opportunity for health workers to learn new approaches and strategies used in different health facilities and to receive continuing education. It can also be a forum to acknowledge their achievements and their sites. Work with organizers to ensure that time is allocated for this.

E. Build sustainability

The first step to ensuring sustainability of supportive supervision is to institutionalize it within the government system. This can be done in several ways:

- Incorporate supervision into the national budget and work plan or into the district-level microplans. This helps make supervision a recurring, funded cost.

- Increase decision maker and manager awareness of the benefits of supportive supervision by:
  - Collecting data on positive results gained from supportive supervision, such as improved performance of health workers, improved immunization coverage, or increased utilization of resources.
  - Lobbying government officials and decision makers on the benefits and effectiveness of supportive supervision. Show data on improved quality, cost-effectiveness (e.g. reduced vaccine wastage), and increased coverage.
  - Continually advocating for supportive supervision at the central-, district-, and health center-levels to maintain visibility of supportive supervision as a key element to quality service delivery.

- Develop a team approach to increase supportive supervision at a health facility and make it a routine procedure, with or without frequent visits from the central or district level. Health facility staff can develop supervision plans that fit their structures and conduct regular self-assessments to monitor their performance.

III. Case studies and available tools

The following case studies illustrate the different approaches to supportive supervision:

1. *District supportive supervision following health sector reform in Tanzania*
   The District Health Management Team in Tanzania involves an integrated supervision team and uses a matrix to conduct and monitor supervision. Supervision is now more frequent and health workers use it as an opportunity to solve problems.

2. *COPE® and facilitative supervision in Kenya and Guinea*
   Using EngenderHealth's Client-Oriented, Provider-Efficient (COPE®) model, (a participatory supervision approach that includes self-assessment and performance plans), immunization services in Kenya and Guinea improved, as did health worker performance and attitudes toward supervision.

3. *Planning and implementing supportive supervision in Honduras*
   A reproductive health, nongovernmental organization (NGO) in Honduras adopted a strategy to improve supervision and service delivery while reducing costs. The group looked at performance issues and developed a supervision system to address them. Performance goals were achieved, service quality improved, and client satisfaction increased.

4. *Innovative strategies for supportive supervision in Andhra Pradesh, India*
   New strategies are being developed and adapted for supportive supervision, including outsourcing supervision to medical schools.

There are many reference tools available for supportive supervision that are easily adapted to suit various program needs. Examples of these useful tools and websites can be found in the annexes to this document.

IV. Conclusion

Supportive supervision fosters a collaborative approach to strengthen health worker performance and immunization services. It has been an effective tool for improving performance for many organizations. These guidelines and tools can be adapted. They can provide a starting point to develop a supportive supervision system or help to streamline already existing supervision systems.

Case studies

Case study 1: District supportive supervision following health sector reform in Tanzania

Following health sector reform in 1999, the MOH in Tanzania developed an integrated health package to guide essential health service delivery. Recognizing the importance of supportive supervision, the MOH included a plan to bring a team of supervisors to district health facilities to evaluate how services are being delivered, provide feedback, and conduct on-site training. Funding for supervision comes from the MOH through basket grants, with funds contributed by various donors to support delivery of essential health services.

All members of the District Health Management Team (DHMT), and some co-opted members, were trained in the objectives of health sector reform: promoting partnerships in the district, managing health resources, and planning and providing district health services. Supervision training was included as a part of the management module.

Prerequisites of integrated supervision

Effective integrated supervision requires:

- A functioning health care system.
- A reliable health management information system (MIS).
- Committed health personnel with training in crucial aspects of priority programs.
- Availability of sufficient financial resources.
- Well-organized and adequate transportation for accessing health facilities.
- Well-prepared supervision plans.
- Integrated supervision tools (e.g. checklists and questionnaires) prepared by representatives of priority programs. These tools should include all essential health services such as HIV/AIDS, IMCI, Malaria, and EPI (WHO regional office, 2003).

Supervision matrix

One of the supervision and management tools to come out of this training is a supervision matrix.

Prior to supervision visits, the DHMT:

- Prepares a matrix listing the months and dates of all the supervisory visits; the routes and vehicles for each trip; the facilities to be visited; and the members of the supervision team.
- Ensures logistics and supplies needed for the visit.

The DHMT matrix highlighted that there was insufficient transportation to carry out the needed supportive supervision visits. As a result, the MOH purchased a vehicle for supervision in each district and trained transport officers with funds received from DANIDA.

During the supervision visit

For each supervision visit:

- The team develops a supervision checklist using national guidelines and the previous supervision report.
- Four members of the DHMT conduct supervision visits on a monthly basis. The teams alternate until all of the district's health facilities (both public and private) have been visited.

- When the team reaches the facility, they divide into specific areas of specialization following the checklist (e.g. disease management, nursing care, vaccine/immunization issues, managerial issues, HIV/AIDS). The team supervises health workers through direct observation and interviews.
- Immediate feedback is encouraged, and the team debriefs with the head of the facility. The team then meets with all staff and provides general feedback, praise, and suggestions for improvement.
- On-the-job training is also provided during the supervision visit.
- If a technical problem is found and the team feels it cannot be corrected, then the problem is presented to the rest of the DHMT members or to the area specialist for further management or action.

After the supervision visit

- The team goes back to the district headquarters, writes a full report, and discusses results with the whole DHMT core and co-opted members. Action items are listed for remaining challenges that were not resolved during the facility visit.
- A copy of the full supervision report is sent back to each visited facility and another copy is sent to Regional Health Management Team (RHMT).
- Difficult issues that could not be resolved by the DHMT are referred to the RHMT. The process then continues until all health facilities in the district have been reached.

Supervision at the regional level by the RHMT follows the same process and format. Difficult problems are sent to the MOH for further discussion and possible solutions.

Lessons learned and results

Since this system has been adopted, health workers have noticed a significant improvement in supervision. Supervisory contact is more frequent, problems are being solved, and on-the-job training is being conducted. Supervisory visits have become an opportunity for health workers to solve problems and learn additional skills. Health workers are no longer afraid to address challenges and are able to work with the DHMT to resolve them.

Case study 2: COPE® and facilitative supervision in Kenya and Guinea

COPE® is part of a quality improvement (QI) package developed by EngenderHealth and implemented with institutions in developing countries. The QI package is a continuous process that involves all levels of staff at a health facility to assess the situation at the site and work as a team to improve services. EngenderHealth uses facilitative supervision, medical monitoring, and whole-site training as part of its overall approach. It uses simple tools to implement these approaches, including COPE®.

Approach

The COPE® philosophy is one of participation, teamwork, ownership, and shared responsibility. There is a large focus on clients, staff development, capacity building, and supervisor engagement. COPE® is a process with a set of tools for health care staff to continuously assess and improve quality of care. It is built on a framework of client rights, staff needs, and consists of the following four tools:

- A self-assessment guide (one for each of the client rights and staff needs)
- A client interview guide
- A client flow analysis
- An action plan

The self-assessment guide encourages staff to review how they perform daily tasks and serves as a catalyst for analyzing the problems they identify. The guides contain key questions based on international clinical and service standards. The tools also highlight client-provider interactions and other client concerns.

Supervision is a key to quality improvement. District and facility supervisors receive training in facilitative supervision that emphasizes two-way communication, coaching, mentoring, and joint problem solving. Supervisors then work with health facility staff to improve quality of service. The COPE® process helps supervisors apply this facilitative approach to supervision by encouraging teamwork among all levels of staff, providing a forum for staff and supervisors to exchange ideas, and relying on staff to identify and solve problems through self-assessment and by learning the group's needs (Dohlie et al., 2002).

