THE UNITED REPUBLIC OF TANZANIA

MINISTRY OF HEALTH

NATIONAL PRIMARY HEALTH CARE SUPERVISION GUIDELINES

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Foreword

These supervision guidelines have been developed at an opportune time to meet the need for uniformity in implementation of Primary Health Care Strategic. It is one of the integrating tools for ensuring effective and efficient health care delivery.

Health Care supervision had been conducted on the basis of individual health divisions or their respective health programmes or projects. There had not been any attempt to encourage the various individual health programmes or projects to produce combined supervision guidelines. Without such national supervision guidelines to act as standards, it has been difficult to measure the extent and impact of success in meeting national health objectives.

In response to the need for bridging this gap. the Primary Health Care Secretariat in collaboration with The Heads of Department and other health ream members working in health planning, health management, health service delivery, nursing services, human resources development and health sector programme support were assigned the task of preparing supervision guidelines that would especially be suited for the management of health care from national to health facility level.

The first draft of the supervision guidelines was finalized in Morogoro in October 1998. Using comments from the PHC Technical Committee the framework of the guidelines was restructured and Held tested with good success.

Development of these supervision guidelines ties in well with the already prepared national health planning guidelines. It is also one of the initial measures in addressing the proposal of the Health Sector Reforms.

These guidelines aim at assisting health managers in overseeing that planned activities and intervene-tions are implemented in a more cost-effective and consistent manner. Supervision is only one way of reaching health workers in the field. The manager needs also to be constantly aware of ongoing activities through routinely collected data. This document is also highly recommended for use as reference material in long - term and short - term training on supervision for management teams in health and health related sectors.

Management teams at different levels of implementation should be conversant with these guidelines to acquire the necessary techniques of supervision in order to ensure that planned supervision objectives are met. In addition there should be training on the use of these supervision guidelines.

It is hoped that the supervisors at different health services levels shall use these guidelines and will offer comments that will serve as inputs for further revisions and adjustments in order to produce the intended results in health care.

M. J. Mwaffisi
PERMANENT SECRETARY
MINISTRY OF HEALTH.

Acknowledgement

The production of these National PHC Supervision Guidelines is a result of many efforts and contributions made by various individuals and Institutions. It is therefore not possible to mention all who contributed to the development of this document. However the Ministry of Health would like to express its appreciation to:-

The Danish International Development Agency (DANIDA) and the World Dank for their technical and financial support through the Health Sector Programme Support 1996 - 99 and Health and Nutrition Project Comp. I. respectively.

Heads of department and sections in the Ministry for their active participation from the onset to the completion of this work.

Groups who pre-tested the first draft in coast, Iringa, Kilimanjaro. Mbeya and Tanga regions for their commendable work in collecting comments and suggestions from the Health management teams in the respective regions.

Regional Health Management Teams of the above regions and two district management teams from the regions enlisted for their valuable comments and suggestions which contributed highly to the development of the final document.

The Ministry of Health would like to underscore the message that the efforts and contribution of nil the people involved in the planning and development of the Guidelines will only be rewarded if heath managers will put it to proper use.

Dr. G. Upunda
CHIEF MEDICAL OFFICER

Acronyms

ACMO/P	Assistant Chief Medical Officer - Preventive Services
ACMO/T	Assistant Chief Medical Officer - Training Acting
AG.ACMO/HS	Assistant Chief Medical Officer - Hospital Services
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
BCG	Bacille Calmette Guerin
B/P	Blood Pressure
CNO	Chief Nursing Officer
DANIDA	Danish International Development Agency
DAP	Director of administration and Personnel
DHMT	District Health Management Team
DHS	District Health Secretary
DMCHC	District Maternal and Child Health Coordinator
DMO	District Medical Officer
DNO	District Nursing Officer
DPT	Diphtheria Pertusis Tetanus
CDD	Expected Date of Delivery
FIFO	First In First Out
G TZ	Gessellschalft fuer Technische Zusammenarbeit
HCDS	Health Care Deliver y System
HIV	Human Immuno-deficiency Virus
HNP Comp. I/II	Health and Nutrition Project Component I/II
HMIS	Health Management Information System
HSPS	Health Sector Programme Support
USDS	Health Services Delivery System
I/C	In-charge
IEC	Information Education Communication
IMR	Infant Mortality Rate
IPD	In Patient Department
KCMC	Kilimanjaro Christian Medical Centre
LNMP	Last Normal Menstrual Period

MCH	Maternal and Child Health
MMR	Maternal Mortality Healthy.
MOH	Ministry of Health
MO I/c	Medical Officer In-charge
MTU HA	Mfumo wa Taarifa na Uendeshaji Huduma za Afya
M47	Life Expectancy for Men 47 years
NACP	National Aids Control Programme
NEDLIT	National Essential Drug List Tanzania
NDHPGs	National District Health Planning Guidelines
NGOs	Non Government Organizations
NOR AD	Norwegian Agency for Development
OPD	Out Patient Department
PHC	Primary Heath Care
PHO	Principal Health Officer
PSU	Pharmaceutical and Supplies Unit
RHMT	Regional Health Management Team
SNO-CE	Senior Nursing Officer - Continuing Education
TB	Tuberculosis
TBAs	Traditional Birth Attendants
VHC	Village Health Council
VHW	Village Health Workers
WHO	World Health Organization
W50	Expectancy for Women 50 years

How To Use The Guidelines

These Guidelines for Primary Health Care supervision are divided into two main sections.

Section one contains information for assisting health managers in the implementation of supervision activities. Issues concerning conceptual framework for PHC supervision, how to supervise and report writing are discussed. Management teams are urged to comprehend the details of this section in order to acquire the necessary skills before conducting any supervision activity.

Section Two presents checklist models to guide the supervision teams during preparation for supervision. Accompanying the models is information and instructions on formulation of checklists. Supervisors are expected to go through the information thoroughly and use the checklists models as a guide to develop their own supervision checklists to suit the local situation in which they arc working.

It is important to note that every supervision is different from another in terms of objectives and expected outputs. The model checklists in this document are purposely included to bring cons and to ensure wide coverage of areas to be supervised. As models they should be adopter based on the level of facility to be supervised. In the end they provide an opportunity for standardization, quality assurance and comparison of one district another.

SECTION I: UNDERSTANDING SUPERVISION

1.0 Introduction

1.1 Background

A situation analysis of the existing system has shown that there is only fragmented effort to ensure that the health care provided is of good quality. With the general increase in public expectations for quality health care in all spheres, particularly now that the public is required to contribute towards the cost of the services, the focus on health care supervision assumes critical importance. Studies on performance of the Health Sector show that there has been lack of effective supervision due to among other factors the absence of integrated guidelines from the government.

The vision of the PHC Strategy is therefore to facilitate the development of quality of health care, provision of essential clinical and basic public health interventions. These consist of cost - effective public health measures of provision of water and sanitation, vaccinations, school health maternal and child programmes as well as control and prevention of communicable diseases.

To assist the process of translating this vision into health cure supervision, these guidelines have been prepared in order to serve as a management tool for different health services delivery levels.

The role of each health management level in implementing these supervision guidelines includes :-

- to adjust supervision plans lo each levels needs, functions and peculiarities with respect to the health reform process.
- to monitor implementation of the health policy and its related policy guidelines and where necessary adjust both the process and means of supervision to the levels, circumstances and mission.
- to identify failure and success in supervision as well as the reasons for subsequent supervisory exercises.

