THE REPUBLIC OF UGANDA

MINISTRY OF HEALTH

National Supervision Guidelines for Health Services

Support each other

DEPARTMENT OF QUALITY ASSURANCE

TABLE OF CONTENTS

Table of Contents

List of Abbreviations ii

Foreword iii

Acknowledgements iv

Chapter 1: Introduction *I* What is a supervision system 1

Chapter 2: Support supervision and levels of the supervision system 5

Chapter 3: Use of supervision information 8

Chapter 4: Implementation of the supervision guidelines 11

Chapter 5: Guidelines for supervision from the centre to districts 13

Chapter 6: Guidelines for supervision from the district to HSD 20

Chapter 7: Guidelines for supervision of health facilities by HSD 26

Chapter 8: Guidelines for supervision with-in health facilities 33

Chapter 9: Guidelines for supervision of community health activities 39

Annexes:

Annex 1: Integrated checklist for supervision of District Health Services by the centre.

Annex 2: Integrated checklist for supervision of Hospital services

Annex 3: Integrated checklist for supervision of health centres.

Annex 4: Checklists for inventory of equipment, drugs *I* supplies, and Available standards and guidelines

Annex 5: Checklist for supervision of technical services and programs.

Annex 6: Checklist for supervision of community health services.

Annex 7: Reporting format

Annex 8: Lists of the consultative group members and DHMT members that participated in developing the guidelines at different stages.

LIST OF ABBREVIATIONS

ACP	Aids Control Program
AMREF	African Medical Research Fund
ARI	Acute Respiratory Infections
CAO	Chief Administrative Officer
CBDA	Community Based Distribution Agents
CHW	Community Health Worker
CMT	Core Management Team
CUAMM	Centro Universitario Aspiranti Medici Missionari (Italian NGO)
DFID	Department of the International Development
DGHS	Director General Health Services
DHMT	District Health Management Team
DHS	District Health Services
DHSP	District Health Services Project
DP	Development Partners
DLC	District Local Council
EDF/RHP	European Development Fund / Rural Health Program
EPI	Expanded Program on Immunisation
EU	European Union
GTZ/BHS	German Technical Co-operation *I* Basic Health Services
H/C	Health Centre
HMC	Hospital Management Committee
HSD	Health Sub District
HUMC	Health Unit Management Committee
HSSP	Health Sector Strategic Plan
I/C	In charge
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illness
MCH	Maternal Child Health
M&E	Monitoring and Evaluation
MOH	Ministry of Health
NGO	Non Government Organisation
OJT	On Job Training
PDC	Parish Development Committee
PHC	Primary Health Care
QA	Quality Assurance
QAC	Quality Assurance Committee
RH	Reproductive Health
SCHC	Sub County Health Committee
SS	Support Supervision
SWG	Supervision Working Group
TB	Tuberculosis
TBA	Traditional Birth Attendant
UHSSP	Uganda Health Sector Support Program (The DANIDA project)
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VAC	Vitamin A capsule
VHC	Village Health Committee

WHO World Health Organisation

FOREWORD

The National Supervision Guidelines are derived from the Mandate of the Ministry of Health (MOH) to fulfill the stated goals and commitments of the Government of Uganda. The National Constitution (1995) requires the state to take all practical steps to ensure the provision of Basic Health Services to the population. The Local Government Act (1997) transfers the responsibility for Health Services delivery to Local Authorities and assigns to the line Ministry the role of National Policy Formulation and the setting of National Standards, Guidelines and Regulations. More specifically, this Act states: **" For purposes of ensuring implementation of national policies and adherence to performance standards on the part of Local Governments, Ministries shall inspect, monitor and shall where necessary, offer technical advise, support supervision, and training within their respective sectors."**

In order to fulfill the above roles, the MOH in collaboration with partners in the Districts, other line Ministries and Donors, has evolved a number of strategies to address priority concerns of this mandate. These include the development of Uganda National Health Policy (1999); The Health Sector Strategic Plan (2000 - 2005); Management of health services through the Sector Wide Approach; Definition of the Basic Package of Health Services and other Health Sector Reforms which address the issues of access, quality and rationalisation of
resource mobilisation. Restructuring of Health Services Management at all levels is also on going. The objective is to ensure sustainability, integration, efficiency and effectiveness.

All these are in support of the mission statement of the MOH, which states that:
"The overall goal of the health sector is the attainment of a good standard of health by all people in Uganda, in order to promote a healthy and productive life." .

In pursuit of this mission, supervision of Health Sector activities will be a key component of the strategy that the MOH will use, among others. These National Supervision Guidelines therefore have been developed to facilitate this strategy. They apply to all levels of the Health Services delivery chain and should become an effective tool for ensuring adherence to performance standards and improving the quality of services provided on a continuous and sustainable basis.

It should be appreciated that Support Supervision activities have been going on in the Health sector. For example in the MOH, the Quality Assurance Program undertakes Integrated Supervision while technical departments conduct Technical Supervision. The Health Manpower Development Centre (HMDC) at Mbale carries out capacity building in Support Supervision to DHMT. Consultant supervision visits to upcountry hospitals have also been introduced. The contribution in many different ways of Development Partners and Implementing agencies like UNICEF, World Bank, WHO, USAID, DISH, GTZ, EDF/RHP, UNFPA, DANIDA, and AMREF to these supervision activities in the Health Sector, is acknowledged and appreciated.

These guidelines have been developed building on the rich experience of existing supervision practices in the sector. The development process entailed a review of these practices, the findings of which directed the development of these· guidelines. Wide and extensive consultations were also held with various technical programs in the MOH, District Political and Administrative leaders, the DHMT, NGO health care providers and Development Partners. They were Pilot tested in 8 districts over a one-year period. This helped to address some practical implementation issues.

The guidelines cover the main levels of Health Services delivery chain i.e. Centre to Districts; District to Health Sub-Districts (HSD); HSD to Health Facility; Community Health Programs and internal supervision within health facilities. Guidelines for supervision of the MOH headquarters itself are being developed separately.

I wish therefore to commend these supervision guidelines to all and it is my conviction that if they are implemented faithfully, the performance of the health sector will be transformed. In the spirit of continuous improvement, I would also like to invite all those who use these guidelines to let us know what can further be improved so that it can be included in future editions.   .

Finally, the MOH conveys appreciation and gratitude to the many stakeholders who have worked so hard over the last two years to develop these supervision guidelines, and in particular, the USAID who funded the development process.'

Prof. F. G. Omaswa
Director General of Health Services

July 2000.

ACKNOWLEDGEMENTS

Development of these National Supervision Guidelines (NSG) lasted two years and was carried out by members of the **supervision working group** (SWG) that included:

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1.	Prof. F. G. Omaswa	-	DGHS / Chairman (SWG 1998/9)
2.	Prof. E. M. Kaijuka	-	Commissioner QAD, (Chairman 1999-2000)
3.	Dr. H. G. Mwebesa	-	Ag. Assistant Commissioner, QAD / Secretary
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9.	Dr. J. M. Ziwa	-	Medical Superintendent Kawolo Hospital
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12.	Ms. Sarah Muledhu	-	Secretary / QAD

Development of these guidelines was a long process. It involved assessment of the current supervision practises; review of various. materials / reports; and a series of consultative meetings, workshops, and person to person contacts. The process also involved pilot testing the guidelines in 8 districts over a 1-year period. All this process would not have been possible without the support and direct involvement of a number of individuals and organisations. The Ministry of Health is therefore deeply indebted to the following that made this process possible:

- The USAID, Uganda Mission, for the financial assistance that enabled development of these guidelines to a fruitful conclusion. In particular, Jay Anderson, the head of Health, Nutrition and Population (up to 1999), is acknowledged for his support. His successor Angela F. Lord, and her team of Rebecca Rohler, Jessica Kafuko, Anne Kabogoza Musoke are also recognised in a special way.

- Prof. Richard H. Morrow, of John's Hopkins University (JHU), Division of International Health, Baltimore, USA deserves special mention for his encouragement and technical input. The contribution of his colleagues, Associate Prof. G. Burnham and Dr. B. Kirstiens also of JHU, and Dr. B. Bouchet and Dr. Diana Silimperi of the Quality Assurance Project, Bethesda USA are acknowledged. This team provided very useful technical assistance at different stages of the development process of these guidelines.

- Representatives of MOH technical programs, Development Partners (DP), Implementing Agencies, and Districts (see lists in annex 7) for guiding the SWG on format, content, and the checklists that make an important component of this document. DP and Implementing agencies active in this exercise included

UNICEF, WHO, DHSP, DISH, GTZ, EDF/RHP, EU/CUAMM, AMREF, DFID, UHSSP, & CARE.

- The Institute of Public Health, Makerere University, for assessing the current supervision practises in the health sector. This provided a vital starting point.

- The DHMT, district leaders and staff of Mbarara, Masaka, Kabarole, Mukono, Kamuli, Mbale, Kumi and Arua districts where the guidelines and checklists were piloted. Their recommendations based on real practical experience were significant in finalising this document. .

The SWG also wishes to thank MOH Top Management for their valuable comments on this document.

Chapter 1

WHAT IS A SUPERVISION SYSTEM?

Introduction

According to the mission statement of the Ministry of Health, "*The overall goal of the health sector is the attainment of a good standard of health by all Ugandans in order to promote a healthy and productive life."* The objectives of the health system, as stated in the Uganda National Health Policy, and developed through the Health Sector reforms, are to ensure **access** to, **and sustainability, integration, efficiency and effectiveness** of, health services.

To reach these objectives, all providers in the health system need to develop and maintain high levels of service quality. Quality of care can be defined as the adherence to performance standards on the part of the provider. These standards are usually defined from a technical point of view, but should also take into account the perception of the users of these services. High quality services are thus services that fulfill appropriate, up-to-date technical standards while being delivered in a way that satisfies the user's needs and expectations. The outcomes of quality care will be: improved effectiveness and efficiency of care; increased satisfaction of client with services; increased use of these services; and ultimately improved health standards of the population.

Support Supervision: a strategy to improve Quality of Care

Support supervision is a process of guiding, helping, teaching health providers at their place of work how to perform their work better, using joint problem solving and an emphasis on two-way communication between supervisor and supervisee.

In order to provide quality health care services at facility level, various essential elements need to be present in that facility: appropriate structure and equipment, trained and motivated staff, and drugs and medical supplies. The other elements include information on diseases and health services, financial resources, management support etc.... Support supervision provides an opportunity for staff to work as a team to review and improve on these essential elements. It is also a powerful tool for monitoring and measuring the quality of services provided, that is, adherence to performance standards, on a continuous and sustainable basis.

The supervision guidelines should not be equated with a supervision system. The guidelines with their checklists, are just one of the inputs into a supervision system. Other inputs include supervisors, financial resources, transport, infrastructure, supervisees etc. Within a supervision system, these inputs are organised into relevant

processes (e.g. planning, budgeting, preparation, actual visit, reporting, follow-up) that will lead to the desired outcomes. Examples of the desired outcomes include improved health worker's competency, improved compliance with standards, improved motivation, improved quality of services and increased client's satisfaction. The figure on page 4 summaries this supervision system.

Unfortunately supervision is often conducted as an isolated, routine, fault-finding activity. Implementing support supervision means moving away from this traditional model towards a problem-solving orientation, that is, using the information provided by the supervision process to actually improve the quality of the services \delivered. The current guidelines provide detailed checklists aimed at guiding the supervision process, but filling these checklists should not become the sole aim of this process. The supervision system will be successful only if actions based on the findings of the supervision visit result in an actual improvement of health services at the service delivery point.

A key feature of support supervision is the full participation of all staff involved, both supervisors and supervisees, in a two-way communication process. Supervision activity is a team work where all contribute to the resolution of existing problems. The supervisees bring their experience of the workplace and the community they live in while the supervisors contribute their technical knowledge and the experience acquired from other places. Teamwork during supervision is one of the approaches to more formal quality improvement activities at facility level.

Implementing the system

Being such a powerful tool, support supervision needs to be allocated full "political" commitment and adequate level of priority at all levels involved. It is this strong commitment and high priority that will make supervision successful in generating improvements in the quality of services. In order to make this happen, managers at district, health sub-district and facility levels will have to assess their existing resources and allocate them appropriately.

• Identification of priority areas

As mentioned before, the purpose of the supervision visit is not to fill all possible checklists in the guidelines, but to use these checklists to identify problems in the delivery of quality health services and take corrective actions. Depending on 'the time and resources available, supervisors should select priority areas for supervision, based on the existence of known problems, emphasizing those that may have the greatest impact upon the quality of health services. The source of information for the selection of priority areas include previous supervision reports, routine HMIS returns, results from internal supervision (self-assessment at facility level) or immediate findings during the visit. Thus, the prioritization of activities can be done before or during the supervision visit. Another element in the choice of priority areas is the composition of the supervision team, taking advantage of the available technical skills.

The selection of priority areas for supervision will allow the team to focus on problem identification and solving. However, it is also important that all functional or

administrative areas in the unit be covered at some time, say at least twice a year.