Lessons learned and results

In 1999, EngenderHealth adapted COPE® tools for use in child health services in Kenya and Guinea. For 15 months, eight selected study sites implemented a COPE® approach and eight control sites were chosen. The hypothesis of this intervention is that by introducing COPE® the providers and sites would undergo personal and organizational changes that would enable them to take action and improve the quality of service provided (Bradley et al., 2002).

At the end of the 15-month study, researchers visited the sites in Kenya and Guinea to observe provider-client interactions. Programmers felt that after the COPE® intervention, providers would examine client interactions and solve problems that may exist, and practices would improve.

Observers watched 160 immunizations of children up to five years old and obtained the following results:

Table 2. Provider-caregiver interactions

	Intervention site	Control sites
Provider discussed immunization schedule	87.5%	72.5%
Provider gave information on side effects after immunization (mentioned at least two)	63.3%	25.3%
Provider discussed what caregivers should do about side effects	69.9%	36.5%

Source: Bradley et al., 2002.

Researchers also conducted exit interviews with caregivers who had not been observed to check their knowledge on immunization after a visit to the clinic. Results showed that the caregivers were getting more complete information in the intervention districts than in the control districts, indicating improved service by the provider.

Table 3. Exit interview results

	Intervention site	Control sites
Caregiver recall of information about measles	55%	40.6%
Caregiver recall of information about polio	69.4%	54.5%
Child received birth polio vaccine	80.0%	56.2%
Child received BCG vaccination	84.3%	78.1%

Source: Bradley et al., 2002.

Focus groups were set up and participants asked how their perceptions of supervision had changed during the intervention.

Table 4. Staff perspectives on outside supervision: percentage of staff who agree strongly with statements

	Intervention site	Control sites
We truly benefit from supervision	61.0%	21.5%
They help us with supplies	66.2%	17.5%
They help us with training	64.9%	22.5%
They help us do COPE®	64.9%	1.3%
They help solve problems	62.3%	20.0%
They include us in their discussions	62.3%	32.5%

Source: Bradley et al., 2002.

Results show that participants felt supervision was better than before and that supervisors were practicing their new skills and were following up on problems identified through COPE®. There was a new focus on the issues being faced at the facility level and on problem solving. In Guinea, supervisors felt that they were part of the facility team and the participants felt that there was improved service delivery because of the supervisors' enhanced skills. Clients of the intervention

sites were “very satisfied” with the overall service received — 69.8% in the intervention sites; 48.4% in the control sites (Bradley et al., 2002).

Case study 3: Planning and implementing supportive supervision in Honduras [(Marquez and Kean, 2002), (Management Sciences for Health, 2001)]

The NGO, Associatión Hondureña de Planificación de la Familia (ASHONPLAFA), is the largest reproductive health provider in Honduras. Cost-cutting measures at ASHONPLAFA had reduced the budget for supervision visits and training and the organization wanted to establish a more cost-effective, integrated supervision system. With technical assistance from Management Sciences for Health (MSH) in 1999, ASHONPLAFA took the following steps to introduce a new supervisory system and strengthen supervisory skills throughout their operations.

Step 1: Stakeholder agreement & institutional context

Stakeholders agreed that interventions should focus on supervisors and supervisees.

Step 2: Conducting the performance needs assessment (PNA)

1. Defining desired status

Desired performance was defined in a workshop involving 25 supervisors from all levels of the organization. The group defined criteria for performance excellence, including supervisory values.

2. Defining actual status

ASHONPLAFA's supervisory system was assessed to look at authority, functions, performance planning, and supervisors' needs and procedures. Findings and recommendations of the assessment were presented to ASHONPLAFA's senior management and selected supervisors. The main findings included:

- Cost-cutting measures had expanded supervisor responsibilities but reduced resources for supervisory visits and skills training.
- Some procedures manuals were in place, but not a supervision system with integrated criteria and policies.
- Standards and procedures were already defined, however their organization-wide communication/dissemination was in process.
- Goals and expectations focused only on productivity and not on quality.
- Bimonthly performance evaluations were frequently subjective. Performance goals were not negotiated and/or previously negotiated goals were not referred to.
- Personnel excellence criteria did not exist.
- The recognition system was measured mostly in short-term results.
- Each area of the organization had different criteria for supervisor performance and different procedures.
- Supervisors complained that completing forms took too much time.

3. Analyzing data and doing root-cause analysis

At a supervisory skills training workshop, ASHONPLAFA's senior management and selected supervisors used the findings and recommendations to define the current supervision situation and address the desired organizational performance within the new context. Results indicated:

- Managers were sometimes cutting important supervision, planning, and training activities in order to reduce short-term costs.
- Operational staff were not included in the development and implementation of organizational policies, due to fewer planning meetings and supervision visits with less opportunity to share information.
- Although ASHONPLAFA had a series of procedure manuals as well as guidelines and standards generated by specific departments, it lacked standard, institution-wide supervision guidelines and procedures. It also needed a systematic process for training managers in supervisory skills.

Multiple problems were related to the same cause; an excessive focus on short-term financial sustainability was producing a conflict between the volume and quality of services provided and long-term organizational sustainability. This conflict was also affecting the work environment.

Step 3: Select interventions

During the workshop, supervision came to be understood as a comprehensive system where everyone is responsible. Components of the supervisory system were defined as:

- Philosophy: objectives, criteria for excellence, supervision style, profiles, and levels.
- Strategies:
  - Quality assurance program: Guidelines and standards are developed in a participatory manner and are available and visible in every service delivery site.
  - Management information system: Data is collected and analyzed each month by every region and clinic.
  - Performance planning and evaluation: Every two months, supervisors and supervisees evaluate and negotiate goals together to improve supervisee performance.
  - Performance recognition system: Based on individual and clinic performance, incentives are distributed every two months to all personnel in the organization.
  - Meeting system: Monthly meetings are held in every clinic and region to analyze data as well as discuss the causes of and solutions to identified problems.
  - Field visits: Visits to clinics are based on identified needs, and staff use standardized procedures and protocols during the visits.
  - Continuous supervision training: Long-distance learning and annual workshops are held to reinforce the new supervision philosophy and skills.

Reducing costs and increasing productivity helped ensure progress towards financial sustainability. Maintaining communications and helping personnel to improve the volume and quality of services is equally important. In order to achieve both goals, the working group realized that the only way to proceed was to focus efforts on individual staff behavior and their capacity to "self monitor". Maintaining productivity and quality of services at a low cost depends upon a comprehensive supervision system with components such as: developing standards and

guidelines, planning meetings, negotiating, providing feedback and evaluation, using indicators and an information system, completing selected field visits, and giving recognition.

Step 4: Implement interventions and change management

ASHONPLAFA formed working groups of supervisors and assigned projects to each working group to develop and implement one of the components of the new supervisory system described above. After a series of workshops, ASHONPLAFA developed new supervision procedures, a manual, and tools to guide supervisory visits. Supervision now includes:

1. Joint performance planning by supervisors and supervisees.
2. Evaluation and determination of performance goals every two months.
3. On-going long-distance learning and annual supervisor workshops to develop and reinforce supervisor skills.