1.2 The Structure of Health Care Delivery in Tanzania

In Tanzania, the Government through the Ministry of Health. Prime Ministers Office and Local Government, provides the majority of health care services (Approx. 60%). Other key players in health care include non-governmental organizations (Approx. 35%) and private for profit organizations and individuals (5%). The main health service delivery points (illustrated in figure 1) can be classified into three levels:-

Level 1; healthcare services include those provided in village health posts, dispensaries, health centres and district hospitals. At present there are 3,500 dispensaries, 302 health centres and 71 district hospitals (both government owned and designated district hospitals). A total of 42 district do not have a district hospital. There are also supplementary health facilities owned by Government institutions (such as the Array, Prisons. Education. Bank, Railways etc.) voluntary agencies (Religious groups) and non-governmental organizations, private corporations, companies and bilateral bodies.

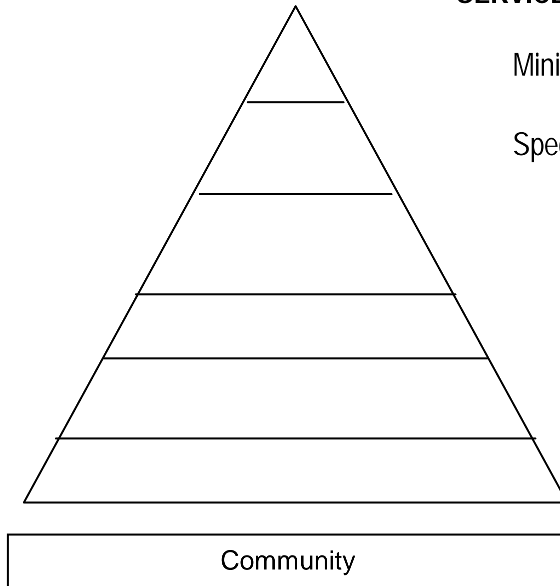
Level 2; health care services are provided by regional hospitals. The services at this level are more specialized than those provided by district hospitals. Out of the 20 administrative regions of mainland Tanzania, 17 regions have regional hospitals while .3 regions (Mbeya, Dar es salaam and Pwani) do not have regional hospitals.

Level 3; health care services are provided by four consultant hospitals (Muhimbili Medical Centre, Rugando Medical Centre, Mbeya referral Hospital and Kilimanjaro Christian Medical Centre) and two specialized hospitals (Mirembe Hospital/Isanga Institution for mental he. and Kihong'oto hospital for tuberculosis). The four consultant hospitals are also used for teaching purposes.

Organization Pyramid of the Tanzania Health Services (Structure)

ADMINISTRATIVE LEVEL

National Level
Regional Level
District Level
Divisional level
Ward Level
Village Level
Household Level



SERVICE STRUCTURE

Ministry of Health
Specialized/ Consultant Health Services
Regional Health Services
District Health Services
Health Centre Services
Dispensary Services
Village Health Services (POST)
Family

PERSON IN CHARGE

Principal Secretary
Medical Superintendent/Director
Regional Medical Officer
District Medical Officer
Assi.Med.Off./Clinical Officer
Clinical Officer
Village Health
Head of Household

!0

1.3 The Rationale for the Development of PHC Supervision Guidelines

The reasons for developing these Supervision Guidelines include the following:

i. There has been no defined or predetermined national supervision tool to judge quality of performance and health care.

ii. Different people define or understand supervision differently and therefore resulting in less consistency of the perceived effective supervision process. As a result of this problem the expected impact of supervision has only minimally been achieved,

iii. Supervision has been individually driven rather than being directed towards team building as emphasized in PHC.

iv. Several versions of supervision strategies prevail, but have not been co-ordinated sufficiently to make sure that national health objectives have been accomplished.

These national PHC Supervision Guidelines are intended to supersede all previous supervision approaches.

1.4 Aim and Objectives:

The aim of these supervision guidelines is to have effective and efficient health care delivery system in the country. Its main objectives are as follows:

- To integrate the existing fragmented PHC Supervision Guidelines/tools.
- To provide guidance to supervisors on how to carry out supervision of PHC activities more effectively and efficiently at alt levels of health care delivery system.
- To promote objectivity, consistency and impact of supervision on quality of health services delivery in the country.
- To rationalize the use of limited resources and logistics in the health system by stimulating supervisors to work as a team rather than as individuals.
- To make supervision an effective tool for on the job learning and professional updating of health workers skills at every level of health care.

2.0 CONCEPTUAL FRAMEWORK FOR PIIC SUPERVISION

2.1 Definition of Supervision

Supervision is a management function planned and carried out in order to guide, support and assist staff in carrying out their assigned tasks. It involves on job transfer of knowledge and skills between the supervisor and the one being supervised through opening of administrative and technical communication channel. The aim of supervision is to determine stall performance in relation to quality and standard in implementing planned activities.

Thus supervision is important for;-

i) assisting the staff to improve their performance
ii) ensuring uniformity to set performance standards
iii) identification of problems and solving them at appropriate time
iv) maintaining and reinforcing the administrative and technical link between high and lower levels
v) follow up decision reached during last supervision visit and
vi) identification of the staffing needs

To accomplish the above, supervisors must emphasise on monitoring, joint problem solving and two way communication system between (hem and the ones being supervised. They should play the intermediary role of facilitating the implementation of National, Regional and District goals and also facilitating local level problem solving and quality improvement. In other words they must provide supportive supervision.

Supervision must be distinguished from inspection. The later is concerned with checking conformity and adherence to set standards and norms. It is controlled by legislation and regulations. Inspection include checking of structures, premises, staff levels, and equipment. Usually Inspection is a one way communication system offering no chance for dialogue.

2.2 The PHC framework for supervision

The PHC strategy (January 1992) emphasises the need for developing guidelines for planning and supervision. Planning for monitoring and evaluation is well described in the National District Planning Guidelines (NDHPGs). Monitoring and evaluation is part and parcel of supervision.

On the basis of the above, a conceptual framework for supervision cannot be different from that of the NDHPGs. The planning conceptual framework is therefore adopted for PHC Supervision. Reasons for adopting the conceptual framework, include:

- It ensures that none of the individual health and health care delivery activities will be forgotten in the course of supervising and monitoring of health interventions, quality assurance and performance standard indicators.

- it helps to focus on health issues without being limited to these issues,

- It requires the least training and experience in health supervision.

2.3 Essential Requirements for PHC Supervision

Primary Health Care supervision has the following important requirements for the plain implementation and evaluation of supervision:-

- A functioning health care delivery system
- A functioning health management information system
  Availability of logistics
- Human resources
  Monitoring and supervision tools
- Accessibility to health care facilities
- Availability of financial resources.

2.4 Levels arid Scope of Supervision

The vastness of the country (Approx. 900.000sq. Km.) and geographical distribution of the health units make supervision to be an enormous management task which can best be handled through appropriate decentralization. In this way, the different levels of supervision depicted in these guidelines attempt to address these real problems lo enforce quality.

To enable future health workers lo be conversant with supervision, it is recommended that these guidelines be made available in all Health Training Institutions.

Supervision roles will he undertaken at three levels: National, Regional and District levels. The co-ordination of the three levels will help to refine the health policy and even set up the implementation of planned activities.