The supervision team will ensure that the first one or two visits cover all possible areas, thus providing a "baseline", and allowing the team to focus on problem areas during subsequent visits.

• Planning of visits

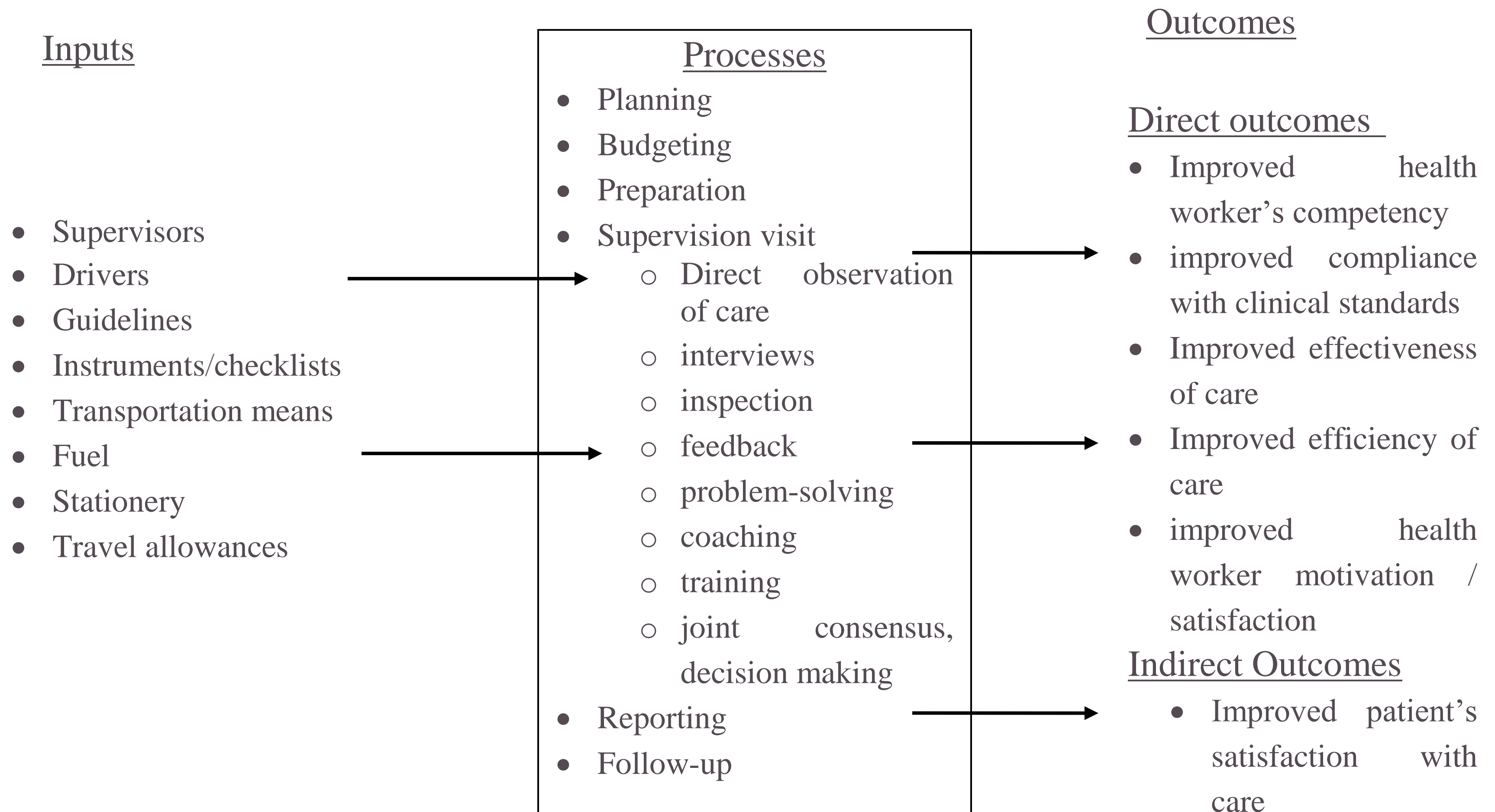
Once a supervision visit has been scheduled and agreed upon, all efforts should be made to complete the visit on the time indicated. However, constraints on time and other resources may reduce the frequency of supervision. The supervision team should then prioritize the units to be visited more frequently, on the basis of known existing problems in service delivery. Planning for supervision activities should be done at all levels. The plans or schedules should be communicated to all those affected. Supervisors should adhere to these schedules.

• Sharing and reporting of results

Even if the time available for supervision is limited, it is essential to ensure that sufficient time is made available for debriefing and sharing the results of the supervision. This activity, jointly conducted by supervisors and supervisees, allows reviewing. the main findings of the visits and agreeing upon remedial actions to be taken, immediately or in the future. Remedial action may be taken by the facility staff supervised, by the supervisors, or by a third party. Proper recording of these actions is also essential for monitoring follow-up activities and evaluation of the impact of the supervision system.

In summary, when planning and conducting supervision, health units and priority areas to be supervised should be selected on the basis of both resources available and desired outcomes. In the context of quality assurance, high priority should be given to supporting staff to comply with clinical standards, as this is expected to have a maximum impact on the quality of health services.

The supervision system



Chapter 2

SUPPORT SUPERVISION AND LEVELS OF SUPERVISION IN THE HEALTH SECTOR

1. Definition

Support Supervision is a process of guiding, helping, teaching and learning from, staff at their places of work in order to perform their work better. Thus support supervision avails the supervisors and supervisees an opportunity to work as a team to meet common goals and objectives. It also allows the team members to learn from each other. In support supervision emphasis is put on joint problem identification, joint problem solving, and two-way communication between the supervisors and those being supervised.

2. General Objective

The overall objective is to improve the quality of health services provided and which are acceptable to all stakeholders.

3. Types of Support Supervision

The Ministry of Health has adapted 3 types of supervision:

- Integrated Support Supervision
- Technical Support Supervision
- Emergency Support Supervision

3.1 Integrated SS

Integrated Support Supervision (SS) aims at covering a comprehensive range of services. However, not all services can be supervised at each one time, but it stipulates that during the course of the year, every service should have been supervised.

Integrated SS requires a multidisciplinary team, using an integrated checklist. The team should possess a mix of the required skills i.e. Management, Clinical and Public Health skills. It is advisable to change teams from time to time in order to spread the different skills among the different service providers.

Integrated SS also allows the sharing of scarce resources (e.g. human and vehicles) and for supervision of a wide range of services at the same time. This too offers an opportunity to supervisors to have a broad awareness of the different programs, and to share information. It also makes priority setting easier.

Occasionally, an integrated supervision team will find that performance has fallen below a certain threshold as defined by standards. In this case, an in-depth analysis of the problem will be done together with the supervisees, in order to address it. In the event that an integrated SS team lacks adequate skills to resolve the problem, it will

request experts and specialists to follow on with a Technical SS mentioned below.

3.2 Technical SS

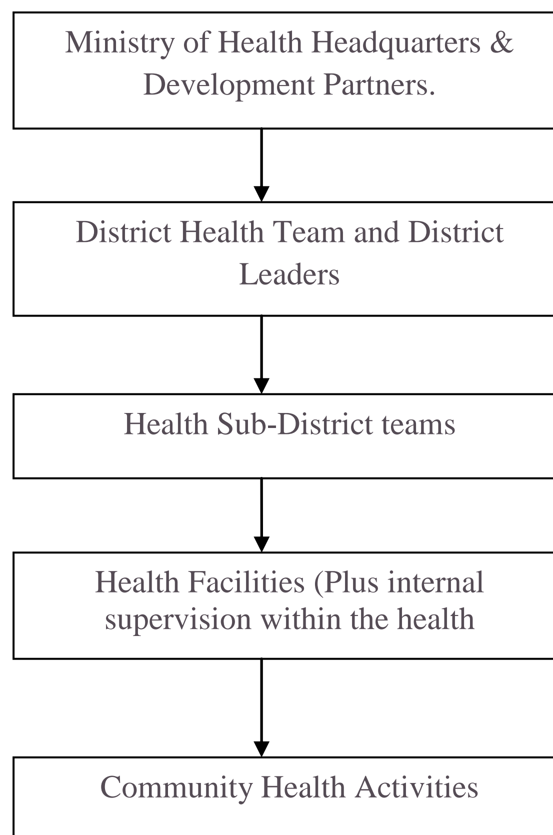
Technical supervision provides technical support in a specific speciality area. Technical SS should be specifically planned for, but may also be in response to a request by an integrated supervision team (as indicated in section 3.1 above). On the other hand technical supervision may be requested directly by the supervisees themselves. Technical SS has the advantage of allowing specialists to work together with the supervisees and the Integrated SS teams to address particular technical or specialised services.

3.3 Emergency SS

The third category of supervision is the Emergency SS. This provides support to a specific emergency problem such as a strike, an epidemic outbreak or any disaster. '

4. Levels of supervision

In the Health services delivery chain, the following levels are recognised:



5. Structure of the National Supervision Guidelines

The national supervision guidelines will give guidelines for each level indicated above.

The guidelines will follow the following format for each level of supervision:

- Broad objectives for that level of supervision.
- Type of supervision at a each level of Health Service Delivery. Specific objectives per type of supervision recommended.
- Frequency
- Duration
- Supervisors
- Supervisees
- Methodology.
- Tools for supervision
- Reporting
- Responses and Follow up actions
- Monitoring and Evaluation of Supervision at that level.

Chapter 3

USE OF SUPERVISION INFORMATION

Introduction

Supervision activities generate information that will be used to improve the quality of health services. The process of collecting information through checklists, record review, observation or discussion is not the sole purpose of a supervision visit. This process should result in continuous quality improvement through the use of this information. It is therefore important that proper recording of supervision findings and recommendations, and monitoring of follow-up actions be done at all levels.

Information obtained from previous supervision activities is used for planning and conducting supervision. It will also help in prioritising health facilities or services that need in-depth supervision.

Supervisors therefore should usually review the following sources of information when planning for supervision and / or during the supervision process:

Previous supervision records / reports;
Results of the health unit self-assessment;
The HMIS database or other HMIS periodic reports;
Minutes of monthly staff meetings or specific meeting reports.

Recording and reporting of supervision information

The supervision team will ensure that proper recording of the supervision findings and actions to be taken is always done at the facility in an appropriate supervision report book before the team leaves the facility. Supervisors will also make a written supervision report and circulate it to the relevant levels. A reporting format attached in Annex 6 of these guidelines is recommended for supervision reports. This format includes a review of positive and negative findings, a list of agreed actions to be taken (both by the supervisees and by the supervisors), and recommendations for other appropriate interventions.

Also, most of the checklists have been developed in a format with columns that allow multiple / successive use. These can be used to record and analyze findings over time in a given health facility. Space has also been availed for comments.

The reporting patterns will also be directed by the need for action as follows:

- There should always be immediate debriefing at the end of each supervision visit.
- Immediate verbal reporting of issues needing immediate action should be made upon return to the next level (HSD, district, or MOH depending on level supervised).
- Written supervision reports should be submitted within two working days after the supervision visit.

- Review of follow-up activities during monthly management meetings or during any other such opportunity.

The sections below highlight, as an example, how supervision information can be used at the health facility and at the district / HSD levels.

Use of supervision information at the facility level

The in-charge and his/her team will use the information generated by the supervision activities in several ways:

- to identify performance gaps and provide on-the-job training,
- to analyze the root causes of the problems, design and implement possible solutions,
- to monitor the results of the interventions,
- to initiate and maintain a dialogue among the health facility team.

This process of working as a team at the facility level to identify problems affecting service delivery and to explore possible solutions together actually constitutes formal Quality Improvement methods. Indeed, supervision activities provide an excellent forum for initiating and developing a more structured process for improving the quality of health services.

As mentioned above, the information gathered during internal supervision activities will be used to define priorities and objectives for future supervision visits, both internal and external.

Use of supervision information at the district and HSD levels

In a similar fashion, the information provided by supervision activities should be used for planning of future supervision activities and prioritising services and health facilities to be supervised. In addition, HSD / district managers need to analyse the information generated across their catchment area and health facilities in order to:

- identify good performing and poor performing facilities,
  monitor trends in service provision,
- design quality improvement interventions,
- allocate resources where needed,
- identify training needs,
- review staff performance in view of promotions / incentives, and
  develop leadership within the HSD and district.

For monitoring purposes, it may be useful to prepare a series of charts showing the status of key indicators within the range of supervised units and its evolution over time (see example at the end of this section).

Using information obtained from the monthly DHMT meetings, the supervision reports from the HSD, and its own supervision experience, the district health team should be able to assess the overall performance of the district in providing quality health services to its population.