Step 5: Monitor and evaluate performance

During the second workshop, criteria for excellence and evaluation procedures for supervisors and supervisees were discussed. Every two months personnel and organizational performance (at local and regional levels) are measured and rewarded by supervisors. After the launch of the new systems and the supervision manual, the supervisors working group decided to meet every six months to evaluate the implementation and results of the new system. The supervisors discussed the following results at their first meeting:

- Senior executive management agreed to increase delegation of authority to regional and departmental supervisors. This resulted in more participatory and inclusive supervisory processes, and opened dialogue between supervisors and supervisees.
- Integrated standards for supervisory excellence into the new organizational quality assurance system.
- Modified the performance evaluation system to eliminate subjectivity, and included performance-planning dialogue between supervisor and supervisee as part of the evaluation process.
- Reviewed and modified the more subjective and divisive aspects of the performance incentives plan.
- Developed streamlined cost- and time-efficient tools and procedures for supervisory field visits.
- Designed and disseminated a new integrated supervisory system and procedures manual.
- Improved transparency and timeliness of dissemination of supervision policies.
- Adapted the functions and responsibilities of certain supervisory positions to better suit departmental, organizational, and programmatic needs.
- Put a plan in place for ongoing training and reinforcement of supervisory skills.

Lessons learned and results

1. Increased open dialogue between supervisors and supervisees regarding performance planning and evaluation and has helped staff achieve performance goals.

2. Standards for supervisory excellence have been integrated into their overall quality assurance system. The proportion of ASHONPLAFA's operating budget obtained from local sources has continued to rise; from 51 percent before the supervision interventions to 63 percent, 20 months after the launch of the new system.
3. Client satisfaction has remained high (97%) and client access, as measured in couple years of protection, has also increased.

Case study 4: Innovative strategies for supportive supervision in Andhra Pradesh, India

In early 2001, the Government of India's Department of Health and Family Welfare, along with the Children's Vaccine Program (CVP) at Program for Appropriate Technology in Health (PATH), initiated a project to improve routine immunization in the state of Andhra Pradesh (AP). Introduction of hepatitis B vaccine is part of this project. During the project's first two phases, 12 districts with 850 health centers serving a population of approximately 40 million people were included. In November 2003 the project will expand to 11 more districts so that the total population covered will be nearly 80 million people—all served by approximately 1,500 health centers. In Andhra Pradesh supervisors do not make regular visits to their sites, and the size of the project poses a significant challenge to carrying out routine supportive supervision visits to help improve immunization coverage.

The project identified the following main challenges to hepatitis B introduction:

- Immunization sessions are not being conducted.
- Hepatitis-B vaccine and DTP vaccine uptake is not equal.
- Auto-disable (AD) syringes are not being used as expected.
- Cold chain management is poor.
- Injection waste disposal recommendations are not being followed.
- Reports are not properly prepared.
- A high proportion of infants are immunized too early or too late.

The Government of Andhra Pradesh and CVP are currently adopting strategies for supportive supervision to help resolve these and other problems, including job satisfaction. The following is a list of strategies currently underway in Andhra Pradesh.

Supervision visits

A national supervisory system exists in AP but does not function well. Supervisors rarely visit health centers, and when they do, they are not usually well informed and rarely look into the details of how the program is supposed to operate. As part of their commitment to improving supervision, the government has recently opened six new posts for supervising supervisors who are responsible for three to four districts with a combined population of about 10 to 12 million people.

Maps and Indicators

Following 23 coverage surveys (each composed of 14 children in 40 clusters), the Government of India developed a series of maps and indicators to benchmark the districts using 13 indicators of program success. The maps are posted in every health center and in offices involved in immunization, right up to the Chief Minister's office in Hyderabad. The data provide a comparison of how health centers are performing, and as a natural result, staffs are having a friendly competition to improve coverage rates. A data tracking system using the same indicators as the surveys is currently being devised to help health workers collect the data they need to track their own performance. When the program expands to cover the whole state in November 2003, all the development effort will be placed on "continuous quality improvements" so that the statewide coverage for full immunization increases from 72 percent to 85 percent by 2006.

Monthly meetings

Monthly meetings are held in each district for health workers to meet, review their coverage data, and share lessons learned. It is a chance for them to compare practices and get further on-site training.

Out-sourcing supervision

The government and CVP are out-sourcing supervision to local medical colleges. Postgraduate medical students and medical school faculty support the government supervision system and strengthen it by providing a fresh perspective to the system. Outsourcing supervision also provides university members with real experiences from the rural and urban slum health service sites. Recent university graduates have status that gives them some perceived authority in the delicate art of supportive supervision. Unfortunately most health workers involved in immunization are female and most recent graduates of medical schools are male. This presents a challenge to equitable program management, but proper supportive supervision protocols can provide the most positive backdrop for the gender imbalance.

The purpose of this outsourcing is to provide a fast upgrade in supervision, while building capacity for the government and encouraging new recruits to public health to develop skills they will need throughout their careers. After just two months of implementation the cost of supervision is approximately US$20 per health center visit. At this rate the statewide total cost per year for all health centers is about US$270,000 (US$20 for each visit to 1,500 health centers every one to two months). This cost is currently being covered by CVP but one of the functions of the pilot project in two districts—with a combined population of over 5 million people—is to demonstrate the feasibility and effectiveness of out-sourcing supervision.

The following strategies are under consideration:

1. Community involvement

   The team is also looking into the possibility of involving village health committees in supervision. Local health committees may pay for supervision and could follow up with supervisors to make sure that they are visiting sites and improving service quality in the local community.

2. Setting up a three-level supervision system

   The team is developing a system to identify high performing, lesser performing, and poor performing health centers. Each center would receive more or less frequent supervision visits according to their status. The status of the centers would be regularly evaluated based on service improvements or declines and performance levels and status would change accordingly. The criteria for each of the three levels would continually increase, encouraging the centers to improve their performance when compared to their colleagues in other health centers.

3. Using local NGOs to support the government health supervision system

With over 1,500 health centers to be visited, supervision is a huge task. Steps are being taken to recruit local NGOs to take on a similar role to that of the medical schools. First indications are that these organizations are willing and enthusiastic about this responsibility and negotiations are proceeding on how the supervisors' findings can be translated into action by the government services.

Annexes

Annex A. Sample checklists

Sample Supervision Checklist for Program Managers and Medical Officers[3]

Indicators to check	Questions to ask
Monthly immunization report	• Is the report up-to-date? • Is the report clear? • How many children were immunized compared to targets? • Are the vaccines indented regularly to each ANM on Wednesday and Saturday? • Does the ANM take enough of each vaccine to a session? • Are all ANMs submitting regular reports on vaccine doses administered?
Fixed and outreach immunization schedules	• Are all the planned immunization sessions being held?
Immunization register	• Look at the summary reports. How many doses of vaccine were administered in each ANMs area? • How does this compare with the eligible beneficiaries estimates for the area?
Monthly surveillance reports	• Have the last three months reports been sent in on time? • Have there been any unusual outbreaks of the disease?
Schedules and micro-planning	• Are the maps of the area covered by the health center available at the health center? • Are sub-center and outreach schedules available on the wall? • Are the dates/times of immunization at each site displayed at a central location?
Vaccine and supply stocks	• Has the ANM properly recorded use of vaccines? • Are all vaccines and supplies in sufficient stock at the health center? • Is the cold chain being maintained? • Have any vaccines expired? • Are all VVMs okay? • Is there enough vaccine to last six weeks?
Injection Safety and Safe Disposal	• Are the ANMs well supplied with AD syringes and safety boxes? • Is there an agreed upon method for safe disposal of the safety boxes at the health center and sub-centers? • Are the safety boxes also being used for all disposable and AD syringes? (They should be used for all syringes.) • Is other waste being put in the safety box—caps, packaging, cotton wool, etc.? (Other waste should not be put in safety boxes.)