This guideline caters for the needs of all parries involved in health care service delivery in the country. However, some vertical programmes and other specialized services may need to develop detailed checklists to cover details which are not shown in this document. It is therefore recommended that they use this guideline as a blueprint in the developing of their own specialized checklists

2.4.1 National level

At the national level, the National Team will have the major task of looking al how the health policy and policy guidelines are being translated into implementable activities at all levels. The team will primarily be responsible for supervision of the RHMT activities. Supervisors at national level shall visit selected districts and health facilities where verification of information is required. The national supervision teams can be of the following categories:-

- General supervision

  Policy Issues - the main objective of this ream is to ascertain adherence of implemented to the laid down national policies and guidelines. The team will consist of the Minister of Health, Permanent Secretary and Chief Medical Officer. Other officers may be incorporated whenever necessary.

  Technical Issues - this team will mainly deal with issues of technical importance. It will comprise of Directors or officers appointed by him/her from all the Ministry of Health departments.

- Specific supervision

  This will be conducted for specific technical issues by individual programmes or section the Ministry of Health. Therefore the composition of the team will commonly be derived from the respective sections and programmes.

2.4.2 Regional level

In the context of the HSR. the regional level is the extended arm of the Ministry of Health and its main role is to co-ordinate and support [he districts in planning, implementation, monitoring and evaluation.

At the Regional level, the RHMT will be responsible for supervision of health services. The major task of the KHMT will be to ensure that the health policy and guidelines form national level are implemented by DHMTs. The team will also ensure collaboration v. health-related sectors within the Regional Secretariat. The RHMT may co-opt or commission their roles of supervision to relevant technical officers/professionals as may be deemed necessary. These may come from within the health sector such as regional hospital, volume hospitals and private practice or other related sectors such as Agriculture, Education and water.

2.4.3 District level

The district is the focal point for the implementation of the health policy and interventions. Its major role is formulating, carrying out and monitoring health intervention packages and quality-assurance programmes. The DHMT will also ensure collaboration with other health related sectors within the district. At the district level, the supervision team will be the DHMT. A member from the community may be co-opted in the team. The DHMT may co-opt or commission its supervision role to technical officer/professionals when deemed necessary These may come from within the health sector such as district hospital, voluntary agencies and private practice or other related sectors such as Agriculture. Education and Water.

Essentially the district team will supervise all health facilities. However, they may visit selected communities where verification of information is required.

At the health facility level Health Facility Management Team will implement the health policy and interventions. Their major role is to, carry out and monitor health intervention package- and quality assurance programmes within the health facility. Also, the team will supervise health related activities in the community within their catchment area. They will work in collaboration with the Diagnostic and Therapeutic Committees in ensuring a better quality of health services in the facility.

2.5 Planning for Supervision

Supervision must be included in the annual health plans at each level. This includes routine and focus supervision. Routine supervision is carried out to check how daily activities are being performed while focus supervision addresses specific areas that need more time and through examination. Ad-hoc or emergency supervision is carried out in the event of changes or divergence from performance and ethical standards in health care delivery. This may also he carried out when serious problems or disasters occur.

2.6 What to supervise

One needs to look at inputs, processes and outputs within the health care system which when coordinated effectively, will lead to a comprehensive range promotive, preventive, curative and rehabilitative health care activities. Supervisors should however be aware it is neither desirable nor possible to supervise each and everything during each visit. Also, they should note that some of the services may not be relevant to he supervised in some areas e.g. laboratory and dental services in a government dispensary. Objectives and prioritization should be the key guide. in determining what to supervise, when and where.

2.6.1 Major areas to be supervised include;

2.6.1.1 Planning monitoring and evaluation:

- General management procedures
- Operational plans
- Operational research
- • Routine recording and reporting
- • Evaluation procedures;

2.6.1.2 Financial Management:

- A health plan translated into a financial plan
- Budgetary control system
- Accounting records
- Sources of funding
- Adequacy of funding
- Compliance with appropriate disbursement procedures
- Adherence to appropriate purchasing procedures
- Documentation of receipts of fee, levies etc. including bank deposits
- Periodic financial reports
- Audited reports and response to auditors issues
- Records of community based revolving funds.

2.6. 1.3 Materials management:

- Established procurement system, its adequacy and/or appropriateness
- Established procedures for the receipt of equipment and supplies
- Presence of inventory control system for equipment and supplies
- Maintenance of supplies records (cards or registers) for all items in stock
- Properly kept records of acquisition, maintenance and disposal of equipment

2.6.1.4 Facilities and equipment management:

- Procedures to keep equipment operating
- Procedures to keep health facilities clean and functional
- Maintenance schedules
- Procedures for disposal of equipment.
- Quality and standards of equipment and supplies
- Adequacy of equipment and supplies
- Condition of equipment and supplies.

2.6.1.5 Transport Management:

- Availability of the vehicles or other means of transport.
- Availability of service points and maintenance schedules.
- Presence of and adherence to regulations and guidelines for vehicle/Iran sport utilization
- Presence of a matrix plan for the use of the available vehicles effectively and efficiently.
- Availability of the necessary records and reports fur all health vehicles/transport means
- Presence of a plan to train vehicle users in proper upkeep and use of their vehicles.

2.6.1.6 Information Management:

- Presence of well functioning HMIS (MTUHA)
- Operational research
- Specialised information system

2.6.1.7 Human Resources Management:

- Placement of staff according to qualification.
- Opportunities for continuing education and development.
- Provision of a feedback mechanism.
- Norms, ethics and standards of performance
- Presence of organization structure

2.6.1.8 Time Management:

- Presence of work plans
- Adherence to time frame for The activities in the work plans.
- Rescheduling of work plans

2.6.2 Health Intervention Packages to be supervised;

Major areas in the health intervention packages to be supervised include activities, outcomes and performance indicators of the following:-

2.6.2.1 Clinical Packages

- Clinical management of patients
- Diagnostic Services
- Hospital referral support
- Pharmaceutical service provision/pharmaceutical care
- Patient nursing care
- Rehabilitative care

2.6.2.2 Public Health Packages

- Reproductive and Child Health
- Disease Surveillance. Prevention and Control
- Community Health and Sanitation
- Health Education
- Traditional Medicine

2.6.3 Health Related Interventions Areas to be Supervised;

- School Health
- Food and Nutrition

2.6.4 **Other health related interventions to be supervised by other sectors**;

- Housing
- Food security
- Functional literacy
- Water Supply

3.0 HOW TO SUPERVISE

3.1 Process of Supervision

Before the supervision team conducts supervision, it should familiarize itself with:-

- The conceptual framework for health planning.
- The understanding of a health system concept and supervision/monitoring.
- The main objectives of supervision.
- The essential health care interventions.
- The meaning of quality health care.
- The roles and responsibilities of staff to be supervised.

The process of supervision can be divided into 3 stages: preparatory, actual supervision immediate feedback. In the preparatory stage, the necessary tools for supervision are assembled, the problems at that level identified and objectives for supervision set. Transport, schedule of supervision arranged. At the actual supervision stage, the supervisors study the perform, at work place or system and identify support needs. Lastly, the supervisors meet with the man agement teams to discuss findings from the respective areas.

3.2 Stage one: Preparation

Activities involved in this stage depend largely on the level of supervision. Preparation start by identifying priority issues for supervision. This involves review of the available documents meats found at that level relating to objectives, operational standards and level of performance. These documents are the current plans, progress reports, previous supervision reports evaluation reports if any.

With the prioritized issues the supervisors will formulate a number of hypotheses potheses will be used to draw a list of specific points, which will be proved or disproved during actual supervision. The checklist will then be prepared based on the formulates hypotheses. Refer the example of checklist question modules in section II.