District / Health Sub-District Indicator Monitoring Chart

District: ________________________ **Health Sub-District:** __________________

Indicator: <u>Is there any documentation of the actions taken as a result of supervision?</u>

	Month when supervision was conducted											
Facility	Jul	Auq	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
F1	X	X	X	X	X	X	X					
F2			X	X	X	X	X					
F3	X		X	X	X	X	X					
F4												
F5	X	X	X		X	X	X					
F6	X	X		X	X	X	X					
F8		X	X	X		X	X					
Total	4	4	5	5	5	6	6					

Indicator: <u>% of client cards reviewed which have been filled accurately and according to guidelines</u>

	Month when supervision was conducted											
Facility	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
F1	50	60	65		60	65		70		75		
F2	45	40	50		50		55		60			
F3		80				85				80		
F4	55	60		70			65		55	60		
F5	55		60		70		75		75			
F6												
F8												
Total	52	53	59	70	59	74	63	70	64	73		

Note: for this indicator, Total % is obtained by dividing total number of accurately filled cards by total number of cards reviewed

in all Facilities supervised during the month.

Chapter 4

IMPLEMENTATION OF THE NATIONAL SUPERVISION GUIDELINES

The National Supervision Guidelines will be implemented in all the 45 districts in Uganda and at all levels of health service delivery. All stakeholders involved in supervision of health services will be required to follow these guidelines. Enough copies will be printed and disseminated to all stakeholders.

Introduction of the guidelines will help to strengthen the supervision system already mentioned in the previous chapters. The dissemination process will therefore require training supervisors in supervision skills. The training will be done for all levels i.e. national, district, health-sub-district and facility level (at least down to H.C. 2). Established community based health providers will gradually also be trained by their respective health facilities. This process of dissemination is important for institutionalisation of a sustainable supervision system.

In view of the above mentioned, a team of national trainers will be trained at the centre. The team will receive an in-depth training in supervision skills through a one-week workshop. This team will be drawn from members of the supervision working group and selected program managers. Technical support for this trainer of trainers (TOT) workshop will be sought from development partners.

The TOT will then train all national level supervisors at the centre who include the Quality Assurance Committee members, Technical program supervisors and other stakeholders. The main objective of this training will be to **orient them on the guidelines, strengthen their support supervision skills and to build consensus for an integrated and well-linked supervision** system. There after the same trainers will hold regional workshops to give similar training to District Health Teams (DHT) and heads of health sub districts. The workshop objectives will be similar. It is anticipated that this will be covered through 8 regional workshops.

During regional workshops, the DHT and HSD heads will develop workplans and schedules for similar training for their health unit in-charges and other district based supervisors. Immediate implementation of the guidelines in the districts will then follow. This is to emphasise that training of health facility staff in districts will be a responsibility of respective DHT and HSD managers. The centre may only provide a co-facilitator if at all required. This is a district activity with budget support and facilitators provided from the districts. Projects and implementing agencies based in districts (e.g. EU, *EDF/RHP,* DISH, GTZ, HSSP etc.) will be expected to play a: key role in facilitating this process e.g. through budget support, joining the DHT as facilitators, and in any other ways agreed upon with the DDHS. PHC conditional grants (the budget item line on supervision) may also be used for dissemination workshops at HSDs.

It is also strongly recommended that District Health Teams give a brief orientation to the district political and civic leaders in this new supervision system - especially the district executive council. This may be through a routine executive council meeting where the DDHS may ask for an item on their agenda to give a bird's eye view of the recommended supervision system and what is expected from district leaders. A similar presentation may also be made to the district council at one of its meetings. Emphasis should be put on soliciting support for supervision of health services in their respective areas. HSD managers should also give similar briefing to equivalent structures at the LC 4 level.

Chapter 5

SUPERVISION FROM THE CENTRE TO DISTRICTS

Supervision at this level links the MOH Headquarters with District Health Services. In this context, District Health Services includes the District leaders, the DHMT, the Health Sub Districts (HSD), NGOs, the Private sector and Community representatives.

1. AIM

To work with the DHMT, District leaders and Community representatives in order to support and improve the delivery of health services at the district and HSD levels by ensuring that National policies and standards are complied with, and administrative issues affecting implementation supported.

2. TYPES OF SUPERVISION

The following types of supervision will take place from the MOH headquarters to the districts:

- Integrated support supervision.
- Technical support supervision.
- Emergency support supervision

2.1. Objectives of Integrated Support Supervision

The specific objectives of integrated support supervision will be:

- To advocate for improved health services delivery in the district.
- To ensure that MOH policies and guidelines have been disseminated to the districts and incorporated into District Health Plans.
- To support compliance with standards and guidelines in the District Health Services.
- To support the districts formulate and implement relevant local policies and strategies.
- To review together with the DHMT the general state of health services In the district.
- To work with the DHMT to identify, prioritise and where possible solve problems on site; there-by building capacity for health services management at the district level including their capacity to supervise HSD.
- To promote team work among health care providers.
- To provide feedback from the districts to the centre and vice versa.

2.2 Objectives of technical supervision

Emphasis should be put on providing technical support to the services in the Uganda Minimum Health Care Package (UMHCP). These include Control of communicable diseases (Malaria, STI/HIV/AIDS, TB); IMCI approaches; Reproductive Health; Other Public Health Interventions (i.e. Immunisation, Health education *I* promotion, environment health, school health and epidemics and disease prevention, nutrition, and diseases targeted for eradication); Mental health, and essential clinical care. Technical supervision will also be provided for support functions like HMIS, health infrastructure, medical equipment, health planning and financial management.

The specific objectives of technical supervision therefore will be:

- To provide advocacy for the particular program or service.
- To support the DHMT promote compliance with standards and guidelines for the program being supervised.
- To build the DHMT capacity for providing technical supervision to HSD in the relevant program or service.
- To ensure continuous skills development in the program or service through On-Job-Training OJT) and consultant outreach program.
- To monitor the performance of the program or service.
- To provide feedback from the districts to the centre and vice versa.

2.3 Emergency support supervision

Emergency support supervision will be in response to an emergency in a district e.g. support to an epidemic outbreak.

3. FREQUENCY

3.1 Integrated supervision

In order to give the necessary support to the districts, integrated supervision from the centre to the districts will take place every 4 months i.e. three times a year.

3.2 Technical supervision

The frequency of technical supervision from the centre to the districts will be:

- At least once a year per district for each technical program or service;
- In response to problems raised by an integrated support supervision team that require technical supervision;
- Each discipline in a hospital should receive a specialist consultant supervision visit at least monthly.
- Upon specific requests from the district.

3.3 Emergency support supervision

Emergency support supervision will be conducted when there is an emergency.

4. DURATION

4.1. Integrated SS will last at least five working days in each district.

4.2 The duration for technical supervision should last at least not less than one working day. However, it is important to realise that the time spent with the DHMT will depend on the support required. Such time may not be prescribed in these guidelines.

5. SUPERVISORS

5.1 Integrated SS

Requires multidisciplinary teams drawn from members of, MOH senior management, the National referral hospitals, the Medical Schools, Institute of Public Health, Development Partners, and Regional Referral Hospitals.

Each team should consist of at least 3 members with a mix of Management, Clinical and Public Health skills.

5.2 Technical Supervision

TS should be carried out by staff with the relevant technical skills from the respective technical departments.

6. SUPERVISEES

Supervisees at the district level include district leaders, the DHMT, Health Sub Districts (HSD), NGOs, the private sector and community representatives. However it should be noted that when supervisors from the centre get to the district, together with the above officers, they form a supervision team.

Remember, effective supervision requires team approach.

Supervisors and those being supervised are both part of the team.

7. STAGES OF SUPERVISION

Support supervision consists of 4 stages; namely Planning, conduct of the supervision, recording of supervision activities and follow up. The first 3 stages are discussed here, while follow up is discussed under No.10.

7.1 Planning for supervision

Planning for supervision (both integrated and technical) should include the following:

- Developing an annual supervision plan with a matching budget. The plans should indicate schedules, which should be communicated to the districts for inclusion in the district plans. Districts should be reminded through a circular at least 4 weeks before the supervision date.

- Setting general supervision objectives for the year. For each round of visits, specific objectives should be determined before going for supervision.

- Reviewing records such as progress reports, previous supervision reports, HMIS returns, self-assessment reports, and any relevant press reports may help to determine objectives for that visit.

- Constituting teams (teams may also depend on the tasks / challenges in individual districts).

- Preparing logistics (transport, fuel, allowances,) and other resources.

- Preparing any materials, supplies, circulars etc. that can be delivered during the supervision exercise. MOH departments should be consulted regarding this.

- Briefing the supervision teams to focus on the objectives for the visit, the crucial areas that must be covered and orienting them to the supervision tools that will be used.

7.2 Conduct of the supervision visit

- Supervisors should arrive in the district as scheduled and on time.

- They should report to the DDHS and then pay courtesy calls to the District leaders.

- A brief period of orientation i.e. introductions, and briefing on purpose of the visit should be held with the DHMT. It is recommended that the secretary for social services at the district level and ACAO (health) be incorporated in the team at this level. This will help to strengthen the supervision team.

- The team will then agree on how the supervision exercise will proceed and the main aspects to be covered.

- Supervision should start with discussion of the general state of health services in the district. Follow up on issues from the previous visits. Use the relevant tools provided for the visit. Also take note of the general environment in which staff work.

- It should be emphasised that **the supervision tools should be used in a facilitative, and not fault finding way - to identify strengths, weaknesses and gaps.** Acknowledge the positive findings. Facilitate joint problem solving for weaknesses,

gaps and constraints identified. Sometimes this may involve demonstration of the skill and asking for return a demonstration. Agree as a team on areas that require improvement. Please note that on site feed' back is a very important process of support supervision.

- The supervision team should visit a sample of HSD to build capacity of the DHMT to' supervise HSD; and consequently improve the HSD supervision and technical performance skills too.

Please note that the expected outputs of support supervision include:

On site problem solving,

On job training,

Staff motivation,

Team building, and

Improved communication between the different levels of the service

Consequently these will lead to

IMPROVED COMPLIANCE WITH STANDARDS

7.3 Recording of supervision findings

The DDHS and HSD offices should have a Supervision Report Book for documentation of supervision findings and recommendations. A format for such reporting is attached in the annex.

7.4 Follow up

Follow up will involve implementing actions agreed upon. Support supervision will not be complete until follow up has been done. This is covered under no. 10 below.

8. SUPERVISION TOOLS

8.1 Integrated supervision

- The commonest supervision tools are checklists and HMIS returns. Checklists are job aides to guide a supervisor on areas he / she intends to review, discuss and observe. Annex 1 of these guidelines contains checklists that can be used for integrated supervision at the district level. Although attempt was made to make this checklist comprehensive, it cannot be exhaustive.

It should also be noted that it is neither desirable nor possible to supervise everything during each visit. Checklists are dynamic and may be revised periodically to address issues at hand depending on the main objectives of the visit.

- Supervision teams should as much as possible use the district HMIS reports as part of important tools for Support Supervision.

- Supervisors should also encourage and guide districts to do self assessment.

8.2 Technical Supervision

- Tools for technical supervision depend on the technical service being supervised. Attached in annex are some checklists for technical supervision of the different programs / services - included in the Minimum Health Care Package for Uganda.

9. REPORTING

The most important aspect of reporting is providing feedback and this will take the following forms:

- **On site verbal feed back** to the supervisees during the process of supervision - as already indicated in 7.2 above.

- **On site written feedback** in a supervision report book at the DDHS and HSD offices as recommended in 7.3 above. As mentioned earlier, a format for such reporting is included in the annex.

- **Immediate verbal feed back to other levels.**
  A wrap up meeting should be held with the district leaders at the end of the visit to debrief them on the major findings and recommendations. Minutes of the wrap up meeting should be taken by the DDHS and circulated.

  At MOH, the team leader should inform relevant departments immediately upon return of any interventions required.

- **Written reports** should be made within one week of completion of the supervision exercise. The reports should be disseminated to relevant stake holders.

  For Integrated support supervision: The reports should be submitted to the CHS (QA). The CHS (QA) will ensure reports are analysed and feedback given to all departments in the MOH (in form of summary reports and through QAC meetings). Copies of reports will be disseminated to the respective DHMT and district leaders, Ministry of Local Government and to relevant Development Partners.

  Technical supervision: Technical supervision reports should be disseminated to the respective Commissioners and districts supervised. Summaries of such reports should be presented in Senior Management Meetings.

10. RESPONSES AND FOLLOW UP ACTIONS

Following supervision it may be identified that some actions need to be taken at the HSD, at the district level and / or at the central level.

The supervision team will work with the DHMT to address some problems that can be solved on site. The DDHS will be responsible for following up actions at the district level, while the central level team leader will be responsible for following up actions at the central level.

These action points should be documented in supervision reports as recommendations; and if possible, the time frame during which they should have been accomplished stated.

11. MONITORING AND EVALUATION

A Monitoring and Evaluation (M&E) system will be established at MOH to assess:

- Adherence to these guidelines e.g. availability of supervision workplan, budgets and schedules in the different MOH departments, if supervision done as scheduled, if agreed actions were followed up, and if supervision reports were submitted in time,

- Indicators will also be developed to evaluate the effectiveness of the supervision system i.e. if there are any observed improvements due to central level SS to the districts. This can be done through annual review of reports, Annual General Meetings with stakeholders, and periodic assessment of supervisees' perceptions of the strength and weaknesses of the supervision process.