[3] Reprinted from *Introduction of Hepatitis B Vaccine in the Universal Immunization Programme: A Handbook for Programme Managers and Medical Officers* with permission from the Government of India, Child Health Division, Department of Family Welfare, Ministry of Health and Family Welfare. Please contact them for further information.

Sample Supervision Checklist for Program Managers and Medical Officers (cont.)

Checklist for immunization session	Satisfactory?	If not, was behavior corrected?
Immunization register is complete and all patients are listed by name and address.		
New immunization cards are given to newborns and exchanged for old cards of babies coming in for their first dose of DPT and Hepatitis B vaccines.		
All children are screened before services are provided (at a minimum, children should be screened for their age and immunization status).		
Mothers are told what vaccine is being given and when to return for her next appointment.		
ANM washes hands before beginning the immunization session.		
Vaccine is reconstituted correctly just before the immunization session.		
Children are positioned correctly for immunizations.		
The injection site is cleaned with water if necessary.		
Intra-dermal injection technique is correct (a small, raised lump should appear at the injection site).		
Subcutaneous injection technique is correct (given in deltoid muscle of arm).		
Intra-muscular injection technique is correct (given in anterolateral aspect of the thigh).		
Oral polio vaccine administered correctly.		
No patients were turned away for false contraindications (such as illness, fever, respiratory infection, diarrhea).		
Mothers are treated with respect.		
Used needles/syringes deposited in safety box immediately after use (no recapping).		
Safety boxes are being filled to appropriate level.		
Filled safety boxes are safely disposed. (Personally verify the site of disposal and the method.)		

EPI Checklist for the Supervision of Health Centers[4]

Health Center: _____
Date: _____ Date of last visit: _____

Any negative response means that there is a problem and causes of which must be found.

Supervise through INTERVIEWS WITH HEALTH WORKERS and EXAMINATION OF REGISTERS

1. Was the temperature of the refrigerator recorded twice a day and did it remain between +2C and +8C since the last visit? Yes No
   Reading of current temperature: _____

2. Have the vaccine stocks always been adequate (that is, sufficient but not in excess) since the last visit? Yes No

3. Have all the planned immunization sessions (fixed sessions and outreach sessions) taken place since the last visit? Yes No

4. Have the vaccination control tables been correctly used and are they up-to-date? Yes No

5. Are the following dropout rates less than 10% (between OPV1 and OPV3, between TT1 and TT2, and between MV and BCG)? Yes No

6. Compare the current immunization coverage of the health center to its annual coverage objectives. Can the health center attain its coverage targets?

	Yes	No
BCG coverage?		
DPT3 coverage?		
OPV3 coverage?		
Measles coverage?		
TT2+ coverage?		
"Protection from birth" coverage?		

7. Do the number of cases of measles, neonatal tetanus, and polio recorded at consultations correspond to the number mentioned in the monthly surveillance report? Yes No

8. Since the last visit, have zero cases of polio or neonatal tetanus been recorded at the health center? Yes No

9. Has any case of measles been recorded since the last visit? Yes No

10. Are vaccination and surveillance reports sent each month to the district on time? Yes No

11. Do you record and notify undesirable post-immunization manifestations? Yes No

12. Do you use auto-disable syringes? Yes No

[4] Reprinted from *Mid-Level Management Course for EPI Managers* with permission from WHO African Regional Office. Please contact them for further information.

13. Do you use safety boxes for the disposal of needles and syringes?
    Yes No
14. Do you administer vitamin A under your routine program?
    Yes No

Supervise through OBSERVATION OF HEALTH WORKERS:
Observe the health workers while they vaccinate at least five women and five children. Answer questions 15 and 16 in the space provided below:

15. Is the immunization status of women and children checked?
16. Is each injection carried out with a sterile syringe and a sterile needle?

WOMEN	**Question 15**		**Question 16**	
First observation	Yes	No	Yes	No
Second observation	Yes	No	Yes	No
Third observation	Yes	No	Yes	No
Fourth observation	Yes	No	Yes	No
Fifth observation	Yes	No	Yes	No
CHILDREN				
First observation	Yes	No	Yes	No
Second observation	Yes	No	Yes	No
Third observation	Yes	No	Yes	No
Fourth observation	Yes	No	Yes	No
Fifth observation	Yes	No	Yes	No

Supervision through INTERVIEWS WITH WOMEN:

17. Ask to see the vaccination card(s). Have the vaccination schedules of the women and children and rules regarding contra-indications been observed today?

18. Ask the women the following question: "When must you come back for your next vaccination and/or that of your child? (Compare the answer to the information provided on the vaccination card. If her answer does not correspond to the nearest date indicated, indicate the answer as "no".)

	Question 17		**Question 18**	
First interview	Yes	No	Yes	No
Second interview	Yes	No	Yes	No
Third interview	Yes	No	Yes	No
Fourth interview	Yes	No	Yes	No
Fifth interview	Yes	No	Yes	No
Six interview	Yes	No	Yes	No
Seventh interview	Yes	No	Yes	No
Eighth interview	Yes	No	Yes	No
Ninth interview	Yes	No	Yes	No
Tenth interview	Yes	No	Yes	No

Ask each woman if she has suggestions for improving the vaccination services:

Supervision Checklist Questions for Reducing Dropout Rates[5]

Supervisors can use the following questions as a checklist for action:

- Who is *being served* by the program?
- Are vaccine levels displayed at the clinic? Are dropout rates calculated? Are wards with low coverage identified?
- Who *should be served* by the program?
- Is a map of the catchment area displayed prominently at the clinic? Can the clinic provide basic information about the population it serves: number of births annually, number of children less than one year of age, population of rural and urban areas by village or ward.
- Are the target diseases occurring?
- Are charts of the EPI target diseases displayed at the clinic? When such cases occur, does staff try to determine why the children were not protected?
- Are supplies and equipment adequate?
- Is the temperature in each refrigerator checked and recorded daily? Have all the readings been within acceptable limits? Have immunization sessions been cancelled because of insufficient supplies? Is any vaccine out of date? Do abscesses occur following vaccination?

[5] Reprinted from *Making existing immunization services more efficient; Increasing immunization coverage by reducing by reducing drop-out rates* with permission from WHO-UNICEF. Please contact them for further information.

Checklist for Improving Supervision: A Team Approach[6]

For Clinic Managers

____ Discuss with your supervisor ways in which supervision can be made more effective.

____ Solicit input from your clinic staff about how the supervisory system can be changed to improve overall clinic performance.

____ Develop guidelines with your supervisor for introducing a team supervision approach.

____ Create a team supervisory system that functions between supervisory visits.

____ Decide with your staff and supervisor what educational and training programs are necessary to improve clinical and management skills.

____ Discuss problems with your staff and work with them to find solutions.

For Supervisors

____ Develop a supervisory system that focuses on supervising clinic activities and achievement of clinic objectives, rather than on day-to-day individual performance.

____ Discuss and agree on an approach to supervision that involves the clinic manager and staff as part of the supervisory team.

____ Be an advocate for the clinic manager and staff to ensure that they can take advantage of educational and training opportunities.

____ Be well prepared for a supervisory visit by reviewing previous recommendations and actions you have taken to support the clinic's activities.

____ At the end of each supervisory visit, prepare a list of actions with the clinic manager and staff that you all agree to implement before the next supervisory visit.