The supervisors will notify the administration at appropriate levels e.g. ministerial, Regional and District levels of their intention or objective to carry out supervision visits

The frequency of the visits should he as follows:

- A team from the National level shall visit regions at least twice in a year. The office of the
- Chief Medical Officer shall co-ordinate these supervisory visits.
- The RHMT shall visit each district quarterly
- The DHMT shall visit each health facility at least once every quarter, Facilities which have more problems can be visited more frequently.

The duration of each visit should correspond to the objectives of the supervision, expected workload, distances and expected output.

Lastly, the supervisors will prepare allowances, transport, and specific timetable for that particular visit.

3.3 Stage two: The Supervision visit

The supervisors, will introduce themselves to the management team. The head of the supervision team, will briefly explain the purpose and objectives of supervision to the management team. The supervisors, may then divide themselves according Lo specialty and proceed to the specific areas of supervision.

The supervisors, will then observe the health workers performing their duties and tasks at various stations or sections using prepared checklists). Performance gaps and problems identified and their causes should be determined. During the supervision, sonic problems can be solved through dialogue between the supervisors and the staff being supervised.

It is important lo note here that part of the checklist which deals with planning, management and organization is discussed with the management team.

3.4 Stage three: Immediate feedback

In this stage, the supervisors will discuss findings with the management team. The supervisors should point out areas which health workers have performed well, then mention areas of weaknesses. Discuss on how improvements can be made. Emphasis should be put on stimulating health workers to think on how to solve the problems instead of relying on the supervisors. Moreover, during feedback both supervisors and supervisees

must agree on a course of Tallow-up action. This commits everybody to ensuring a positive and desirable change and impact demanded by the supervision process. A copy of the checklists should he left to the management learn for future reference. Lastly, the supervisors will W required to provide written feed back, to the responsible administrative level of health services

Remember:

Supervisors must avoid the tendency to think that they KNOW IT ALL but be prepared to open dialogue with health workers as partners in supervision and not subjects. They should also be prepared to be criticized and to learn from the process.

4.0 SUPERVISION REPORT

4.1 The purpose of supervision reporting is to inform the supervised health workers and those who have the authority to make decisions.

4.2 Contents/Composition of the supervision Report:

The supervision report is composed of the following;

- Title page
- Acknowledgement
- Acronyms
- Executive summary
- Background
- Main report: Analysis of findings/observation/situation analysis: Needs, service and systems.
- Conclusions and recommendations.
- Appendices

4.3: Explanation of the above contents:

Acknowledgement: Word of appreciation to individuals and organizations which participated and assisted in the supervision.

Acronyms: elaborate meaning of short forms.

Executive Summary (if required): This section may be important if the report has to be sent to lop officials who often do not have time to read the whole report. The Executive Summary is not supposed lobe more than one page. It needs to disclose to the reader the most essential points of what are in the whole report. Most of the essential points are: Aims of the supervision, objectives of the supervision, how supervision was conducted, what were the constraints, what are the conclusions and recommendations. In the report the summary comes first, but it is written after all the proceeding sections of the report have been completed.

Introduction: Describes the objectives of the supervision, places visited and people met. A brief description of the methodologies lo do supervision should be included in this

section.

Main report: Analysis of findings/observations/Situation analysis: This section describes all the constraints and weaknesses observed during supervision.

Conclusions and recommendations: Recommendations include action taken on the spot and action to he implemented based on conclusions- There will be action taken on the spot an actions to be implemented by the supervised health workers and those which will need in pi from the higher level.

Appendices: This section may not be necessarily be included in every report. It will include the references which are not reflected in the main text.

SECTION II: CHECKLIST MODELS

1.0 Overview

1.1 Introduction

The purpose of a checklist is to guide the supervisor on areas to be addressed during supervision. It also serves as a reminder lo the supervisors on areas which would otherwise be overlooked. A well filled in checklist will act as a good reference in the future for the supervisors and the health staff who arc supervised in the subsequent visits.

It is stressed that these checklist models have been prepared to act only as a guide, It is expected that supervisors will prepare their own checklists based on die, prevailing situation. During the preparatory stage of supervision the supervisor should always ask themselves whether the checklist they have is still viable or needs some changes.

- After supervision, supervisors should enter their observations/comments in MTUHA Book 2, table 6.

- For hospitals, there can be two kinds of supervision: internal supervision carried out by the hospital management team and external supervision carried out by RHMT's and DHMT's

However, it is neither an easy task nor desirable to have a blue print of a "standard checklist" because:-

- Decentralization means the empowerment of people at the lower level to make decision affecting their day to day activities. A "standard checklist" will therefore tend to stress issues of priority to the party developing the checklist.

- Within the management team, members ha\c different background knowledge, skill and experience. This will alywas dictate the limit which a supervisor can go in supervising subordinates.

- There are difference in the types of problems between one place and another.

- There arc difference in the types of services offered.
- New programmes bring new priorities which need to be reflected in the checklist.

1.2 Format for recording observations;

In order to reduce the amount of paper required, the supervisors draw a table for recording observations and a copy lo be left at the health facility as shown in the diagrams below. This tabular format will also give the supervisors an overall picture which will facilitate comparison of performance amongst the health facilities and give an overview to the supervised health on the progress made through time.

Note: Different types of Health Facilities should not be mixed in one form for the of convenience comparison purposes.

To be kept by supervisor:

Name of supervisor: ……………………………………………..
Date: …………………………………………………………

NAME OF FACILITY	CHECKLIST ITEMS						
1							
2							
3							
4							

The supervisor will record the items being checked in the first row. Across the respective health facility a tick will be put when the checklist question is answered affirmatively and a cross if the answer is no.

To be left with the supervised health staff.

Checklist items	Date	Date	Date	Date	Date	Date	Date	Date	Date
1									
2									
4									

The supervisor will record The items being checked in the first column. Under the respective date a tick will be put when the checklist question is answered affirmatively and a cross if the answer is no.

The checklist questions should be asked in such a way that the answer is always "Yes" if the correct thing has been done.

The checklist models are organized by type and level of service:

- Community level
- Health Facility level
- District level

In the development of the checklist by the supervisory team care must be taken not to include collection of routine data. This is expected to be reported through the MTUHA to the supervisor before they set out for a supervision visit. Supervisors should have looked at these data during the preparatory Stage hence collection of routine type of data on the site becomes super fluous.

2.0 Examples of Checklist Questions

There are two types of checklist questions;

- Health systems checklist question;

These are examples of questions to be used for supervising Planning. Implementation, Monitoring and Evaluation activities. These are dealt with under Community and District/Region, levels of services.

- Health facility checklist questions;

  These are for supervising Health Workers al health service delivery points questions which are placed under Health Facility Level of service cover the following major operational areas in a health facility.

- Environment
- Outpatient
- Medical records
- Pharmacy/Dispensing room
- Laboratory
- Store (General. Food, drugs and Laboratory)
- Inpatients and
- MCH

2.1 Community Level

Planning;

Σ is the Village Health committee involved in village Health Planning?

Σ Does the plan reflect village health priorities?

Check for the following:

- Water and sanitation
- Community managed water supply system
- Functioning water supply system
- % of house hold with access to safe potable water
- % of house holds with improved latrines
- Proper waste collection and disposal

- housing sitting and layout, market places, slaughter of animals, food establishments
- hazard (works places) - prevention and use of protective measures.