- Each team's accomplishments during the year through self-assessment

- Achievements of the supervision system in the MOH at the end of each year by Top Management.

Chapter 6

SUPERVISION FROM THE DISTRICT TO HEALTH SUB-DISTRICTS

This level involves supervision of Health Sub Districts (HSD) by members of the District Health Team (DHT) and District leaders. In the new MOH policy, supervision of health facilities and other service delivery points in districts is now a responsibility of HSD. The districts (DHT and district leaders) on the other hand:

- Will supervise HSD headquarters for planning and management functions.
- Will supervise the quality of care provided at HSD head quarters (i.e. technical supervision to hospitals and He IVs).
- May provide additional resource persons (DHT members) to be co-opted on the HSD teams to lower health facilities depending on need.

1. AIM

The aim of DHT and districts leaders' supervision of HSD is to support and improve the quality of health services in HSD by promoting compliance with standards and addressing administrative issues that affect service delivery.

2. TYPES OF SUPERVISION

The DHT and district leaders will conduct three types of supervision to HSD·

- Integrated support supervision (SS)
- Technical SS
- Emergency SS

2.1 Integrated Supervision and its objectives

Integrated supervision at this level will involve a multidisciplinary team supervising a cross section of services at the HSD i.e. clinical, management, and health promotive / preventive services.

The objectives of integrated supervision at this level will therefore be:

- To review with the HSD staff the general state of health services in the HSD.
- To promote use of service standards at the HSD and in all health facilities in the HSD.
- To provide management support to staff at the HSD.

- To provide support in the quality of clinical care at the HSD.
- To assist HSD implement and monitor promotive and preventive health services.
- To identify and where possible solve technical problems or link HSD with relevant technical personnel.

2.2 Technical supervision and its objectives

The DHT will identify and facilitate supervisors with relevant technical skills to supervise technical services at HSD. Examples of technical services that may require technical supervision include the cold chain, IMCI, reproductive health services, X-rays or laboratory services, medical equipment, etc.

The objectives of technical supervision are:

- To respond to specific technical problems that have been raised by integrated supervision teams or identified by a HSD.
- To support the health workers comply with standards in services being supervised.
- This will be done jointly with the technical supervisors at the HSD.
- To assist HSD identify and solve problems in the particular field in which technical supervision is being provided.
- To support Continuing Medical Education (CME) and in service training programs being implemented by the HSD.

2.3 Emergency supervision

- To assist HSD prepare for and respond to emergencies, disasters and epidemic outbreaks.

3. FREQUENCY

3.1 Integrated supervision

Districts should provide an integrated supervision to each HSD at least quarterly. (However, every opportunity a supervisor gets should be used to provide supervision i.e. "No missed opportunity")

3.2 Technical supervision

The frequency of technical supervision will depend on need. However, every program or service should be supervised at least once a year.

3.3 Emergency supervision

Emergency supervision will be provided when there is need.

4. DURATION

Two working days are recommended for each HSD. One day will be spent providing at the HSD headquarters (whether technical or integrated supervision). This will allow for sufficient time to support both management and service delivery systems at the HSD HQs. On the second day, the DHT should move with HSD supervisors to supervise one health facility. This is aimed at building capacity of HSD in supervision and problem solving skills through supervised practice.

5. SUPERVISORS

5.1 Integrated Supervision

A multidisciplinary team should be constituted from DHT members, and district leaders. It may include the Secretary for Health and the Assistant Chief Administrative Officer (CAO) in charge of health.

5.2 Technical Supervision

Technically competent staff will provide technical supervision. This may even involve co-opting staff from any other place other than members of the DHT e.g. from a referral hospital if applicable.

6. SUPERVISEES

The supervisees include the in-charges and staff at the HC IV heading a HSD.

Where the HSD is headed by a hospital, district supervisors will supervise the Hospital Core Management Team and heads of departments and sections. Staff below this level will be supervised by the internal supervision system of the hospital.

Remember, effective supervision requires team approach. Supervisors and those being supervised are both part of the team.

7. METHODOLOGY

Support supervision at the HSD level involves 4 phases; Planning, conducting the supervision, recording of the supervision activities and follow up.

7.1 Planning for supervision

- Developing an overall annual supervision plan with a matching budget.
- Drawing quarterly schedules and communicating them to HSD.
- Before each visit, the objectives for the supervision should be determined and agreed among the district supervisors. The objectives however may be revised during supervision depending on findings.
- Review records - progress reports, previous supervision reports, HMIS returns and many other relevant reports to come up with priority areas for the supervision.

- Constitute supervision teams, based on the objectives of the visit.

- Review relevant records - especially previous supervision reports, HMIS returns, progress reports and any other communications about the HSD.

- Prepare the relevant logistics (e.g. transport, allowances, fuel, supplies to be delivered etc.) and other resources.

7.2 The supervision visit

- Supervisors should arrive at the HSD as scheduled and on time.

- There should be a brief period of orientation i.e. introductions and briefing on objectives of the visit. Agree with supervisees on how the supervision exercise will proceed.

- Discuss the general status of health services and management issues in the HSD. Follow up issues from the previous visit and actions taken. Also take note of the general working environment.

- Review the HSD supervision plan, the visits done and an over view of their findings. Select a health facility to be supervised jointly on the second day. It is better usually to select problem health facilities.

- Then use the relevant checklist in these guidelines to conduct the rest of the supervision at the HSD. **Checklists should be used as job aides to facilitate observation and discussions.** They will help to identify strengths, weaknesses and quality gaps. **Checklists should not be used as instruments for merely looking for faults.**

- Positive findings and strengths observed should be acknowledged. This motivates staff and reinforces good performance.

- Assist staff to perform better where weaknesses, quality gaps or constraints are identified as part of **joint problem solving.** Where skills improvement is required, on job training, demonstration and return demonstration should be done.

- At the end of day one, hold a meeting with the HSD staff to wrap up on findings, follow up actions and priorities for next visit. Also agree on plans for the second day's visit to a health facility.

Please note that the expected outputs of support supervision include:

On site problem solving,

On job training,

Staff motivation,

Team building, and

Improved communication between the different levels of the service.

Consequently these will lead to

IMPROVED COMPLIANCE WITH STANDARDS.

7.3 Recording of the supervision findings

Every HSD should have a supervision report book where the major findings of the supervision will be recorded. The positive findings, the quality gaps found and the quality improvements agreed should be recorded at the end of each visit in line with the format indicated in the annex.

7.4 Follow up

Follow up will involve implementing actions agreed. The supervision process is not complete until follow up has been done. This is covered under item 10.

8. TOOLS FOR SUPERVISION

8.1 Integrated Supervision

An integrated checklist in annex 3 should be used for integrated supervision of HC IV. For hospitals, annex 2 or 3 may be used depending on the objectives of the visit.

HSD should also be helped to use the self-assessment tool developed by Ministry of Health as a routine.

8.2 Technical Supervision

Tools for technical supervision depend on the technical service being supervised. Checklists for supervision of technical services are contained in the annex. Relevant checklists should be selected.

9. REPORTING

- **On site verbal feedback:** Direct verbal feedback should always be given during the supervision process. As indicated above, a meeting should also be made at the end of each visit to wrap up on major findings, improvements agreed and other follow up actions.

- **On site documentation:** A written report **should always** be made in the HSD supervision report book as indicated in 7.3 above.

- **Written supervision reports:** A *brief* supervision report should be written within 2 days by the supervisors- copied to the respective HSD, the secretary for health and the CAO.

- **DHMT monthly supervision meetings:** DDHS should organise monthly meetings

for all managers of HSD to share experiences on major supervision findings during the previous month. This will allow for follow up of actions requiring interventions at the district level.   .

10. RESPONSES AND FOLLOW UP ACTION

- The DDHS takes overall responsibility for ensuring that supervisors follow up on agreed actions in the different HSD supervised. This will be done in close collaboration with the CAO and the secretary for Health.

- In charges of HSD will be responsible for following up implementation of actions at the HSD level.

11. MONITORING AND EVALUATION

The DHT should develop a mechanism to monitor and evaluate whether:

• the supervisory activities are being implemented according to schedules

• the supervision system is improving compliance with standards by service providers.

• actions are being taken on issues identified during the supervision visits.

• etc.

Chapter 7

SUPERVISION FROM HEALTH SUB DISTRICTS TO HEAL TH FACILITIES

This level involves supervision of health facilities and other service delivery points by members of the health sub districts (HSD). The MOH policy clearly states that among other functions, HSD will carry out support supervision to lower level health units in the HSD, including community outreach activities provided by staff. In addition, HSD will provide technical support to community based health activities on top of monitoring and evaluating the impact of health interventions in the HSD. Against this background of heavy responsibility, the heads of HSD were accorded a status of Deputy DDHS and hence membership to the DHMT.

It is important to emphasise from the start that, **this is a very important level of** supervision **because it provides support to health care providers who get in direct contact with the clients / patients.**

1. AIM

The aim of supervision at this level is to promote compliance with standards and guidelines among health care providers and hence improvement in the quality of care provided. Supervisors at this level should focus on ensuring that standards and guidelines of care are availed to the providers and that they are being complied with.

2. TYPES OF SUPERVISION

HSD will provide three types of supervision to the facility levels:

- Technical support supervision (SS).
- Integrated SS.
- Emergency SS.

2.1 Technical supervision and its objectives

It has been recommended that, to improve providers' skills to deliver quality health services, the more regular type of supervision at this level should be technical supervision - to support actual service provision by promoting compliance with standards.

Consequently, the objectives of technical supervision at this level are:

- To promote use of service standards and guidelines.
- To support the quality of clinical care and continuous skills development through On Job Training.
- To respond to specific technical problems that have been raised by an integrated supervision team or upon request from the facility staff.

- To empower health workers identify and solve problems in the particular field in which technical supervision has been provided.

- To assist providers quickly identify cases requiring referral.

2.2 Integrated supervision and its objectives

Integrated supervision at this level involves HSD staff going to a health facility to supervise a cross section of service i.e. management, health promotive / preventive services, and some clinical issues. During integrated supervision, the team looks more at the general state of affairs affecting delivery of health services, with less focus on any particular program or service.

The objectives of Integrated supervision will be:

- To review together with the facility staff the general state of health services in the facility.

- To provide management support to staff at the facility level.

- To assist staff provide improved health promotive and preventive services.

- To ensure continuous skills development through On Job Training (OJT).

- To reinforce use of standards and guidelines.

2.3 Emergency support supervision

- To respond to an emergency situation or problem in the district.

. 3. FREQUENCY

3.1 Technical supervision

Each HSD has on average 6-8 health facilities in its catchment area. It is possible to supervise each facility at least monthly. In view of the emphasis on technical supervision, it is recommended that technical supervision be carried out monthly - except during the months when HSD will carry out integrated SS as recommended below. However, during technical supervision, supervisors will also address some management issues that affect service delivery.

Supervisors are advised to select a relevant checklist in these guidelines for the technical area being supervised each time. Attempt should be made to supervise each program or service in each facility at least once in a year. It will be noted that, some programs / services may require more frequent supervision than others. The supervisors will judge based on their experience, the existing skills of providers and the burden of disease in the HSD, which services will require more frequent supervision.

In the event that it will not be possible to visit all facilities in the HSD during the

month,
priority should be given to health facilities with more problems. (**However, effort should be made to avoid this scenario).**

3.2 Integrated supervision

It has been proposed that HSD conduct an integrated supervision to each facility in the HSD every 6 months - to do a general check of a cross section of issues. The checklist in annex 3 may be used for this type of supervision.

3.3 Emergency supervision

Emergency supervision is carried out when there is need.

3.4 No missed opportunities

If a supervisor gets any opportunity to be at a health facility in the HSD for any reason, he / she should take the advantage to do some form of supervision depending on the situation on site.

4. DURATION

One working day should be devoted to each health facility for either type of supervision. This will allow for sufficient time to observe performance, discuss issues, demonstrate skills to health workers and to give a feed back to staff.

5. SUPERVISORS

5.1 Technical Supervision

Staff with relevant technical skills will be identified from each HC IV or Hospital to do technical supervision. These may include for example the doctor, clinical officers, registered nurses, registered midwife, comprehensive nurse, health inspector, health educator (if available), and laboratory technician. For HSD based at hospital level, supervisors may be drawn from members of the Community Health Department and Heads of departments.

A supervision team may comprise two supervisors (or more depending on resources).

5.2 Integrated supervision

A multidisciplinary team may be constituted from supervisors at the HSD, a DHT member, and some leaders from LC IV (e.g. Secretary for health and ACAO). If adequate notice is given, HUMC members of the supervised facility should also be invited to participate.

6. SUPERVISEES

The in -charge and staff at each health facility will be supervised.

If the facility being supervised by the HSD is a hospital (which is not a HSD itself), supervisors should concentrate on supervising heads of departments and sections. Staff below this level should be supervised by the internal supervision system of the hospital itself.