____ Be committed to providing timely and regular feedback to your clinics.

[6] Reprinted from *Improving Supervision: A Team Approach* with permission from Management Sciences for Health. Please contact them for further information.

Kingdom of Cambodia
Nation – Religion – King

Ministry of Health
National Center for Maternal and Child Health
I. National Immunization Program

Check List for the Supervision of Immunization Program Province/Municipality/District[7]

Name of Supervisor :……
Province/Municipality: ……Operational District :……..
Date of Supervision:……../…..…/…..….Date of Previous supervision : …/……/…

A- Checking Activities of Regular Immunization:

1- Is the number of providing technical assistance to immunization section equally implemented as the number planned?
* Yes / No
2- Have the result reports on immunization activities been received on time from operational district?
* Yes / No
3- Has the result report on immunization activities been appropriately calculated?
* Yes / No
4- Have the report documents about immunization activities been appropriately kept and stored?
* Yes / No
5- Has the graphic of the following up the coverage rate of the vaccination been appropriately done every month?
* Yes / No
6- Has the rate of waste between vaccine under 10% been checked?
- BCG/ Measles Yes / No
- Polio 1-3 Yes / No
- DTC-HepB 1-3 Yes / No
- Tetanus 1-2 Yes / No (pregnancy)

7- Comparison of Immunization's results:

Type of Vaccines	Implementation	Annual Plan
BCG	……..%	……..%
DTC	……..%	……..%
Polio 3	……..%	……..%
Measles	……..%	……..%
TT2+	……..%	……..% (Pregnancy)
TT2+	……..%	……..% (no pregnancy)

8- Did they do the PAB? Y/N

B- Control cold chain, vaccine and immunization tools:
Name of person responsible for cold chain: ……..
9- Is the fridge working and kept appropriately? Y/N
10- Are the vaccines kept appropriately? Y/N
11- Are the vaccines being kept in the cold chain have debris or freeze? Y/N
12- Are the vaccines expiry date? Y/N
13- Is there any vials unlabelled? Y/N
14- Does the color of VVM change? Y/N
15- Is there anything besides vaccine been kept in the fridge? Y/N
16- Is there any vaccine supply record and has it been filled correctly? Y/N

[7] Reprinted from *Monitoring and Management Support Strategy* with permission from the Cambodian National Immunisation Program, National MCH Centre, Ministry of Health. Please contact them for further information.

a- Vaccine? Y/N correct/incorrect
b- Tools? Y/N correct/incorrect
c- Compare the number of vaccine in monthly report with the inventory record within the last 3 months? correct/incorrect

Vaccine	vial	Vaccine	Vial
BCG……..dose		DTC…….dose	
Polio…….dose		Tetanus…….dose	
Measles…….dose		Hepatitis B…dose	

d- The actual number of vaccine has been used within the last 3 months?

Vaccine	vial	Vaccine	Vial
BCG……..dose		DTC…….dose	
Polio…….dose		Tetanus…….dose	
Measles…….dose		Hepatitis B…dose	

17- Is the transportation of central medical store appropriate on time and sufficient within the last trimester? correct/incorrect
18- Number of receiving vaccines and tools that are dropped off within the last 6 months: …….
19- How many districts that vaccines and tools reporting system from lower level are appropriate and regular: …….
20- Since the last supervision until now has the stock been ever interrupted or short:
a- vaccine? Y/N
b- Tools? Y/N

No	Vaccine & Tool which are short	Amount of vaccine which is short	Place where the vaccine is short	Duration of short

C- Control the research of the diseases:

21- At provincial level is there any assignment to people to be in charge of follow up and disease research? Y/N
Name of people in charge: ……
22- Since the previous supervision are monthly reports resulting from follow up and the research of program diseases, and reactions occurring after vaccination have been sent appropriately and on time? Y/N
23- At provincial level, does it have a table to follow up the research of disease and it is filled appropriately? Y/N
24- Does it have a recording list for disease case at provincial level? Y/N
25- Since the previous supervision is there any case of program's diseases and any reactions occurred after vaccination at provincial level? Y/N
If yes, please fill it in :

Name of diseases	# of village reported	# case of disease	# case of death
Polio			
Measles			
New born alive and die before getting 28 days			
Tetanus for baby			
Pertussin			
Reaction after vaccination			

26- Does it have a map showing a research of disease and have it filled appropriately? Y/N
27- Have provincial and district level received budget and T-shirts

to support poliomyelitis measles and babies' tetanus reporting cases Y/N

D- Good point that should be noticed:

……
……
……

E- Problems and causes had been observed during the time of supervision:

Problems/Constraints	Actual causes	Appropriate solving

Suggestion: ……

……
……

Date: ……/……/…….

Name and Signature of Supervisor

Seen and approved by
Program Manager……..
Chief……

Kingdom of Cambodia
Nation – Religion – King

Ministry of Health
National Center for Maternal and Child Health

II. National Immunization Program

Supervisor Check list for Immunization Program at Health Center level[8]

Name of Supervisor :……
Province/Municipality: ……Operational District :……
Health Center : ……..... Date of Supervision:……../…..…/…..….
Date of Previous supervision : …/……/……

General situation :
# of staff :…… Villages covered: …… Total population:……
Target children<1year……..

III. I Questioning to Health Staff and Reports Checking

1- Is the number of immunization days implemented equal with the number planned? * Yes / No
2- Has the graphic of the following up the coverage rate of the vaccination been appropriately done every month? * Yes / No
3- Has the rate of wastage between vaccine under 10% been checked?
- BCG/vaccine for Measles Yes / No
- Polio 1-3 Yes / No
- DTC-HepB 1-3 Yes / No
- Tetanus 1-2 Yes / No (pregnancy)

4- Comparison of the immunization 's results:

Type of vaccine	Implementation	Annual Plann
BCG	……..%	……..%
DTC 3	……..%	……..%
Polio 3	……..%	……..%
Measles	……..%	……..%
TT2+	……..%	……..% (Pregnancy)
TT2+	……..%	……..% (no pregnancy)

5- Check the immunization's result in the reports and count the number in the immunization log sheet in the previous month:

Type of vaccine	In the reports	In the immunization log sheet	Correction
BCG			Yes / No
Measles			Yes / No
DTC3			Yes / No
TT2+(pregnant women)			Yes / No

6- Are there any appropriate refrigerator or glaciere to keep the vaccines? * Yes / No
7- Has the graphic of monitoring the cold chain "refrigerator or glaciere " been correctly and regularly drawn every month?

* Yes / No

[8] Reprinted from *Monitoring and Management Support Strategy* with permission from the Cambodian National Immunisation Program, National MCH Centre, Ministry of Health. Please contact them for further information.