Reproductive and Child health

- village child weighing
- vaccination of the under-five
- recording of births by sex
- recording of deaths by age. sex and cause
- sensitization of community in common preventable diseases.

Implementation;

- are the planned activities carried out as scheduled?
- do the Health Committees meet?
- how frequent are the meetings?
- are the minutes recorded and available.?
- are there any permanent item on the agenda?
- do the agenda consist of priority problems?
- are the funds spent according to the planned activities?

Monitoring and Evaluation

- is there a village register'?
- do the register contain the following information?
    - Births
    - Deaths
    - immigration/Emigration
    - Literacy level
    - Village population
    - Demographic information
- are there progress reports

2.2 Health Facility Level

2.2.1 Environment;

Water supply

- Is water available at the health facility ?

  Check :-

- if there is adequate water for the facility?
- how close is the water point from the health facility?

Sanitation

- are there toilets?
- are the toilets structurally sound?
- are the toilet facilities clean ?
- is there a hand washing facility?
- if they have sewerage system, is it functioning properly?

Waste disposal

- are the surroundings of the health facility compound clean ?
- do the health facility have a proper waste disposal method for different type (e.g. infectious, sharps etc.]
- is the waste disposal method at a proper place and in a marked plate (i.e. fenced or closed to make sure that children or files do not go in and that people walking can see it so that they do not fall in it at night if it is a pit)
- if yes - check if there is overflow or scattering of litter around?

Building/s

- are the rooms adequate? (compare with standard guidelines)
- are the buildings in a good state of repair?
- Are buildings adequately ventilated?
- Do buildings have proper sewerage and drainage system?

2.2.2 Outpatient Department;

Equipment

- Do they have the essential equipment ? (see Standard List of OPD Equipment)

Performance Assessment;

- what is the title of the health worker you have found prescribing?
- does the health worker know his job description?
- is then? privacy for the patients?
- is the clinician/patient relationship good?

  Check:-if

  - the clinician welcomed the patients?

- is history taking adequate?
- does clinician give the patients enough lime to explain their problems?
- does the clinician explains to the patient regarding his/her illness and management plan?
- are (he patients examined ?
- are correct investigations carried out? (Where applicable)
- did the treatment correspond to the diagnosis and in accordance with standard treatment guidelines?

  Cheek:-

  - Choice of drug(s)
  - dose
  - frequency
  - course (duration)

- did the clinician give the relevant counseling/health education instructions to the patient on the disease condition? are the patient cards filled, in correctly?

  Check:-

  - Symptoms
  - Signs
  - Investigations
  - Diagnosis
  - Treatment

- are the monthly tally for the diagnosis up-to-date ?
- are the classification of the diagnoses correctly done?
- are the registers and tally sheets kept in the appropriate place?
- are there inventory list of equipment in the OPD rooms ?
  - If yes are they up-to-date ?
- is dispensing done according to standards?
- At the end of this section you may wish to ask a few clients to assess their satisfaction the services they have received.

2.2.3 Medical Records:

Performance Assessment;

- is there a trained medical recorder?
- does the section have a calculator for doing summaries?
- is the arrangement of patient files/cards m good order?
- can the retrieval of patient's files/cards be done promptly?
- does the medical recorder enter all the necessary information in the patient file/card?.
- are the registers filled in correctly?
- are the registers currently not in use kept in appropriate places?
- are the monthly summaries up-to-date?

  Check if the following are recorded
  - OPD attendance's
  - OPD diagnoses
  - IPD daily census
  - IPD diagnoses

Where cost-sharing money collected at the medical records: -

- are all the patients charged according to cost sharing guidelines?
- is the money kept in a secure place?
- is a correct receipt issued?
- are the appropriate records filled in correctly?
- are the documents kept securely in a proper place?

Equipment;

does the section have file racks and cupboards for safekeeping of records?

2.2.4 Pharmacy/Dispensing Room;

Equipment and supplies;

- are the equipment maintained in good condition?
- is there an inventory record of drugs and medical supplies?
    - if yes; is it up to date?
    - check the balance, in the ledger for ten items if they correspond with physical stock
    - are shortages and surpluses recorded in the ledger book
    - are the ledgers currently not in use kept in an appropriate place.
- are refrigerators working? (where applicable)
- are packing/dispensing materials available?
- are current drug information materials available?

Performance. Assessment;

- are there trained dispensing personnel?
- are drugs dispensed correctly?

Check if

- the correct drug is dispensed
- the correct amount was given to the patient
- the dispenser gives instructions to the patient on use of drugs
- there is a long queuing of clients

- does the dispenser to I low dispensing procedures?

Check if

- the dispenser takes time to verify the prescription
- the dispenser, labels the containers/packs of medicines to be supplied to patients
- he containers from which medicines are dispensed are properly covered,
- the dispenser knows the procedure for disposing expired drugs,
- are drugs/supplies ordered in time following specified procedures?

2.2.5 Laboratory;

Equipment/Supplies;

- do they have the necessary equipment and in working condition?

Check:-

  - Microscope
  - Centrifuge
  - Machine
  - Haemoglobinometer
  - Staining racks
  - Reagents.

- is there an inventory list of equipment in the room?
- if the answer to the above question is yes, is it up-to-date?
- are there essential chemicals and reagents for the required tests at that level?
- is the ledger filled in correctly?
- do the balance in the ledger correspond with the amount in the laboratory? (check few items).
- are commodity shortages and over stocks recorded?
- are the ledgers currently not in use kept in appropriate places.

Performance Assessment;

- do they have qualified laboratory staff at the facility?
- is there a standard bench procedure manual?
- are the tests done according to bench procedure manual are the necessary procedures followed in the preparation of specimens?
- do the laboratory personnel identify abnormalities in the specimens accurately
- do the personnel make correct recordings in the patient specimen form?
- are the results sent to clinicians without undue delay? Cross check with clinicians
- are the registers filled in correctly?
- are the registers currently not in use kept in appropriate places?
- are the monthly summaries up-to-date?

2.2.6 Store (General, drugs, food and Laboratory Stores);

Equipment/Supplies:

- is the store located In an area with adequate security
- are all the items stocked in the store recorded?

Check;

- presence of a ledger book
- whether it is up to date
- if the balance in the ledger correspond with physical stock
- if surpluses and losses are recorded
- if ledgers which are currently not in use are kept in an appropriate and secure place,
- are there shelves and pallets for keeping medicines

Performance;

- check it' supplies are stocked on shelves and pallets?
- is there a systematic arrangement of supplies in the store?

check if drugs are arranged;

- alphabetical
- pharmacological
- check whether a FEFO or FIFO rules are followed.
- is there a systematic procedure of ordering drugs?

Check if the storekeeper has knowledge of;

- minimum stock levels
- maximum stock levels
- lead time
- buffer Mock/safety stock
- monthly consumption of drugs and other medical supplies.

- arc drugs ordered classified basing on health facility requirements?

Check the knowledge of the storekeeper on the following:-

- vital drugs
- essential drugs
- non-essential drugs

- is there a systematic method of estimating drug requirements? If yes; what method?
  - morbidity method

- consumption method
  - are there reference manuals to guide the store personnel in their daily work?
    Check
      presence of treatment guidelines
      presence of a standard list of drugs.
  - are drugs/supplies ordered in time according to needs and resources?
    are there well written instructions on procedures for ordering drugs and supplies?