7.

Remember, effective supervision requires team approach.
Supervisors and those being supervised are both part of the team.

Support supervision at the facility level involves 4 phases; Planning, conducting the supervision, recording of the supervision activities and follow up. The first 3 stages are discussed here, while follow up is discussed under no. 10.

7.1 Planning for supervision

Planning for either integrated or technical supervision includes the following:

- Developing an annual supervision plan with a matching budget.
- Drawing quarterly supervision schedules and communicating them to health units in the HSD. A copy should be sent to the DDHS.
- Before each visit, the purpose and objectives for supervision should be determined and agreed with all supervisors. However, objectives may be revised just before, or during the supervision.
- A supervision team will be constituted based on the objectives of the supervision.
- Reviewing relevant records - especially previous supervision reports, HMIS returns, progress reports and any other communications (e.g, from HUMC, local councils etc.) about the health facilities.
- Preparing the necessary logistics (e.g. transport, allowances, fuel, stationery etc.).
- Preparing any supplies and logistics that can be delivered to health units during supervision (e.g. gas, drugs, vaccines, stationery, guidelines etc.)

7.2 Conducting the supervision visit

- Supervisors should arrive at a health facility or service delivery point as scheduled and on time.
- There should be a brief period of orientation i.e. introductions and briefing on objectives of the supervision. The team will then agree on how the supervision exercise will proceed and the main areas to be covered.
- Supervision will start with a brief discussion of the general state of affairs in the health unit. Follow up on issues from the previous visit and what actions have been taken. Also take note of the general working environment. Then use the relevant checklist in these guidelines to conduct the rest of the supervision.
- Please note that checklists should be used as job aides to facilitate observations and discussions. They will help to identify strengths, weaknesses and quality gaps. They should not be used as instruments to merely look for faults.

- Positive findings and strengths observed should be acknowledged. This motivates staff and reinforces good performance.

Always appreciate and thank staff for positive findings and strengths before pointing out weaknesses and deficiencies.

- Assist staff to perform better in areas where weaknesses and quality gaps have been identified. This may be through discussion or demonstration. Carry out on job training where skills improvement is required. Where demonstration has been given, always ask for a return demonstration.

- At the end of the visit, hold a meeting with the health workers (and HUMC members in case of an integrated supervision if present) to agree on areas for improvement and other follow up actions. All issues agreed should be documented.

Note that a good supervision exercise will provide:

- **On site problem solving,**
- **On job training,**
- **Staff motivation,**
- **Team building and**
- **Improved communication between the different levels of the service.**

Consequently these will lead **to**

IMPROVED COMPLIANCE TO SET STANDARDS.

7.3 Recording of the supervision findings

Every health facility should have a supervision report book where the major findings and improvements agreed should be recorded at the end of each visit. Positive findings, weaknesses, actions taken and recommendations made should be indicated. A reporting format is indicated in the annex.

7.4 Follow up

Follow up will involve implementing actions agreed upon. The supervision process is not complete until follow up has been done. This is covered under item 10 below.

8. SUPERVISION TOOLS

The commonest supervision tools are checklists and HMIS returns. Checklists are job aides to guide a supervisor on specific areas for supervision. These guidelines contain checklists that can be used for integrated and technical supervision at a health facility.

Checklists cannot be exhaustive. **Supervisors are even not being asked to cover all items on the checklist - but to select sections of the checklist that cover the area or service they intend to supervise.**

It should be emphasised that supervisors should not merely fill checklists like questionnaires but use them as job aides to facilitate discussions and observation of skills.

8.1 Technical Supervision

Checklists for supervision of technical programs or services are contained in annex 4 of these guidelines. Supervisors should select checklists of the service they wish to supervise.

8.2 Integrated supervision

The checklist in Annex 3 should be used. However, it may be adapted to local specific problems. HMIS reports should also be discussed.

9. REPORTING

- On site verbal feedback: Direct verbal feedback should always be given during the supervision process. As indicated above, a meeting should also be made at the end of each visit to wrap up on major findings, improvements agreed and other follow up actions.

- On site documentation: A written report should always be made in the supervision report book at the health facility as indicated in 7.3 above.

- Written supervision reports: A brief supervision report similar to the one left at the facility should be kept by the supervisors.

- DHMT monthly supervision meetings: DDHS should organise monthly meetings for all managers of HSD to share experiences on major supervision findings during the previous month. This will allow for follow up of actions requiring interventions at the district level.

- Monthly supervision meetings: As the supervision system gets well established, heads of HSD are advised to organise monthly supervision meetings for in-charges of health facilities in the HSD to share experience and allow for follow up action.

10. RESPONSES AND FOLLOW UP ACTION

In-charges of HSD take responsibility for following up recommended actions for health facilities in their respective HSD, in close collaboration with the DDHS, secretary for health and CAO.

11. MONITORING AND EVALUATION

Through monthly DHMT and health facility in-charges meetings, a monitoring mechanism will be developed to look at issues like:

- availability of supervision workplans in HSD,
- dissemination of schedules by HSD to units being supervised,
- whether supervision schedules are being followed,
- prompt release of supervision resource
- effective utilisation of resource
- if actions are being taken on issues identified during the supervision,
- whether the supervision system is making any improvements in the quality of care through a review of accomplishments at the end of the year.
- etc.

Supervisors as a routine should monitor if the supervision system is improving the use of standards by providers.

The HSD should as much as possible assess itself for the effectiveness and efficiency of the supervision they are providing.

Chapter 8

SUPERVISION WITHIN A HEALTH FACILITY
(This may be a hospital or any level of health centre)

This refers to supervision of a facility (Hospital or Health centre) by supervisors based **within** the facility itself. Existing information indicates that internal supervision **within** health units is still very weak. It is a challenge to all of us to strengthen this level of supervision.

1. AIM

The aim of supervision at this level is to promote compliance with standards and guidelines among health care providers; hence improvement in the quality of care. Hence supervisors at this level should ensure that standards and guidelines of care are availed to the providers and that they are being complied with.

2. TYPES OF SUPERVISION

Like at any other level, there are three types of supervision with in a health facility i.e. integrated supervision, technical supervision and emergency supervision.

2.1 Integrated supervision
Integrated supervision involves supervision of a cross section of services in the health centre or hospital - clinical, preventive and administrative.

The objectives of integrated supervision within health facilities are:

- To review the general state of the facility (or departments in case of hospitals) and the conditions under which services are being provided.
- To provide management / administrative support where necessary.
- To check if services are being provided according to agreed standards and norms.
- To improve communication and information sharing among the different departments / sections of the facility.
- To promote team-work and conducive working environment hence increasing staff motivation.

2.2 Technical supervision
Technical supervision **with in** a facility covers specific technical services being provided by the health centre or hospital department / section. Examples of technical services that may be covered include those in the Uganda Minimum Health Package e.g. maternity services, immunisation, and prescription habits, IMCI, growth monitoring etc. Hospital related technical supervision may also include supervision of surgical operations, infection control in theatre, supervision of x-ray or ultra sound procedures / services etc.

The objectives of technical supervision with in health facilities:

- To support providers in the use of standards and guidelines,
- To support the quality of clinical care and continuous skills development through on job training and major ward rounds (in hospitals).
- To respond to specific technical problems being experienced by service providers.
- To empower health providers identify and solve problems in the particular field in which technical supervision has been provided.
- To assist providers identify cases requiring referral.

2.3 Emergency supervision

May be conducted to any section or department of a health facility to address an emergency situation as the case may be.

3. FREQUENCY

3.1 Integrated supervision

In Hospitals, integrated supervision will be done in the different departments and sections at least monthly. It may not be possible to go through all the departments and sections each month. It is advisable to select different departments / sections at a time. In any case, some departments / sections may need more frequent supervision than others.

In Health centres, the in-charge and his / her deputy should do integrated supervision of the unit at least monthly.

3.2 Technical supervision

In hospitals, formal supervision of technical areas by technically competent supervisors should be done weekly. This can be at section or department level.

In health centre, formal supervision of each technical service / program should be done at least monthly by selected technically competent supervisors.

Major ward rounds as part of technical supervision and on-job-training should also be conducted weekly in every hospital.

However, informal supervision, as part of day to day implementation of activities will continue in both health centres and hospital departments.

4. DURATION

The duration depends on the type of supervision and <u>the task at hand.</u> However, ample time should be given to address issues identified. For example, the monthly integrated supervision in hospitals could last at least a day.

It is again emphasised here that in health facilities, supervision should be an ongoing

process during all working hours on top of what is outlined above.

5. SUPERVISORS

5.1 Integrated supervision

In hospitals, the core management team together with heads of departments should form a supervision team that will carry out integrated supervision.

In health centres, the i/c and his / her deputy should carry out integrated supervision.

Where necessary, members of the Hospital Management Committee or Health Unit Management Committee may sometimes be co-opted as part of internal supervisors to address specific management issues. Any other personnel with the required skills may be co-opted for internal supervision as the case may be.

5.2 Technical supervision

In hospitals, technical supervision should be done by Heads of departments and / or selected supervisors with the relevant technical skills.

In Health centres the in-charges together with any other technically competent staff in the facility, will do technical supervision.

5.3 Emergency supervision

Emergency supervision in a health facility will be carried out by facility managers and any other co-opted member(s) depending on the emergency.

6. SUPERVISEES

All service providers working in a health facility will be supervised by the supervisors indicated in No.5 above.

Remember, effective supervision requires team approach.
Supervisors and those being supervised are both part of the team.

7. METHODOLOGY

The methodology, like for any other level, involves Planning, conducting the supervision, and Recording of supervision activities.

7.1 Planning for internal supervision

- Every health facility should have an internal supervision plan. As an example, in a health facility, integrated supervision may be scheduled for every first Wednesday of the month.

- All staff should be sensitised on the new supervision program of the health facility - i.e. expectations. Supervisors should be given an orientation in supervision skills.

- Supervisors should communicate supervision schedules to the respective departments or sections, well in advance e.g. a quarterly schedule.

- Objectives and purpose for each supervision should be agreed in advance by the supervisors.

- Previous reports in the departmental/section supervision report book should be reviewed.

- Relevant checklists/ tools should be used to guide the supervision process.

7.2 Conducting the supervision

- The supervision exercise should start on time.

- Team problem solving approaches and self-assessment should be encouraged (shared responsibility).

- Together with the providers being supervised, review and discuss the previous supervision reports and the HMIS they compile.

- On the part of skills improvement, observe health providers as they perform tasks. Their strengths and weaknesses should be noted. Tasks done well should be acknowledged. Demonstration (On Job Training) should be given where weaknesses and gaps exist. Ask for a return demonstration to ensure that the supervisee(s) have understood the skill. On site feed back is very essential.

- Supervisors may organise refresher sessions (Monthly or fortnightly) for skills improvement in areas where weaknesses or gaps are identified regularly. i.e. Supervision could help to identify the providers' training needs. This would be incorporated in the facility Continuing Medical Education (CME) program.

7.3 Recording of supervision findings at the facility level

Every health centre and hospital department should have an internal supervision report book in which supervision findings are recorded. The reports should clearly indicate positive findings, weaknesses identified and actions agreed. The reporting format in annex should be used.

8. TOOLS FOR SUPERVISION

The commonest supervision tools are checklists and HMIS returns. Checklists are job aides to guide a supervisor on specific areas for supervision. These guidelines contain checklists for integrated supervision of health facilities (annex 3) and specifically for· hospitals (annex 2). Although attempt was made to make them comprehensive, they cannot be exhaustive. Supervisors are even not being asked to cover all items on the checklist at a go. They should select sections of the checklist that cover the area or service being supervised, depending on the objectives of the supervision.

It should be emphasised that supervisors should not merely fill checklists like questionnaires but use them as job aides to facilitate discussions and observation of

skills.

8.1 Technical Supervision

Checklists for supervision of technical programs or services are contained in the annex of these guidelines. Supervisors should select checklists of the service th.ey wish to supervise.

8.2 Integrated supervision

As stated before, the checklist for integrated supervision of hospitals is attached in annex 2. This may be adopted to the needs of each hospital.

HMIS reports should also be discussed.

Self-assessment should be initiated using relevant tools provided by the QA department of the MOH.

9. REPORTING

- **On site verbal feedback:** Direct verbal feedback should always be given during the supervision process. A meeting should be held with the providers at the end of each supervision exercise to wrap up on major findings, improvements required and other follow up actions.

- **On site documentation:** A written report should always be made in the supervision report book kept in the health facility or hospital departments. The format in annex 6 should be used.

- **Monthly senior staff meetings:** In hospitals, heads of departments should make summaries from supervision reports in the department for presentation in monthly senior staff meetings. The reports should highlight major findings, support given, improvements noted, and challenges.

  Supervisors at health centre level should also make a brief supervision report for presentation and discussion in monthly staff meetings.

10. RESPONSES AND FOLLOW UP ACTION

The supervisors in the health facility and in hospital departments / sections are responsible for follow up action of problems identified.