8- Are there vaccines expiry date?
* Yes / No
9- Are there any vials unlabelled?
* Yes / No
10- Does the color of VVM change?
* Yes / No
11- Is there anything besides vaccine being kept in the refrigerator?
* Yes / No
12- Are there any stock record and filled correctly? * Yes / No
a- Vaccine? *Yes / No Correct / Incorrect
b-Have the vaccines ever finished in the stock since the previous monitoring ?
(running out of the vaccine in the refrigerator over one day) * Yes / No
c- Tools? *Yes / No Correct / Incorrect
13- Have the cases of program's diseases and allergies occurred after vaccination since the previous supervision at district level?
* Yes / No
If yes, please fill in the table below :

Name of diseases	Number of village reported	# case of disease
Polio		
Measles		
Baby die before 28 days after delivery		
Tetanus of baby		
Pertussin		
Allergy after vaccination		

14- Activities panning for providing vitamin A:
- Have the children at the age of 6 months to 5 years been provided as scheduled? Yes / No
(……..%)
- Have the women who breastfeed (at the age of the first 2 months) been provided? * Yes / No
(……..%)
15- Are there any activities of providing Mebendazol? * Yes / No
16- Have you received budget for immunization activities since the previous monitoring? * Yes / No
17- Are there any "golden books" ? Have the supervisors write on it during monitoring? * Yes / No

II Observation Immunization officers' activities during immunizing (Name of controlled place ……)

18- Are the immunization days done regular every month? * Yes / No
19- Do the places, used for vaccination have the large shade? * Yes / No
20- Have the record forms been correctly filled during immunization day * Yes / No
21- Are the vaccine in its vial freezed before being destroyed? * Yes / No
22- Is there enough quantity of ice in the vaccine container? * Yes / No
23- Are the vaccines appropriately packed? * Yes / No
24- Are the vaccines, which are not expiry yet, used? * Yes / No
25- Are there any vaccines' vials unlabelled * Yes / No
26- Is the vaccine appropriately mixed? * Yes / No
27-Have women and children been appropriately selected for immunization? * Yes / No
28- Do they appropriately sterilize a syringe and a needle for immunization a woman or a child? * Yes / No
29- Do they provide subcutaneous injection of BCG vaccine on the left shoulder ? *Yes / No
30- Do they provide intramuscularly injection of DTC vaccine on the right shoulder ? * Yes / No
31- Do they provide subcutaneous injection of measles vaccine on the thigh? * Yes / No
32- Do they provide vitamin A into children's mouth by pining and pressing the capsule? * Yes / No
33- Do they provide mebandazol by inserting tablet into children's mouth? * Yes / No
34- Do they provide vitamin A to women who breastfeed (the first two months) * Yes / No

35- Did health staff tell mother and child about the date of the next vaccination? * Yes / No
36- Is the date of immunization day at the community appropriate? * Yes / No
37- Did you ask any information or research on program's diseases during immunization day? * Yes / No
38- Do the commune leaders or volunteers help immunization activities? * Yes / No
39- Asking women about their awareness on immunization activities:

a- Asking for immunization card and check it to find out whether they have been appropriately vaccinated today as mentioned in the calendar for woman and children? - Correct / Incorrect
b- Question for women: When do you and your child have to come for the next vaccination?(compare the answer with the immunization card, if it is not correct as recorded, please tick the "incorrect".

	Question A	Question B
First woman	correct/incorrect	correct/incorrect
Second woman	correct/incorrect	correct/incorrect
Third woman	correct/incorrect	correct/incorrect

Ask women's opinion for improving immunization program:
……
……
……

III- Key points that should be noticed:

……
……
……

IV- Problems and causes, which have observed during the monitoring

Problems/Constraints	Actual causes	Appropriate solving

Community suggestion: .....

……
……

Date: ……/……/…….

Health Center Chief Chief of Immunization section Name and Signature
at Health Center of Supervisor

Annex B. Sample supervision budget

This is a sample tool for planning and calculating the cost of supervision visits. Distances, per diem rates, and fuel and maintenance costs are normally found in district/regional microplans or in national/district budgets.

Table A: Transportation costs per supervision visit

A	B	C	D	E	F	G
District	**Total kms**	**Cost of fuel per km**	**Maintenance per km**	**Transportation cost of supervision visit = (C+D) x A**	**Number of supervision visits per year**	**Total transportation costs per year = E x F**
District 1	4,460	49 CFA	60 CFA	486,140 CFA	3	1,458,420 CFA
District 2	4,200	49 CFA	60 CFA	457,800 CFA	4	1,831,200 CFA
District 3	22,512	49 CFA	60 CFA	2,453,808 CFA	3	7,361,424 CFA
District 4	4,200	49 CFA	60 CFA	457,800 CFA	3	1,373,400 CFA
District 5	4,620	49 CFA	60 CFA	503,580 CFA	4	2,014,320 CFA

Table B: Per diem costs per supervision visit

A	B	C	D	E	F
District	**Per diem rate**	**Number of per diem days per visit**	**Number of supervisors per visit**	**Number of supervisors visits per year**	**Total per diem costs per year = B x C x D x E**
District 1	5000 CFA	2	1	3	30,000 CFA
District 2	5000 CFA	2	1	4	40,000 CFA
District 3	5000 CFA	4	2	3	120,000 CFA
District 4	5000 CFA	2	1	3	30,000 CFA
District 5	5000 CFA	2	2	4	80,000 CFA

Table C: Total supervision costs per year

A	B	C	D
District	**Total transportation cost per year (Table A, column G)**	**Total per diem costs per year (Table B, column F)**	**Total supervision cost per year = B+C**
District 1	1,458,420 CFA	30,000 CFA	1,488,420 CFA
District 2	1,831,200 CFA	40,000 CFA	1,871,200 CFA
District 3	7,361,424 CFA	120,000 CFA	7,481,424 CFA
District 4	1,373,400 CFA	30,000 CFA	1,403,400 CFA
District 5	2,014,320 CFA	80,000 CFA	2,094,320 CFA

Annex C. Supervisory roles assigned to each level of the national health system[9]

National level

The national EPI manager is responsible for the following supervisory roles:

- Definition of quality standards and norms as well as development of technical guidelines for the implementation of EPI policies.
- Dissemination of these policies and guidelines to reach to sub-national level for implementation (provinces, regions, districts, etc.)
- Training of staff on the policy and policy implementation guidelines to facilitate proper application of standards and norms.
- Development of a supervisory checklist for central and sub-national level supervisors to ensure uniformity of policy interpretation and its correct application throughout the country.
- Development of a supervision plan and schedule to undertake supervision visits.
- Giving feedback on the results of supervision individually and through supervisory reports, bulletins/newsletters or circular letters.

The role of the national EPI manager, therefore, consists of ensuring that national standards relating to EPI are observed at all levels.

Sub-national levels (regional, provincial, and district)

The role of the sub-national EPI manager is to assist health workers at field level to provide quality services. Health workers at this level encounter many problems, particularly when they are posted to remote locations, where they often operate on their own. They need help in planning their work, technical advice, in-service training, support in handling grievances, disciplinary problems, good leadership and motivation.

The supervision at this level therefore entails:

- Making sure that the objectives at lower levels are consistent with the national objectives.
- Determining what is being done well and encouraging staff to continue good work.
- Observing immunization procedures at immunization sites to see if the target population is vaccinated according to EPI guidelines.
- Helping staff identify and solve problems using in-service training approach.
- Giving feedback in person or through letters and records in the special supervision record books.

[9] Reprinted from *Module 21: Supervision for EPI Managers* with permission from WHO African Regional Office, Mid-Level Management Course for EPI Managers. Please contact them for further information

Annex D. Suggested service delivery workplans[10]

The following workplans can be used to plan activities and monitor progress.

Once a supervisor has worked with health center staff to identify problems, they can use the following work plan to organize and prioritize implementation.