2.2.7 Inpatients;

Equipment;

- do the ward have the necessary equipment in working condition?

check standard list.

Performance Assessment;

do the health staff in the ward have the required qualifications?

- does each category of staff have job description?
  is there a duty roster for each category of staff?
- what is the title of the health worker attending patients m the ward?
  does she/he have a job description?
- is privacy maintained when the patients are nursed/examined?
  check the following;-
    are the patients given explanations before starling any procedure. Altitude of patients towards health workers attending the ward.
- are there nursing plans for the patients ?
- are the plans followed by the nurses ?
  do The nurses make correct observations?
  Countercheck:-

- Blood Pressure
- Pulse
- Temperature
- Respiration
  - do the nurses administer prescribed drugs correctly?
    Check:- treatment chart if drug are administered:-

- to right patient
- Correct drug

- correct dose
- correct intervals
- correct route of administration
- correct instructions given to patients

- are drugs stored properly in the wards to ensure safety?
- arc drugs used properly recorded (e.g. DDA drugs)?
- do the nurses maintain sterility where it is appropriate ?
- do the nurses make correct recordings in the:-
  - Observation chart
  -- Treatment chart
- is the admission register filled in correctly ?
  are the summaries of diagnosis up-to-date ?
- are registers currently not in use kept in the appropriate place?
- are the patient case-notes (files) sent to the appropriate place soon after patient's discharge?
  is it easy to retrieve patient case-notes (file) ?
- is there an inventory list of equipment in the wards? if yes are they up to date ?

2.2.8 MCH Clinic;

Equipment and Supplies;

- do they have essential equipment?

Check: -

- examination bed
- screen
- foetal-scope
- blood Pressure machine
- sterilizer
- refrigerator
- clinical Thermometer
- weighing scale
- ice packs,
- vaccine carriers,
- weighing trousers.
- monitor cards,
- freeze watch.

- was there an inventory list of equipment in the rooms?
- if the answer to the above question is yes. is it up-to-date?

- are the equipment in good working condition?

If they have a MCH-store;

- are the drugs and contraceptives locked in a safe place?
- are the First item to expire the First to be issued (FEFO)?
- are there no expired drugs and contraceptives?
- is the ledger filled in correctly?
- does the balance in the ledger correspond with the amount in the store? Randomly check five items.
- is responsibility to take charge of the store assigned to specific person?

Antenatal Services;

- is there a qualified antenatal/postnatal service provider?

  is there privacy for the client during counseling and examination?
- is the service provider/client relationship good?

Check if:-

- service provider welcome mothers
- service provider discusses the findings and management plan with the mothers?

- is the establishment of LNMP correct?
- is the EDD calculated correctly?
- is the Gestation period established correctly?
- are the risk factors screened adequately?
- is the correct fundal height established?
- is the foetal presentation correctly established?
- is the foetal heart established correctly?
- do the service provider make correct decisions and take appropriate action for mothers with risk factors?
- do the service provider give individual health education and counseling to mothers?
- are prophylactic drugs given to the clients with adequate instructions on use? i.e.
  - Chloroquine
  - iron tablets
  - Folic acid tablets

Vitamin 'A'

- do the service provider record findings in the Antenatal card correctly?
- is the Antenatal register filled in correctly?
- are the monthly summations done? If yes, arc they up-to-date?
- are registers currently not in use kept in appropriate places?

Postnatal Care;

- are postnatal services provided?

  is there postnatal register?
- check if the following arc done;-

  Postnatal check-up for mothers

  Individual health education on breast feeding family planning, diet, and exercises

  Immunization of the infant.

Vaccination:

- is there a trained service provider?
- is the service provider/client relationship good?

Check: -

- how the service provider welcomes mothers

- do the service provider explain to mother, possible side effects of vaccines and how to manage them at home

- if mothers are informed about their next visit.

- do the service provider adhere to vaccination schedules?
- is the sterilization procedure correct?
- are the vaccinations done correctly?
- is the chalk board recording up-to-date?
- is the refrigerator working properly?
- check that the temperature in the refrigerator is between 4 - 8 degrees Centigrade.
- check if the Cold Chain Monitor is normal
- check if the freeze watch is normal
- check if the vaccines are stored correctly in the refrigerator
- do the service provider record the vaccinations correctly in the Road to Health/
- Vaccination card and the vaccination tally sheet?
- are the tally sheets currently not in use kept in their appropriate place ?

- are the monthly summation of the clients done?

Child Weighing:

- is there a trained service provider?
- is the service provider/mother relationship good? Check:-if
  - the service provider explains to the mothers/caretakers the interpretation of findings and advise given?
- does the service provider follow the necessary steps before getting the child's weight?

check:-

- if the scale is pre-set
- if the provider faces the weighing scale perpendicularly when reading the weights
- if the provider leaves the scale to stabilize before determining the weight

- are the readings made by the service provider correctly
- does the service provider record the weights in the Road to Health Card correctly?
- is the Child register filled in correctly?
- are the tally sheets filled in correctly?

are the registers and tally sheets currently not in use kept in their appropriate place?

Family Planning;

- is there a qualified service provider
- is there privacy for the client during counseling and examination?
- is the service provider client relationship good?

Check :-

- how the service provider welcomes the clients
- if the service provider allowed enough time for the client to explain herself/himself?

- is history taking adequate?
- is the client examined adequately?
- does the service provider describe all the available method to the client?
- does the service provider record findings in the client card correctly?
- is the Family Planning day to day book filled in correctly?
- are the monthly summations done? if yes, are they up-to-date?

Diarrhoea Treatment Corner (DTC)

- is there Diarrhoea treatment guideline chart
- is the DTC operating?
- are there necessary equipment and supplies?
- is the treatment schedule understood and followed?
- is the DTC register filled properly?
- is the ORS preparation demonstration done?
- is the demonstration done in a hygienic way?
- are FEFO or FIFO rules followed?
- are drugs not expired?
- is there a demonstration table?

Planning;

- are the quarterly and annual objectives set?
- do the plans reflect priority problems?
- are strategies set for the priority issues? If yes, are they workable?
- determine whether the Health Facility prepared the following schedules:
    - duty roster?
    - annual leaves
    - staff meetings
    - PHC meetings
    - continuing education sessions for the staff
    - training of VHW,TBAs and Traditional Healers
    - health education sessions in the facility and in the community
    - outreach visits
    - transport

Implementation;

- are the schedules followed as planned?
- are the minutes for the various meetings available?
- do the agenda consist of priority problems?
- are all the staff on duty present?
- is the available transport in good working condition?
- is transport facilities available to all the staff who are in need?
- is communication amongst the staff good?

Check:-

  - are the objectives known by the majority of the staff
  - are the schedules known to all the concerned staff

- is the progress made during the last quarter and year known to majority of the staff.
- is there learn work spirit? Check if;-
  - meetings are held regularly
  - minutes for the various meetings indicate participation of key members
  - agenda consisted of priority issues?
  - all members are involved in problem solving
  - all members were involved in planning implementation, monitoring and evaluation
  - all members have knowledge of plans, stains of implementation and outcome
  - all members have access to important information e.g. plans, progress report.
- are the funds spent as planned?
- are there any bottlenecks in securing the funds?

Monitoring and Evaluation;

- check the operations of the HMIS. See appendixes

2.3 District Level

Planning and Budgeting;

- do the RHMT/DHMT Learn prepare quarterly/annual objectives?
- do the objectives reflect priority issues?

  do the DHMT/RHMT set targets?
- is there an annual plan made?
- do the plan preparation involve majority of members (**RHMT/DHMT** and co-opted pro fessionals)?
- are the local/community leadership involved in planning of health care delivery?