11. MONITORING AND EVALUATION

There should be a mechanism for monitoring and evaluating the effect of the supervision system using indicators such as:

- Reduction in rate of sepsis.

- Utilisation of service data at point of collection.
- Good Provider - Client interpersonal relationship.
- Consistent supply of logistics.
- Improved team work among staff.
- Evidence of self-assessment at the facility.
- Adherence to supervision schedules.
- Actions taken on issues identified during supervision.

Chapter 9

SUPERVISION OF COMMUNITY HEALTH ACTIVITIES

This refers to supervision of Health Programs or activities provided by community representatives e.g. the activities of Community Health Workers (CHWs), Traditional Birth Attendants (TBAs), Community Based Distributing Agents (CBDAs), Parish Development Committees (PDC), Village Health Committees (VHC), Water and sanitation committees, and Traditional healers. The supervisors may be based in the community (e.g. health assistants) or may come from the health facilities with in the community.

In the community, people respond to their health needs; with or without intervention of the formal health system. The community health system offers various services that sometimes people strongly believe in. It involves many providers - some of whom we may have influence on e.g. CHWs, CBDAs, etc. and others we have a loose link to e.g. Traditional healers. In order to supervise these people properly, we have to understand the community health system and our influence on them has to be through a negotiated approach since they may not be responsible to us.

1. AIM

The aim of supervising community health programs is to work with the community based health providers in order to improve the quality of services provided they provide. This supervision should also strengthen the interface between the community and the formal health system and also promote community participation.

2. TYPES OF SUPERVISION

The type of supervision at the community level is usually technical; i.e. assisting the service providers in their specialised field of work e.g. the TBAs, or the CHWs.

Objectives of supervision at the community level

- To strengthen community participation in the program being supervised.
- To improve the technical skills of providers in their speciality areas so as to provide services of acceptable standards.
- To empower community based health providers identify and solve problems in their particular field of work.
- To ensure continuous skills development through On-Job-Training.
- To strengthen partnership with the formal sector in the program being supervised.

3. FREQUENCY

The frequency of supervision of community health programs should at least be quarterly but can vary from program to program depending on need. It may be more frequent for programs that are still in infancy. However every opportunity should also be taken to supervise a community program whenever supervisors go to the community for any other reason i.e. "No missed Opportunity".

4. DURATION

The duration spent on supervision will depend on the activity being supervised or the task involved. However, at least one working day is ideal for supervision of a community health activity.

5. SUPERVISORS

The primary supervisors of Community Health Programs are Staff of the health facility serving that community. Such staff should be equipped with skills to supervise the Community Health Programs in their catchment area.

Supplementary support could be provided by the DHMT; local politicians, Sub County Health Committees (SCHC), Project staff (such as staff from Reproductive Health Programs or Water & Sanitation Program), and Community Development Assistants.

6. SUPERVISEES

These include Community Health Providers based in the catchment area of the health facility for example members of Village Health Committees (VHCs), TBAs, CHWs, and CBDAs. The table next page outlines some of health providers that may be found in the community and the recommended supervisors.

Remember, effective supervision requires team approach.
Supervisors and those being supervised are both part of the team.

Examples of community health providers and programs supervised at the community level.

Services	Community Health Providers	Supervisors / Resources Persons.
Education and Mobilisation	Traditional Midwives, Community Health Workers (CHWs), Local Leaders, Traditional Practitioners.	Staff of the Health facility found in the community and CDAs are the main supervisors,
Water and Sanitation	CHWs, Water Committees, Parish Development Committees (PDCs)	Other supervisors that may supplement the above include some members of the DHMT, HUMC; Project staff; SCHC; Community Development officers / Assistants; and local opinion leaders and other extension staff.
Immunisation	CHWs, Vaccinators, Mobilizers.	
Antenatal/Delivery	TBAs, pregnancy monitors/ community reproductive health workers (CRHW).	
Family Planning	Community Based Distribution Agents (CBDAs), CRHW.	
Curative treatment	TBAs, CHW s, First Aid groups, bone setters.	
Counselling	Community Counseling aides, Home based care aides, local drama groups.	
Referral	Traditional midwives, CHW s, PDCs, Stretcher groups, community ambulance groups, teachers.	
Nutrition and Growth monitoring	PDCs, CHWs.	
Medical rehabilitation	Local artisans	

7. METHODOLOGY

Support supervision at the community level involves 3 phases too; i.e. Planning.

Conducting the supervision, and Recording of Supervision activities.

7.1 Planning for supervision of community health programs

- Supervision of community health programs should be incorporated in the workplan of the Health Facilities with a matching budget. Regular supervision schedules should be drawn and communicated to the supervisees.
- Determine overall supervision objectives for the year. The purpose and specific objectives should be set prior to each visit.
- Identify the providers to be supervised each time and notify them in advance.
- Review records - progress reports, previous supervision reports, community based data, and any other relevant reports before each visit.
- Identify supervisors with the relevant technical skills.
- Relevant supervision. checklists / tools should be obtained.
- Prepare the relevant logistics and any supplies to be delivered to the community providers.

7.2 Conducting the supervision visit

Supervisors should always get to the supervision sites on time.

- Have a brief period of introductions, discussion of purpose of the visit, and agreeing on the procedure of supervision.
- Use the supervision tools In a supportive and not fault finding way to identify strengths and weaknesses.
- Then observe health workers performing tasks if applicable. Identify and discuss areas of strength and weakness in the providers' skills. Acknowledge areas of strength. Support the community health providers to identify their weaknesses and solutions to those weaknesses. Agree on areas for improvement as part of on spot feed back.
- Carry out On-Job- Training where skills improvement is required. Sometimes this may require carrying out demonstrations and asking for return demonstrations.

7.3 Recording of Supervision Activities

An appropriate Supervision Report Book should be maintained by the community health care provider(s) where supervision findings will be recorded. Whatever book is kept by these providers, the supervision reports should always follow the agreed format i.e. indicate positive findings, weaknesses identified, and the improvements agreed.

8. TOOLS

Supervision tools in the form of discussion guide and observation checklists should be

used.

They should be simple and understandable. A sample of checklist for supervision of community health programs is contained in the annex and supervisors can adapt **it** to their needs. Most often however, supervisors will require to use technical checklists and observation of skills.

9. REPORTING

- On site verbal feedback: Direct verbal feedback should always be given during the supervision process. A meeting should be held with the providers at the end of each supervision exercise to wrap up on major findings, improvements required and other follow up actions.

- On site documentation: A written report should <u>always</u> be made in a supervision report book kept by the community health provider(s) and following the format in annex 6.

- A verbal and written brief should be given to other levels responsible for providing interventions e.g. to the DHMT, SCHC, or district leaders.

10. RESPONSES AND FOLLOW UP

It is the responsibility of the supervisors to ensure that on site problem solving has been provided and interventions from other levels have also been followed up;

11. MONITORING AND EVALUATION

The Supervision system at this level should be monitored and evaluated for effectiveness. Issues that can be monitored for example include:

Availability of Supervision plans for Community Health Programs in Health facilities;

- Provision for a Supervision budget at the Health Facility.
- Adherence to Supervision schedules.
- Problems solved during Supervision.
- Written reports at the community level
- Referred issues followed up.
- Quarterly reports submitted to the SCHC and the HSD.

ANNEXES

ANNEXES	PAGE
ANNEX 1	44
ANNEX 2	55
ANNEX 3	63
ANNEX 4	73
ANNEX 5	80
ANNEX 6	105
ANNEX 7	109
ANNEX 8	111

ANNEX 1

CHECKLIST FOR INTEGRATED SUPPORT SUPERVISION OF DISTRICTS BY THE CENTRE.

CHECK LIST FOR INTEGRATED SUPERVISION FROM THE CENTRE TO DISTRICTS.

1. PLANNING AND MANAGEMENT OF DISTRICT HEALTH SERVICES.

1.1. Annual Plans:

i. Is there a comprehensive workplan and budget, drawn according to MOH guidelines and addressing the priority health interventions in line with MOH policy? *(The plan should indicate all sources of revenue e.g. conditional grant, delegated funds, local district revenue, user fees, donor contributions etc.).*

ii. Are there quarterly work plans?

iii. Are all the relevant stakeholders involved in the planning process e.g. DHMT members, health committees, implementing agencies at the district level etc?

iv. Is there a written evaluation of the performance of the previous annual plan i.e. achievements, failures, constraints, and way forward?

v. Does the DHMT and district leaders monitor implementation of district health plans quarterly?

vi. Did the district implement at least 75% of the planned activities for the last quarter?

vii. If not, what were the constraints?

1.2. Management of finances:

i. Check whether relevant accounts are in place with the appropriate signatories.

ii. Are the District /Hospital budgets in line with guidelines from MOH?

iii. Have expenditures been made in line with approved workplans and budgets?

iv. Is there a mechanism to monitor financial discipline?

v. Are there disbursement constraints at any level I.e. from the CAO to the DDHS and to HSD?

vi. Check for availability and use of the following financial guidelines (where applicable), e.g. Guidelines on use of delegated funds for hospitals; Guidelines on use of conditional PHC grants; Guidelines for use of funds in NGO hospitals; Guidelines for use of DHSP/STI drugs (where applicable); Local government accounting regulations.

vii. Discuss prompt accountabilities for all funds - from central Government, donors (e.g. Unicef, DHSP, STIP, EDF/RHP) and cost sharing scheme.

viii. Does the district have alternative financing mechanisms e.g. Cost sharing schemes, health tax or health insurance? Do they have guidelines for the

mechanism in place?

ix. Are the charges displayed on a public notice board?

1.3. Management of Personnel:

i. Is there a staff list?

ii. Discuss if all health workers are paid promptly and in the correct salary schedule for health workers. Are staff receiving lunch allowance along with their salaries?

iii. Advise districts that all personnel and salary related matters have to be handled at the district level (CAO's office), except for referral hospitals.

iv. Are job descriptions available at the district level for all cadres of staff?

v. Are staff appraisals being done regularly?

vi. Does the district have at least 75% of the recommended minimum staffing positions (according to MOH guidelines)?

vii. Are there monthly DHT and quarterly DHMT meetings? Verify with minutes.

1.4. Monitoring and Supervision of Health Services:

i. Is supervision (both integrated and technical) incorporated in the district annual and quarterly workplan, and with a matching budget?

ii. Do district leaders (especially secretary for health and ACAO i/c health) participate in supervision of district health services together with the DHT?

iii. Are there written reports for supervision done in the last quarter? Is there evidence that the required actions identified in the last visits are being followed up?

iv. Is self assessment being carried out among the DHMT?

1.5. Management of Drugs, Supplies and Medical equipment.

i. Has the drug quantification for the district been done in the last 1 year?

ii. Are there health units which missed essential drugs in the last quarter? Why? What mechanisms have been put in place to avoid this problem happening again?

iii. Are drugs and medical supplies purchased according to MOH guidelines in the districts?

iv. Does the district have an inventory of medical equipment and the details of equipment available at each facility? Is there a working system for maintenance of medical equipment?

v. Are there on-going activities to promote and control rational use of drugs?

vi. Is there objective evidence of drug pilferage from health facilities in the district? (If yes, discuss and agree on measures to address this concern e.g. through proper recording of drugs-stock cards, ledgers, patient registers).

1.6 Health Management Information System (HMIS).

i. Have all relevant staff in health facilities been trained in HMIS?

ii. Have all health units submitted their monthly HMIS reports for the last quarter?

iii. Has the DHMT analysed data on HMIS returns from HSD and health units and used it for planning and monitoring health services in the district? Have health facilities received feedback on analysed HMIS returns?

iv. In the last quarter, did the DHT conduct any technical support supervision for HMIS to the facilities? If so, what kind of problems were identified and addressed?

v. Is there a mechanism to provide the required HMIS forms, client cards & medical forms etc.?

vi. Have you submitted your last quarterly report to MOH / Resource centre?

1.7 Self Assessment for Quality of Health Services.

The DHT and HSD staff should be encouraged to do self-assessment every 6 months using a self-assessment instrument provided by MOH. The tool may be adapted to local situations.

2. QUALITY OF CARE *I* CASE MANAGEMENT IN HOSPITALS AND HSD SUPERVISED.

In Hospitals and up graded health centres (HC IVs), the following factors that affect the quality of care should be checked (by observation, exit interviews or discussions). The main findings should be discussed with the managers and providers:

i. Prompt attendance and good attitude to patients / clients. Good communications and interpersonal relations between the clients and the providers.

ii. Cover of emergencies (causality units) and patients arriving at the facility after 5.00 p.m.

iii. Adequacy of drugs and medical supplies for common conditions and services.

iv. Availability of basic equipment and in good working condition.

v. Availability of essential staff and arrangements made to address shortages. (Compare with minimum staffing levels recommended by MOH).

vi. Regular review, investigations, and adequate clinical notes for in-patients.

vii. Availability and use of standards and guidelines.

viii. Infection control and prevention measures in the facilities.

ix. Availability of a regular blood supply.

x. Plans and schedules for Continuing Medical Education (CME) e.g. refresher courses, clinical meetings, reading materials, and On Job Training (OJT).

xi. Staff welfare e.g. uniforms, break teas, soap etc.

xii. Patient welfare e.g. beds, mattresses, meals etc.

xiii. General status of infrastructure (state of repair, cleanliness, privacy, water supply, lighting, sanitation, placenta pit, refuse disposal, and attendants shelter) etc.

xiv. Is self assessment being done?

xv. Provisions for referral - both ways.