Activity	Person(s) Responsible	Proposed Goal	Next Evaluation
1)	•		
2)	•		
3)	•		

Example:

Activity	Person(s) Responsible	Proposed Goal	Next Evaluation
1) Visit community leaders to discuss best immunization calendar	• Doctor • Vaccinator	• Appropriate days for immunization sessions identified	May 15, 2001
2) Train health staff on national immunization schedule and contraindications on immunization	• District Management Team	• All health staff will be knowledgeable on these topics	July 30, 2001
3) Check vaccination cards and/or clinical histories of any child <5 years of age visiting the health facility (for any reason)	• Pediatric Nurse • Auxiliary nurse • Vaccinator	• All children with incomplete vaccination status will have a mark "needs vaccination" on the record • All eligible children are immunized	May 20, 2001
4) Staff training on inter-personal communications	• District management team	• All staff to have friendly and helpful attitude	July 30, 2001

[10] Reprinted from *Making existing immunization services more efficient: Increasing immunization coverage by reducing by reducing drop-out rates* with permission from WHO-UNICEF. Please contact them for further information.

Suggested format for follow-up activity implementation

Activity	**Person(s) Responsible**	**% Complete**	**Obstacles to Completion**	**Solutions**

Annex E. Sample observation worksheet[11]

This is a problem analysis exercise/worksheet. It lists the observation, what are the possible or likely causes of the problem/issue; who should initiate action; and possible/recommended solutions.

Some observations from a visit to ……, District……, (date)

1. Not clear what mechanism for tracking/fetching leftout/dropout.

2. No Male public health worker involved on health side - possibilities?

3. No BCG since 10 April (6 weeks)
   Vit A not at session

4. Nurse-midwife register is session wise, cannot track individual women/children easily

5. Plenty of immunization cards with nurse-midwife and those attending for second time had cards. Counterfoils had been taken off by nurse-midwife but not clear what use she had made of them;

6. Sterilization - insufficient needles/syringes (reusing); needle left in vial; no reconstitution (mixing) syringes; no rack in sterilizer – nurse-midwife said had left to TBA to do sterilization as she had to go to get vaccines at short notice

[11] Courtesy of Alasdair Wylie, Immunization Consultant

Annex F. Skills matrix for monitoring and management support for provinces and districts[12]

TEAM ROLES	TASKS	KNOWLEDGE SKILLS REQUIRED FOR TASK	KNOWLEDGE & SKILL COMPETENCY LEVEL OF TEAM MEMBERS FOR EACH TASK High / Medium / Low
Team Leader	Lead the team Problem solve Advise PHD and OD on solutions Monitor and Health Plan and CIP Monitor status of outreach funding Monitor NGO activity	Team leadership Problem solving Knowledge of health sector and EPI planning Report writing Knowledge of MOH finance system	
Health Information / Surveillance	Assess current coverage Follow up target disease reporting Recommend strategies for improved coverage Responding to reported disease outbreak	Data analysis Data reporting Problem solving Disease outbreak response Report writing	
Logistics/ Cold Chain	Monitor cold chain and report problems Monitor vaccine stocks Monitor injection safety	Immunization safety Vaccine management Cold chain principles	
HRD / IEC	Conduct training needs assessment Conduct training follow up Assess human resource requirements for immunization Report on AEFI Monitor impact of IEC materials	How to conduct TNA How to conduct training Follow up How to plan human resources for immunization Knowledge of AEFI How to respond to AEFI	

[12] Reprinted from *Monitoring and Management Support Strategy* with permission from the Cambodian National Immunisation Program, National MCH Centre, Ministry of Health. Please contact them for further information.

Annex G. Sample drop-out rate monitoring chart[13]

[13] Courtesy of Uganda Expanded Programme on Immunization (UNEPI) and Dr. Robert Steinglass

Drop Out Rate Monitoring Chart, 200_.

Sub Health District: _____

Health Facility: _____ **District: _____**

			Month										
			J	F	M	A	M	J	J	A	S	O	N	D
DPT 1	A. Month													
	B. Cumulative													
DPT 3	C. Month													
	D. Cumulative													
E. Cumulative Drop Out DPT 1 - DPT 3 (B - D)														
F. Cumulative Drop Out Rate %														
G. Bar Chart		**60%**												
		55%												
		50%												
		45%												
		40%												
		35%												
		30%												
		25%												
		20%												
		15%												
	Good Performance	**10%**												
	Drop Out Rate	**5%**												
	10% or less	**0%**												
		- 5%												
		-10%												
		-15%												
		-20%												
		-30%												
			J	**F**	**M**	**A**	**M**	**J**	**J**	**A**	**S**	**O**	**N**	**D**

INSTRUCTIONS:

A. Enter the monthly total of DPT1 immunisations given to children below the age of one year.

B. Enter the **cumulative total** of **DPT1** immunisations given. Cumulative includes the current monthly total plus the monthly totals for all of the previous months during the year.

C. Enter the monthly total of **DPT3** immunisations given to children below the age of one year.

D. Enter the cumulative total of **DPT3** immunisations given.

E. Subtract the cumulative total for **DPT1** from the cumulative total for **DPT3**. This is the cumulative total number of drop outs for DPT1 to DPT3 for the year.

F. Calculate the **Cumulative Drop Out Rate** as follows:

$$\frac{\textbf{DPT1 Cumulative Total - DPT3 Cumulative Total}}{\textbf{DPT1 Cumulative Total}} \times 100$$

G. Chart the **Cumulative Drop Out Rate** by shading in the area up to the drop out rate on the chart.

PLACE THIS CHART WHERE IT CAN BE SEEN BY YOUR STAFF, EVERY DAY ! 04/02

Annex H. GAVI core immunization program indicators[14]

The following are some of the indicators identified by the GAVI Implementation Task Force in their publication "Monitoring national immunization systems using core indicators" (www.vaccinealliance.org). For the GAVI alliance partners monitoring purposes, the time period for all indicators is one calendar year. Supervision should monitor and interpret district or subdistrict indicators on a more frequent basis. We encourage you to adapt these indicators according to your national, district, or sub-district context needs.

OPERATIONS

Service delivery

Proportion of districts in the country with >/= 80% DPT3 coverage among infants

Sub-function (area): coverage
Comment: Key measurements of system performance and output. Major indicator corresponding to GAVI milestone: 'by 2005, 80 percent of developing countries will have routine immunization coverage of at least 80 percent in all districts. In the equity perspective, it allows identification of a high priority geographic area.

For example:
- The country indicator (s) could be "proportion of districts in each quintile"
- The country would then only report on one of the indicators "the proportion of districts in the 80-100% quintile

Proportion of districts in the country with >/= 90% measles coverage among infants

Sub-function (area): coverage
Comment: Major indicator towards achieving reduction of measles mortality goal; also emphasized under GAVI's objective to support the national and international accelerated disease control targets

Proportion of districts in the country with dropout rate (DTP1 to DTP3) of less than 10%.

Sub-function (area): utilization
Comment: A major indicator for the utilisation of existing services. Compares the number of infants that started to receive immunizations with those who did not receive the last of vaccines. May reflect problems of supply, staffing, quality of service delivery and demand.

Proportion of districts in the country that have been supplied with adequate (equal or more) number of AD syringes for all routine immunizations during the year

Sub-function (area): injection safety

[14] Reprinted from *Monitoring national immunization systems using core indicators* with permission from the GAVI Implementation Task Force. Please contact them for further information.

Comment: reflects the adoption of auto-disable (AD) syringes policy (and the progress toward the adoption of the WHO – UNICEF – UNFPA joint statement) and the adequacy of supply management (procurement and distribution of appropriate related equipment). Particularly important to monitor as the Vaccine Fund decided to provide the injection safety supplies for all infant immunizations.

Logistics and cold chain

National level wastage rates of DTP and new vaccines (Hepatitis B and Hib).

Sub-function (area): vaccine management
Comment: critical indicator regarding GAVI requirements for new vaccines. Interpretation will need to be done according to the various factors influencing vaccine wastage: vial size in use, open vial policy adoption, etc. The calculation of national wastage needs to be well documented.