  Check involvement in:-
  - situational analysis
  - problem identification
  - problem finances
  - materials
  - labour

- does the plan reflect the objectives?
- do the plans conform with the national planning guidelines
- do the planned activities conform with national health policy and policy guidelines?
- are the plans achievable given the prevailing conditions?
- do the activities planned reflect the objectives?
- is the budget allocated various; components of the plans realistic?
- what are the source of funding for health?
  - Central government
  - Local authorities
  - External partners
  - Voluntary agencies
  - Private practice
  - Community based revolving funding.

- is human resource placement and skills mix rational?

  Cheek staffing levels and postings.
- is equipment allocation adequate and relevant to the workload?

  Check inventory
- are the following schedules prepared in time?

: annual leaves

: DHMT/RHMT meetings

: PHC meetings

: workshops and seminar

: supervision to the lower level

: transport utilization

: preventive maintenance for vehicles, equipment and buildings.

Implementation

- are the objectives set last year/quarter met?
- are the planned activities carried out as scheduled?
- to what extent were funds disbursed according to requirement in amount and time?

Organization

- is communication amongst the team members good?

  Check if;-
  - minutes for various meetings involve all the key members?
  - the quarterly and annual plans arc known to all team members?
  - the objectives are known to all team members?
  - non-team members participate as co-opted members in matters requiring specific technical skills. How frequent?
  - the schedules are known to all the concerned team members?
  - the progress made during the last quarter and annual are known to all the u members?

- Are other sectors involved for a multi-sectoral approach in health related issues?
- is there team work spirit?

  Check if:-

  - meetings are held regularly
  - minutes fur the various meetings indicate participation of key member-.
  - agenda consisted of priority issues?
  - all members are involved in problem solving
  - all members were involved in planning implementation, monitoring and evaluation

- a l l members have knowledge of plans, status of implementation and outcomes,
- all members have access to important information e.g. plans, progress report etc.

Transport Management;

- is the available transport in good working condition for official use?
- is transport facilities available to all the learn members in pursuing official duties?
- Are the transport facilities used according to schedules?
- Arc the criteria set for conducting unscheduled visits?
- Does the unscheduled visit meet the above criteria?

Financial Management;

- Did expenditures adhere to financial regulations and procedures?

Check there is:-

- compliance with appropriate disbursing procedures
- adherence to appropriate purchasing procedures

- are there any bottlenecks in securing the funds?
- are financial records accurate, balanced and updated?

Check

- cash book entries
- imprest records
- check book
- bank statement
- documentation of receipts of fees/levies
- well prepared monthly, quarterly and annual financial reports

Monitoring and Evaluation;

- Does the RHMT/DHMT assess the performance, check progress reports and action plans to determine the degree of implementation vis a vis the planned level?
- Does the RHMT/DHMT use Health Management Information System in monitoring? (See MTUHA indicator- in appendix 1 and other local indicators if available)
- Is there any operational research canned out ?Check if the results were used by the District and how?
- Does the RHMT/DHMT evaluate their performance?

Check whether;-

- activities that are planned are carried out
- the resources applied (inputs including external professionals) to all activities are utilized effectively
- the output of health services delivered achieved the intended goals: i.e. Medicare, child survival, safe motherhood and community based health, vaccination coverage.

APPENDICES

Appendix 1: Areas to be checked for existence of Problems

Quarterly: (from HMIS/MTUHA)

- prompt arrival of the drug kit/drug supplies
- commodities running out of stock
- check the ledger and the stock to ascertain accuracy of recording
- check if the commodity was used rationally
- commodities in oversupply
- check the ledger and the stock to ascertain accuracy of recording
- check it' the commodity was used rationally
- community outreach conducted
- coverage of BCG. DPT3, Measles vaccines
- ma I nutrition among the under five
- HIV prevalence among blood donors
- proportion of dental filings done
- proportion dental patients returning with complications
- proportion of dental referrals
- the rate of Tuberculosis case finding
- proportion of leprosy cases with unknown disability

Annually;

- availability o\ Village Health Workers in the villages
- stall' workload
- utilization of health facility by the community
- repairing and replacement of equipment broken down
- completion rate of Polio vaccine
- protection against tetanus
- Antenatal attendance
- Antenatal attendance before 20 weeks of gestation
- Proportion of women delivering at the clinic
- family planning method available

- proportion of current users
- early childhood mortality rate
- rate of maternal deaths
- proportion of diarrhoea cases coining with dehydration
- rate of syphilis
- Leprosy disability rate
- Tuberculosis cure, rate

Evaluation;

Does the RHMT/DHMT evaluate their performance to determine whether;

- activities That are planned arc earned out
- the resources applied (inputs including external professionals) to all activities are utilized effectively
- the output of health services delivered achieved the intended goals; i.e. Medicare, child survival, safe motherhood and community based health care, vaccination coverage.

Appendix 2: National Performance Indicators

1. Maternal and Child Health	CURRENT COUNTRY STATUS	GOALTO BE REACHED	YEAR
Infant Mortality Rate	115/1,000	115/1.000	2000
Under of <5 Mortality Rate	191/1,000	62/1,000	1996
Maternal Mortality Rate per live births	600-1000/100.000	70/1.000	2000
Severe Malnutrition	6%	92/1.000	1996
Moderate Malnutrition{wt/age)	45%	400-600/100.000 2%.	2000
Access to safe drinking water	48%	22%.	2000
Access to sanitary means of excreta disposal	64%	100% 100%	2000
Deaths from Measles <5 of all deaths	72%	2%	2000
Complete Immunization Coverage		90%	2000
Reduce deaths from Malaria among <5 by 50%		50%	2000 2000
Reduce malaria incidence by 25%		25%	2000
Poliomyelitis		Eradicated	2000
Neonatal Tetanus		Eliminated	2000
Reduction deaths from diarrhoea among <5 by 50%		25% reduction	2000 2000
Reduce incidence of diarrhoea by 25%		1 3 reduction	2000
Reduce deaths from ARI among <5 by 1/3	W50 M47	level number	1995
Level number of new HIV/AIDS cases			1988
Life expectancy Family		40% prevalence	2000
Family planning users		Elimination	2000
Consequences of vitamin A deficiency		Elimination	2000
Iodine deficiency disorders			
Reduction of iron deficiency anaemia		by 1/3	

Appendix 3: Scoring Systems

Scoring system in the monitoring of performance during supervision

There arc several methods that can be used in assigning a score on the performance of various activities observed during supervision. Supervisors are at liberty to select any method of their choice as long as it is rational and consistent. Four scoring methods are described below:-

1. YES and NO method

In this method checklist items arc made into questions to be answered by either >YES= or >NO=. The questions are designed in such a way that a >YES- answer will be obtained when the performance is good and a >NO=answer performance is poor.

Since the method involves only two variables, this is a simple method to use. However, this method docs not allow scoring for midway performance. Therefore, either the supervised staff scores a full mark for a good performance or scores nil for poor performance. This method has [he disadvantage of being insensitive to moderate changes in performance.

In this method a >tick - or >cross = can also be used instead of the >Yes = and >NO= respectively with the same effect.