INTEGRATED SUPERVISION OF SPECIFIC PROGRAM ACTIVITIES

IMMUNIZATION SERVICES (EPI.)

i. Have the EPI activities that were included in the district workplan been implemented according to schedule?

ii. Do you have adequate stock of vaccines and gas to last you this quarter? Do all static units in the district have a stand by gas cylinder?

iii. Has the DHMT been able to calculate the District EPI coverage and is the information collected routinely used at the district level? e.g. Is there EPI coverage by sub-county? Are targets for immunisation being achieved?

iv. Is there evidence of an active surveillance system for EPI target diseases especially measles and acute poliomyelitis?

v. Is the cold chain well maintained in the District and is there a mechanism for its regular maintenance?

INTEGRATED MANAGEMENT OF CHILD HOOD ILLNESSES.

i. Is IMCI implementation included in the district workplan?

ii. Did the district implement at least 75% of the IMCI planned activities in the last quarter?

iii. Is there an active IMCI focal person / working group at the DHMT level? How many DHMT members / district supervisors have been trained as IMCI trainers?

iv. What proportion of health workers are trained in IMCI in the district?

v. In the last quarter, was IMCI, supervision done as part of Integrated supervision by the DHMT?

vi. In case health units run short of the following drugs, ORS, cotrimaxazole, chloroquine, paracetamol, iron, folate, mebendazole, tetracycline eye ointment, GV. and Vit. A, what are the arrangements to have them restocked?

MALARIA CONTROL AND MANAGEMENT

i. Is there a malaria control plan for the current FY within the District Health Plan?

ii. Has the district received a technical supervision on malaria control from the centre in the last 1 year?

iii. Are there guidelines on case management of uncomplicated and severe complicated malaria in all health facilities in the district?

iv. Does the District regularly analyse HMIS data for morbidity and mortality due to malaria and is such information displayed for quick reference / used?

v. Does the District store have first and second line anti Malaria drugs to supplement health facilities in case they run out of stock during this quarter / or in case there is an out break of malaria?

vi. Do all HSD have functional laboratories that can do basic investigations especially BS and Hb?

NUTRITION.

i. Are nutrition activities (e.g. Vit. A supplementation, Iodine Deficiency Disorders, breast feeding, growth monitoring and Iron Deficiency Aneamia) incorporated in the District Health plan?

ii. Is there a DHMT member who is responsible for coordinating nutrition activities in the district?

iii. Are health facilities in the district participating in VAG supplementation? If yes, have they been provided with VAG supplement / treatment guidelines?

iv. Do at least 75% of the HSD in the district have demonstration facilities for nutrition?

v. Are there records indicating regular testing of iodized salt in retail shops in the district?

REPRODUCTIVE HEALTH (RH) SERVICES

i. Are RH activities included in the District Health Plan?

ii. Did the district implement at least 75% of the planned RH activities in the last quarter?

iii. Is there an adequate supply of contraceptives in the district stores to last 3 months? (especially Oral contraceptives, injectables, and condoms).

iv. Are all health facilities providing RH services provided with sufficient IEC materials on RH?

v. Do all Health facilities providing RH services have clearly identifiable logos?

vi. Has the DHMT received supervision in RH services from the centre in the last 6 months?

vii. Does the DHMT know the following vital indicators for the district: Population of women in the reproductive age group, CBR, TFR, IMR, and CPR? Is this information used in planning and monitoring of RH services in the district? (Districts should be encouraged to use district specific data).

viii. Has the district conducted training in RH skills I activities in the last one year? Specify in which area.

ix. Check to see that the main RH guidelines have been disseminated to the DHMT and to health facilities especially RH minimum package, adolescent health policy, life saving skills manual, guide to use of a partogram, essential obstetric care guidelines, FP procedural manual, and communication *I* counselling skills for adolescents.

TB AND LEPROSY CONTROL PROGRAM

i. Are the district TB and leprosy registers up to date and fully completed (i.e. all information provided?)

ii. Is there an adequate supply of TB and Leprosy drugs, and laboratory reagents in stock to last at least 3 months?

iii. Is there a technical supervision schedule for TB / Leprosy? Was this schedule complied with in the last quarter; and have supervision reports been made and disseminated to all concerned parties?

iv. Does the Zonal TB / Leprosy supervisor regularly supervise and support the district?

v. Has the DTLS compiled the last quarter summary report on statistics of case finding and treatment outcome and forwarded it to the DDHS?

WATER SUPPLY AND ENVIRONMENT HEALTH

i. Are environment health activities included in the District Health Plan?

ii. Is water quality testing being carried out and are records of this available to the DHMT?

iii. In the last quarter, was water source protection carried out according to the workplan?

iv. Is there industrial pollution of water sources (including pollution by car washers) and are steps being taken to address the problem?

v. Does the district have at least 75% latrine coverage?

vi. Are there reports from field health workers on home visiting for supervision of hygiene and community health standards?

EPIDEMIC AND DISASTER PREVENTION, PREPAREDNESS AND RESPONSE

The priority diseases for MOH for integrated disease surveillance system are:

Diseases targeted for eradication or elimination: Guinea worm, AFP/Polio, Neonatal tetanus, and leprosy.

Epidemic prone diseases: Cholera, Bacillary dysentery, plague, measles, yellow fever, meningococcal meningitis, viral haemorrhagic fevers, and rabies.

Diseases* of *Public Health importance: HIV/AIDS, Malaria, Trypanosomiasis, Tuberculosis, Onchocerciasis, Schistosomiasis and Injuries.

i. Does the District have an Emergency Preparedness Plan and Budget for management of epidemic outbreaks (e.g. Cholera) and disasters? (consider stock of emergency drugs, medical supplies e.g. fluids, emergency fund etc).

ii. Is there a district epidemic I disaster management committee?

iii. Does the district have capacity to confirm by laboratory the priority diseases?

iv. Does the district analyse data collected on priority diseases and use the information for action?

v. Does the district report cases of priority diseases to the national level weekly?

vi. Is supervision of integrated disease surveillance carried out on a regular basis?

HEALTH EDUCATION / HEALTH PROMOTION AND SCHOOL HEALTH ACTIVITIES.

i. Are health education and school health activities incorporated in the district work plan? Are the planned activities addressing the district priorities?

ii. Was the district able to implement at least 75% of the planned HED and school health activities for the last quarter?

iii. Have at least 75% of the health units been provided with IEC materials on common conditions / services i.e. Reproductive Health, EPI, water and sanitation, AIDS/HIV and nutrition?

iv. Have the DHE and other H/Educators in the district had refresher courses in Health Promotion / IEC methods in the last one year.

v. Is the HED equipment provided to districts in good working condition and is it being put to proper use?

vi. Is there an active school health program in the district?

AIDS CONTROL PROGRAM / STI PROGRAM.

i. Are AIDS / STI activities included in the District Health Plan? Is there co-ordination between other programs / NGOs involved in AIDS / STI activities and the DDHS's office?

ii. Are there adequate stocks' of condoms at the district stores to last at least 3 months?

iii. Is there supervision of rational use of STI drugs?

iv. Is the district doing a regular aggregation of statistics on HIV patients in the district?

v. Has the district got programs for support of HIV patients in the community?

vi. Has the district received and disseminated guidelines for ACP / STD to relevant providers in the district? (e.g. guidelines on training in counseling, training of OPL health workers, STD syndromic management, surveillance of HIV/AIDS in Uganda).

MENTAL HEALTH AND MEDICAL REHABILITATION.
(QA teams are requested to visit rehabilitation units and mental wards in hospitals).

i. Does the district health plan include activities on mental health and medical rehabilitation of people with disabilities (PWDs)?

ii. Has the district identified a focal person to co-ordinate mental and rehabilitation of PWD activities in the district?

iii. Does the district hospital offer the following services: mental health, and orthopaedic and physiotherapy services?

iv. In the event that a PWD requires referral, does the hospital or upgraded health centre know where to refer such a client for appropriate treatment / rehabilitation?

ORAL / DENTAL HEALTH

i. Are basic dental treatment services with relevant equipment and supplies provided in the district hospital and upgraded health centres?

RABIES CONTROL AND MANAGEMENT.

i. Is the district/hospital stocked with rabies vaccine? If yes, how many doses are in store? Note the expiry date. If no, ask why and find out if any requisition for the rabies vaccine was made in writing.

ii. Is there evidence of IEC materials and guidelines on rabies? e.g. wall posters, flow-charts, treatment booklets, report forms etc.

iii. Observe the work plan; are rabies prevention and management activities incorporated in the district/hospital annual work plans? If yes, what activities were implemented in the scheduled period? If not, emphasize the need for including rabies preventive activities in the work plan.

iv. What evidence is there that rabies data is collected, analyzed and utilized by the

district / hospital?

v. In order to reduce human rabies the control of animal rabies is a pre-requisite. Is there evidence of collaboration between the hospital / DDHS and the district veterinary office .ln the control and management of rabies? e.g. joint meetings / mobilization, workshops/seminars, correspondence.

ANNEX 2

CHECKLIST FOR INTEGRATED SUPPORT SUPERVISION OF HOSPITALS

(This checklist is for use by internal supervisors e.g. Heads of Departments and the Hospital Core Management Team. Occasionally external supervisors may use some sections of the checklist when doing supervision in a hospital).

CHECKLIST FOR INTEGRATED SUPERVISION OF HOSPITAL SERVICES

Name of Hospital:................... ....Dept./ Section ....

Answer Y for Yes, N for No and NA if Not Applicable.

Date						
Supervisor(s)						
Supervisee(s)						
ADMINISTRATION						
Does the dept. / section have a written schedule of activities and is it posted up for all to see and comply?						
Is the schedule being followed?						
Do staff rotate through the different schedules or tasks?						
Are there monthly departmental meetings? Verify with minutes.						
Are actions being taken on meeting recommendations? Verify from minutes.						
Do staff register arrival and departure times?						
Does the unit have a duty roster? (verify)						
Is the duty roster observed?						
Is there team work among the staff in the department?						
SUPERVISIO N						
Is technical supervision in the dept. carried out weekly?						
Is there a supervision report book in the dept. for recording findings and recommendations?						
Was supervision done last week & a report written in the book?						

Verify						
Is there evidence of follow up and actions on supervision recommendations						
Is feedback given during and after supervision? Verify.						
Does the dept. / unit have guidelines and standards for management of patients / clients in the dept./ unit? Comment below on available guidelines and their use.						
Others						

Comments and date when made:

Answer Y for Yes, N for No, and NA for Not Applicable

Date						
Supervisor(s)						
Supervisee(s)						
PATIENT MANAGEMENT						
Do staff attend to patients promptly? This information may be got by observation.						
How long does it take to attend to new patients? Record time in minutes.						
Does the Unit have a mechanism for handling critical / emergency patients urgently?						
Do staff have good attitudes towards patients? May also be through observations.						
Does the Unit have an admission and report book?						
Do staff monitor patients using the report book?						
Do staff give the prescribed treatment?						
Is this treatment given on the specified times?						
Are investigations on patients carried out as requested?						
Are specimens taken and results collected in time?						
Do clinicians provide sufficient clinical notes to guide staff in the management of patients?						
Do staff abide by clinical notes?						
Does the unit have adequate staff to cover all activities?						
Are there ward rounds to review patients daily?						
Are there weekly major ward rounds?						

Does the Unit have adequate medical supplies for common conditions and services?						
Is ordering of supplies consistent with consumption?						
Does the unit have a system of record keeping and monitoring supplies						
Does the Unit have minimum equipment to handle the common services needed?						
Are there clinical meetings / or clinical audits?						
Is there an emergency cupboard with the relevant emergency drugs?						
PATIENTS VIEWS (Interview of patients)						
Are you as a patient attended to promptly? For OPD, ask exit clients						
Are you satisfied with the way staff handled and treated you?						
Would you describe the attitude of staff towards patients as satisfactory?						
Have you ever been asked to pay for the service without getting a receipt?						
Are there staff on the ward each time you need help?						

Comments and date when made.

Answer Y for Yes, N for No and NA for Not Applicable

Date						
Supervisor(s)						
Supervisee(s)						
COST SHARING						
Does the Unit collect user-fees? (Verify with record book or receipt)						
How much per month on average?						
How much was collected last month?						
Does the user fees collection affect the process of patients rnanagement cycle?						
Do staff appreciate the contribution of Cost-Sharing as a motivating allowance?						
Does the Unit remit collection to the cashier daily?						
Does the money collected match with the workload/Output?						
Are all cash books posted up to date?						
Are monthly returns compiled in time?						
What are other problems associated with cost sharing						

Comments and date when comments made.