The vaccine wastage rate (%) = 100 – vaccine usage rate

Where the vaccine usage rate (%) =
No. doses used for immunization / {(number of vials opened for use + number of closed vials discarded) * number of doses per vial}

Vaccine supply & quality

Proportion of districts in the country that had no interruption in vaccine supply during the year

Sub-function (area): vaccine supply
Comment: definition of interruption in vaccine supply = district vaccine store has no remaining doses of any one EPI vaccine, for any period of time. The above is a reflection of vaccine management, vaccine storage and handling.

Surveillance and monitoring

Proportion of districts disease surveillance reports received at national level compared to number of reports expected

Sub-function (area): reporting system
Comment: Evaluates the completeness of reporting, however, it does not assess whether the reports are representative or well presented. This is crucial to evaluate the reporting system information. The district disease surveillance report definition is the monthly or quarterly report that should mention all vaccine preventable diseases. This is not disease specific.

Proportion of districts coverage reports received at national level compared to number of reports expected

Sub-function (area): reporting system
Comment: Evaluates the completeness of reporting, however it does not assess neither the quality of the reports themselves nor their representativeness (of delivery facilities). This is crucial to evaluate reporting system information.

Advocacy and communication

Existence of an advocacy and communications strategic plan (annual) with identified focal point and annual budget

Sub-function (area): political commitment
Comment: Reviews a country's proposed advocacy and communications activities but does not give an indication of the quality of activities carried out. The level of resources allocated gives an indication of commitment by the government.

FINANCIAL SUSTAINABILITY

Government financed recurrent program-specific immunization spending in the past year per million US dollars of total government spending

Sub-function (area): financial sustainability
Comment: Shows the financial effort made from national sources for immunization. Spending means actual expenditures, not budgeted or planned amounts.
Government financed includes direct Government spending and the expenditure of loan funds. It excludes any external public financing, i.e. any support from the Vaccine Fund (GAVI) or any grants from bilateral (DFID, JICA….) or multilateral (UNICEF, WHO…) agencies provided to national government for immunization services.
Recurrent program-specific spending includes all recurrent spending on items such as vaccines and supplies; wages and benefits for those personnel working exclusively on the immunization program; and fuel, maintenance and per diem associated with immunization-specific activities. It excludes spending on capital items (e.g. vehicles, cold chain equipment, buildings) and all 'shared' personnel and other inputs (e.g. health workers who perform immunization along with other service delivery and wages, per diem, and fuel for supervisors who oversee immunizations along with other service delivery and health promotion activities).

The denominator will be obtained separately from recognized international sources.

STRENGTHENING HUMAN AND INSTITUTIONAL RESOURCES

Proportion of districts that have had at least one supervisory visit of all health facilities in last calendar year

Sub-function (area): supervision
Comment: Extremely useful for capacity building. Although once a year appears as a minimum requirement for supervision, logistical field difficulties make the target (all health facilities once a year) challenging. The supervisory visit may not necessarily be specific to immunization but should include the supervision of immunization activities.

For example:
- The country indicator (s) could be "proportion of districts that have had 4, 3, 2, 1, or 0 supervisory visits in the last calendar year"
- The country would report only one part of the indicators: all districts minus those in the 0 group.

MANAGEMENT DEVELOPMENT

Proportion of districts with microplans that include immunization activities

Sub-function (area): strategic planning
Comment. Does not give any information on the quality of the plan or to what extent activities have been implemented. Reference guidelines: "Increasing immunization coverage at health facility level" module.

Other relevant key indicators to measure progress towards global immunization goals[15]

Immunization policy

Proportion of countries with measles 2nd dose opportunity.
Proportion of countries combining delivery of vitamin A with immunization.
Proportion of countries with substantial disease (Hib) burden having introduced Hib with routine.
Proportion of countries having introduced Hepatitis B.

Process indicators

Proportion of countries providing written feedback on immunization to district level at least every quarter.
Proportion of countries with 3-5 year strategic plan for the national immunization system.
Proportion of countries with national annual work plan for immunization services.
Proportion of countries with injection safety as a component to the national workplan.

[15] Not exhaustive list. These key indicators are the ones presented in the advocacy set by the partners of the alliance

Output indicators

Proportion of countries with HepB3 coverage $\geq$ 80% .

Outcome indicators

Proportion of countries certified polio-free.
Proportion of countries with MNT elimination status
number of districts as being of high risk for MNT (% of districts with <1 NT case per 1000 live births).

Annex I. Summary health management Field Report[16]

Province_____ District_____
Date_____

HEALTH INFORMATION

Coverage

What are the existing coverage rates for DPT3?

Are they increasing, or decreasing compared with the same quarter last year?

Cause of change in coverage:

Action taken in the Province/District:

Follow up action required

Reported Diseases (Disease Surveillance)

What target diseases were reported in the last quarter?

Has there been a recorded disease outbreak in the last quarter?

Action taken in the Province/District:

Follow up action required

[16] Reprinted from *Monitoring and Management Support Strategy* with permission from the Cambodian National Immunisation Program, National MCH Centre, Ministry of Health.

PLANNING & EVALUATION

Health Sector Plan & Coverage Improvement Plan

Are activities being implemented according to plan in the last quarter?

What are major problems with implementation?

Causes:

Action taken in the Province/District:

Follow up action required

Supervision, Post Activity Assessment, Data Quality Audit

Is supervision conducted on a regular basis?

Has post activity assessment been undertaken in the last quarter?

Result?

Have any major problems been identified during supervision?

What was the action taken in the Province/District/Health Center?

Follow up action required

HEALTH FINANCING

What is the funding source for the PHD / OD?

Are finances being disbursed according to budget in the last quarter?

What are the Problems with financial disbursement?

What are the Causes of poor financial disbursement?

Indicators –

% Funds dispersed to province in the current year
% Funds dispersed to District in the current year
% Budgeted funds dispersed to health centers in the current year

Action taken in the Province/District/HC

Follow up action required

SERVICE DELIVERY & QUALITY IMPROVEMENT

Priority problems –

Cold Chain…….
Vaccines…….
Equipment……..
Transport……
Immunization safety……..

Causes

Action taken in the Province/District

Follow up action required

BEHAVIOUR CHANGE & HUMAN RESOURCE DEVELOPMENT

Any adverse events following immunization reported in last quarter?

Are there current weaknesses or strengths in IEC activity?

What is the level of support from local authorities for immunization?

Are sufficient health education materials available at PHD / OD / HC

Action taken in the Province/District/HC

Follow up action required

Training conducted in last quarter:

Training needs identified by managers:

Training follow-up conducted:

% of health centers with adequately trained staff:

Follow up action required

Report Written: **Report Reviewed by:** **Report Reviewed by**

TEAM LEADER **REGIONAL MANAGER** **NIP MANAGER**

Date:

Cc :

Provincial Health Director
Provincial EPI Manager

Annex J. Web sites

Management Sciences for Health – The Managers Electronic Resource Center
For information on supportive supervision and many other managerial issues
www.erc.msh.org

EngenderHealth
For information on Quality Improvement and COPE®
www.engenderhealth.org

Immunization Training Partnership
For information and materials related to global immunization training activities.
www.who.int/vaccines-diseases/epitraining

PRIME II
For training and supervision resources
www.prime2.org/prime2/section/60.html

Children's Vaccine Program at PATH
For training and immunization resources
www.childrensvaccine.org

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