2. Alphabetical method

In this method performance is scored using a letter assigned for each category of performance as shown in the example below:-

A = Excellent
B = Very Good
C = Good
D = Satisfactory
E = Poor

This sealing method has the advantage of allowing supervisors to record midway performance. Because it has more than two options analysis of scores through time and across units is more complicated than in example one. Also, the use of alphabets makes it difficult to obtain average scores for several activities. In order to facilitate calculation of averages, a numerical system can be used.

3. Numerical scoring method

In this method each performance category is assigned a number as shown in the example below:-

1 = Excellent
2 = Very Good
3 = Good
4 = Satisfactory
5 = Poor

The numerical scoring method allows calculating average score through time and across fad

Example:

In the year 2000. Kisarawe District Health Management Team identifies two priority problems that require close supportive supervision in order to be rectified. The problems are:-

1. *Poor drug and supplies logistic system it-suiting into 80 percent of health facilities reporting shortages of some drugs and 70 percent of them reporting overstock of other types of*

2. *Poor Health Management Information System as evidenced by a reporting rate of 35 percent. Even with the few who report, the quality of data was seen to be poor*

Therefore, in that year the DHMT had in its plans supportive supervision of health facility workers focusing on the above two subjects. This was to be done throughout the year in all health facilities. The objective was to improve personnel knowledge and skills on the above, two subjects so as to reduce stock-out and overstock of drugs to 30 percent or below, and reporting rate to 75 percent by the end of the year.

A checklist was made with the following questions, adopted from the National Supervision Guidelines:-

Availability of drugs:
I Did the treatment correspond to the diagnosis?
2. Was the treatment in accordance with standard treatment guidelines with reference to:-
- *2a. Choice of drug*
- *2b. Dose*
- *2c. frequency*
- *2d. Course*

3. Is dispensing done correctly? Check if:-
- *3a. the correct drug is dispensed*
- *3b. the correct amount was given to the patient*
- *3c. The dispenser gives instruction to the patient on the use of drugs*

etc.

Performance, in HMIS
!. Are the patient cards filled in correctly with reference to:-
- *1a .Symptoms*
- *1b. Signs*
- *1c. Investigations*
- *1d. Diagnosis*
- *1e. Treatment*

2. Are the OPD registers filled in correctly?
3. Are the monthly tally for the diagnoses up-to-date ?
4. Are the classification of the diagnoses correctly done?
5. Are the registers and tally sheets kept in the appropriate place?
6a. Are there inventory list of equipment in the OPD rooms?
6b. If 6a is yes, are they up-to-date?
etc.

For each round of supervision visits, performance of each health facility was recorded in a form designed by the DHMT to record scares for each respective health facility. Again, the format found in the National Supervision Guidelines was adopted. The scores in performance arc shown here for few of the question in some few selected health facilities us a birds-eye view. The supervisor are expected to fill in all the questions checked and health facilities visited in that supervision round.

(Note: This is u mere example and does not reflect the actual performance in the reported District and Health facilities)

Quest ton	*Maneromango HC*	*Mzenga HC*	*Mkamba HC*	*Masaki Disp*	*Gwata Disp*	*Average for*
Question 1	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*	*5/5 (100%)*
Question 2	*No*	*Yes*	*Yes*	*Yes*	*No*	*3/5 (60%)*
Question 3	*Yes*	*Yes*	*Yes*	*No*	*No*	*3/5 (60%)*
Question 4	*Yes*	*No*	*Yes*	*Yes*	*No*	*1/5(60%)*
Question 5	*Yes*	*No*	*Yes*	*Yes*	*No*	*1/5 (60%)*
Question ft	*No*	*No*	*Yes*	*Yes*	*No*	*3/5 (60%)*
Average for Health Facility	*3/6 (50%)*	*3/6 (50%)*	*6/6 (100%)*	*4/6 (67%)*	*1/6(13%)*	

In the above scoring sheer a >YES - is filled in when the hem in question is found to be well per formed and a >NO = when poorly done. A tick, and cross can be used instead of the > Yes — and >NO - respectively with the same effect. To accommodate midway performance a scaling scoring system with more than two options can be used as follow s:-

In the is a mere example and dues not reflect the actual performance in the reported District and Health facilities

Quest ion	*Maneromango HC*	*MzeneaHC*	*Mkamba HC*	*Masuki Disp*	*Gwata Disp*	*....*	*Average for district*
Question 1	*B*	*B*	*B*	*B*	*H*		*11*
Question 2a	*C*	*A*	*A*	*C*	*D*		*B*
Question 2b	*A*	*B*	*B*	*D*	*E*		*V*
Question 2c	*D*	*D*	*B*	*E*	*D*		*D*
Question 2d	*R*	*D*	*A*	*C*	*D*		*C*
Question in	*E*	*E*	*A*	*B*	*E*		*D*

Key: A = Excellent

B = Very Good

C = Good

D = Satisfactory

E = Poor

The score written in numerical form will therefore appear as follows: -

(Note: This is a mere example and does not reflect the actual performance in the District and Health facilities)

Question	Maneromango HC	Nzenga HC	Mkamba HC	Masaki Disp	Gwata Disp	…	Average for district
Question 1	2	2	2	2	2		2
Question 2a	3	1	1	3	4		2
Question 2b	1	2	2	4	5		3
Question 2c	4	4	2	5	4		4
Question 2d	2	4	1	3	4		3
Question 3a	5	5	1	2	5		4
…							
Average for Health Facilities	3	3	2	3	4		3

Key: 1 = Excellent

2 = Very Good

3 = Good

4 = Satisfactory

5 = Poor

Al the Maneromango Health Centre the DHMT supervision scoring sheet was filled in at the end of each visit. At the end of the year the scoring sheet found at the health facility looked like the one below:-

(Note: This is a mere example and does not reflect the reported District and Health Facilities)

Question	*7Jan 2000*	*9 Mar 2000*	*24 Jun 2000*	*17 Aug 2000*	*13 Dec 2000*		*Average for district*
Question 1	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*		*5/5 (100%)*
Question 2a	*No*	*No*	*No*	*Yes*	*Yes*		*2/5 (40%)*
Question 2b	*Yes*	*Yes*	*Yes*	*Yes*	*Yes*		*4/5 (80%)*
Question 2c	*No*	*Yes*	*Yes*	*Yes*	*Yes*		*4/5 (80%)*
Question 2d	*Yes-*	*No*	*Yes*	*Yes*	*Yes*		*4/5 (80%)*
Question 3d	*No*	*Yes*	*Yes*	*Yes*	*Yes*		*4/5 (80%)*
Average for Health facility	*3/6 (50%)*	*4/6 (67%)*	*5/6 (83%)*	*5/6 (83)*	*6/6 (100%)*		*(80%)*

Appendix 4: List of Reference Text Books

1. Franklin A. et. al Supervision of Health Personnel at district level, WHO

2. Ministry of Health Tanzania (1995). National District Health Planning Guide lines, MOH

3. Monekosso G. (1994). District Health Management; Planning implementing and monitoring a minimum health for all package from mediocrity to excellence in health care, WHO, Regional office for Africa.

4. Ministry of Health, Tanzania (1990). National Health Policy.

5. Ministry of Health, Tanzania (1992). PHC strategy

6. Ministry of Health. Tanzania (1994). Proposals for Health Sector Reform.

7. Ministry of Health, Tanzania (1996). Health Sector Reform Plan of Action 1996 - 1999.

8. Janovsky K. and Kielmann AA. District Health Systems: Rapid Assessment