Answer Y for Yes, N for No and NA for Not Applicable

Date						
Supervisor(s)						
Supervisee(s)						
INFRASTRUCTURE AND OTHERS. (Use for dep'tal. Level or for entire hospital).						
Is the hospital or dept. in a good						
Is the hospital or dept. well labeled with signs to direct patients, visitors and clients?						
Is the general level of cleanliness good?						
Is the compound well maintained?						
Does the hospital or dept. have clean bath rooms and toilets?						
Does the hospital or dept. have a proper place for disposal of medical wastes?						
Specific to maternity: Is there a good, covered placenta pit?						
Is there a good constant supply of clean safe water supply?						
Is there a good lighting system or the hospital or dept. to ensure good security of equipment and assets?						
Does the facility have a running ambulance (s)?						
HOSPITAL STORES						
Are accurate stores records kept e.g. bin cards/ledgers?						
Does the Unit do inventories of major equipment every 6 months?						
Is there a register of fixed assets e.g. vehicles and heavy plants?						
Does the store keep track of distributed items?						

Does the store have a system of retrieval of items not in use or broken down?						
Is ordering made in line with the departmental requirements?						
RECORDS AND RECORD KEEPING						
Are the following registers kept up to date? • Out patients • Maternity • In-patients • Antenatal • Family Planning • Immunization • TB • Others						
Are monthly summary forms compiled and sent in time?						
Is the information collected used routinely for planning and monitoring services in the facility? Hospital?						

Comments and date when made.

ANNEX 3

CHECKLIST FOR INTEGRATED SUPPORT SUPERVISION OF HEALTH CENTRES.

(It may also be used for internal integrated supervision or self assessment)

CHECKLIST FOR INTEGRATED SUPERVISIONOF HEALTH CENTRES.

Name of Health Centre: ...., ...

Answer Y for Yes, N for No and NA for Not Applicable

Date							
Supervisor(s)							
Supervisee(s)							
	ADMINISTRATION						
1.	Does the facility have written workplan?						
2.	Does the work plan include the following:						
	• Outreach activities?						
	• Repair of the health facility infrastructure						
	• Procurement of drugs and medical supplies						
	• Purchase of simple / basic equipment?						
	• Repair of faulty equipment?						
	• Continuing Medical Education (CME) e.g. OJT, refresher courses, case presentation & discussion?						
3.	Are the activities on the work plan on schedule?						
4.	Do all members of staff have up-to-date written job descriptions?						
5.	Does the facility have guidelines and standards required for management of clients/patients?						

6.	Are all staff in the facility allocated to positions according to their training and experience?						
7.	Are there regular monthly meetings (confirm with minutes)?						
8.	Has an annual staff appraisal been carried out in the last 12 months? (verify).						
9.	Does the HUMC meet quarterly and are there minutes of the last meeting?						
	SUPERVISION						
1.	If HSD, is there a schedule and budget for supervision of peripheral health facilities?						
2.	Is there a schedule for internal supervision of this facility?						
3.	Is there a supervision report book for documentation of supervision findings in this unit?						
4.	Is there evidence of follow up on actions of the last supervision recommendations?						
5.	Are staff doing self assessment on the quality of care in this health facility?						
	FINANCIAL MANAGEMENT						
1.	Is "The Local Government Financial and Accounting regulations 1998" in the HSD? available						

2.	Are all cash books posted and up-to-date?						
3.	Are all cash books reconciled (and reconciliation entered in cash book FAR 147) to books? bank statement and vote						
4.	Are monthly (or quarterly) comprehensive income and expenditure statement sent to the DDHS?						
5.	Are payment vouchers filed according to FAR 109 (2) and 117 (2)?						
6.	Is there a register of vehicles and heavy plants FAR 92(1) and updated every 6 months?						
7.	Are the user fees clearly posted and visible to the clients?						

Comments and date when made:

Answer Y for Yes, N for No and NA for Not Applicable

	FACILITY RECORDS REGISTERS AND						
1.	Are accurate stores records being kept i.e. bin cards, ledger, etc.						
2.	Does the facility have up to date inventories?						
3.	Are the following registers well kept and up to date?						
	• Out patient?						
	• Maternity?						
	• In-patient?						
	• Ante-natal?						
	• Family Planning?						
	• TB?						
4.	Are there copies of the monthly Summary report forms (105) and are they being submitted on time?						
5.	Is the information collected used routinely for planning and monitoring services in the facility?						
	INFRASTRUCTURE						
1.	Is the facility ill good repair?						
2.	Is there a constant supply of water or a near by supply of protected water source?						
3.	Is the facility well labeled with signs to direct clients and patients?						
4.	Is the compound well maintained?						
5.	Does the facility have clean latrines or toilets for staff and patients/clients?						
6.	Does the facility have the following disposal facilities for refuse and medical wastes?						
	• Rubbish pit?						
	• Placenta pit?						
	• Incinerator?						

Comments and date when made:

Answer Y for Yes, N for No and NA for Not Applicable

Date							
Supervisor(s)							
Supervisee(s)							
	IEC						
1.	Are health education talks given to clients on a daily basis?						
2.	Do service providers distribute printed materials to clients?						
3.	Are posters on the following topics available and clearly posted for clients to see?						
	• Family Planning?						
	• STDs / HIV?						
	• Breast feeding?						
	• Infant nutrition?						
	• Maternal Health?						
	• Immunisation?						
	• Water and sanitation?						
MANAGEMENT OF UNDER FIVE ILLNESSES							
1.	Are IMCI guidelines available to health providers who rnanage under fives?						
2.	Are the IMCI guidelines being used?						
3.	Are there National Standard Treatment Guidelines (NSTG)?						
4.	Are the NSTG being used?						
5.	Is there a functional ORT corner?						
IMMUNISATION							
1.	Are immunisation services provided on a daily basis in this facility so as to reduce on “missed opportunities”?						

2.	Do staff maintain a proper cold chain especially the following?						
	• Twice daily temperature charting even on weekends?						
	• Temperatures maintained at 4-8 degrees centigrade always?						
	• Availability of a thermometer in the						
	• Availability of vaccine carriers and ice packs in good condition?						
	• Availability of vaccine monitors (colour indicators)?						
	• Availability of a stand by gas cylinder (where relevant)?						
3.	Is EPI data collected monthly and analysed for use at the facility level e.g. calculating coverage data, and estimating vaccine/supplies/other resources required.						
	NUTRITIO N						
1.	Is weighing and growth monitoring of under fives done daily in the health facility. Verify from cards and availability of weighing services.						
2.	Is there a functional nutrition program?						
3.	Are there facilities for nutrition demonstration in the facility?						
	REPRODUCTIVE HEALTH (RH)						
1.	Are RH services provided on a daily basis?						

2.	Is there a qualified midwife in the health facility (or a comprehensive nurse if no EMW).						
3.	Do clients who receive other services e.g. mothers who come to the young child clinic (YCC) also receive RH services at the same time (integration of services).						
4.	Does the facility work closely with community based RH providers in its catchment area e.g. TBAs, CBDAs?						
5.	Are service providers routinely providing condoms to STD clients?						
6.	Are STD clients routinely receiving information on HIV?						
7.	Were there any maternal deaths in the health facility in the last month? Were these deaths discussed in clinical meeting (maternal a death audit). Comment below on what lessons were learnt as part of that audit						
	TB MANAGEMENT						
1.	Does the facility have a system for tracking TB defaulters?						
2.	Is the facility using contact tracing?						
3.	Is the facility using DOTs system?						
4.	Does the facility have a functional laboratory for testing sputum smears?						

Comments and date when made:

Answer Y for Yes, N for No and NA for Not Applicable

Date							
Supervisor(s)							
Supervisee(s)							
EPIDEMIC AND DISASTER PREVENTION, PREPAREDNESS AND RESPONSE							
1.	Does the facility (or HSD) have emergency preparedness plans and budget for emergencies?						
2.	Are there emergency drugs and medical supplies reserved for epidemic outbreaks and disasters?						
3.	Does the facility have guidelines for management of epidemics?						
	SURVEILLANCE						
1.	Does the facility maintain a surveillance system for the following priority diseases?						
	• Malaria						
	• TB						
	• Measles						
	• Neonatal tetanus (NNT)						
	• AFP/Polio						
	• Cholera						
	• Guinea worm (where applicable)						
	• Meningitis						
	• Rabies						
	• STIs						
	• Dysentery						
	AIDS / HIV						

1.	Is there collaboration between the health facility staff and NGOs involved in AIDS/HIV control activities and patient care in the community?						
2.	Is the health facility involved in AIDS counseling and community based patient care?						
3.	Does the health facility provide condoms?						
	INFECTION PREVENTION AND CONTROL						
1.	Does the heath facility provide adequate infection prevention and control in the following areas?						
	• Hand washing?						
	• Sterilisation of equipment?						
	• Disposal of contaminated waste?						
	• Disposal of sharps and needles?						
	• Disposal of soiled linen?						
2.	Does the health unit isolate patients with infectious diseases?						
3.	Do service providers use clean protective clothing e.g. boots, gloves, masks, mackintosh, uniforms?"						
4.	Are the following areas being maintained as clean service environments?						
	• Delivery room?						
	• Operating theatre (where applicable)?						

	• Wound dressing areas (separate from the injection room)?						
5.	Do service providers use new gloves with each new patient? (Where the procedure requires use of gloves)?						
	MANAGEMENT OF REFERRALS						
1.	Is the health facility receiving late referrals in the following areas						
	• Obstetric care?						
	• Malaria cases?						
	• Paediatric emergencies (e.g. severe dehydration, anaemia, pneumonia etc.)?						
	• Malnutrition?						
2.	Is the health facility doing anything to address the problem of late referrals (specify in the comments space below)?						
	MENTAL HEALTH SERVICES						
1.	Is the facility able to identify and manage mental health cases?						
2.	Are there drugs for common mental health conditions?						
3.	Do staff have the capacity / skills to identify mental patients requiring referral?						
	DISABILITIES AND REHABILITATIVE HEALTH						
1.	Are staff trained in management of people with disabilities (PWD)?						

2.	Are PWD identified, managed and / or referred to the appropriate levels?						
3.	Is the management of PWD included in the facility outreach program?						
4.	Is the management of PWD included in the facility CME program?						

Comments and date when made:

ANNEX 4

CHECKLISTS FOR INVENTORY OF EQUIPMENT, DRUGS, SUPPLIES AND AVAILABLE STANDARDS / GUIDELINES AT FACILITY LEVEL.

(May be used at any level and where a supervisor decides to do inventory of any of the above).

EQUIPMENT INVENTORY

	Number Available	**Working condition Good/Not working**	**Any other Comments.**
IMMUNISATION (EPI)			
Refrigerator with thermometers			
Ice packs			
Vaccine carriers			
Vaccine monitors			
Gas cylinders (2 per static unit)			
Bicycles			
Steam sterilizers			
REPRODUCTIVE HEALTH			
Speculum			
Examination tables			
Delivery beds			
Trolleys			
Covered trays for instruments			
Delivery kits			
Lighting / lamps			
Fetoscope			
Stethoscope			
BP Machine			
INTEGRATED MANAGEMENT OF CHILD ILLNESSES			
Weighing scale			
Thermometers			
Clock with seconds hand			
ORT equipment			

	Number Available	Working Good/Not working	Any other Comments.
LABORATORY EQUIPMENT			
Microscope			
Centrifuge			
Others (e.g. for handling emergencies)			
Airways			
Ambubag			
Oxygen cylinders (in hospitals and HSD)			
Suction machine			
Catheters			
Autoclave			
Sterilizers			
Anaesthetic equipment (hospitals and HSD)			
ANY OTHERS			

INVENTORY FOR DRUGS, CONTRACEPTIVES, AND OTHER Please answer Yes or No in columns 2 & 3			
	Was available in last 1 month	Available stock can last 1 month	Any other comments
EPI VACCINES			
Polio			
DPT			
TT			
Measles			
BCG			
IMCI DRUGS			
Chloroquine			
Fansidar			
Cotrimoxazole			
Amoxycillin			
Folic acid			
Iron			
Vit. A caps			
Paracetamol			
ORS			
REPRODUCTIVE HEAL TH			
Condoms			
Pills			
Depo			
IUDs			
Implants			
Spermicides			
Ferrous sulphate			
ANTIBIOTICS (other than those for IMCI)			
Doxycycline			

INVENTORY FOR DRUGS, CONTRACEPTIVES, AND OTHER Please answer Yes or No in columns 2 & 3			
	Was available in last 1 month	Available stock can last 1 month	Any other comments
Ciprofloxacin			
Benzathine Penicillin			
Erythromycin			
Tetracycline capsules			
Tetracycline eye ointment			
Metronidazole			
Nystatin Pessaries			
lni. Chloramphenical			
Podophyllin			
OTHER DRUGS			
TB drugs			
Leprosy drugs			
SUPPLIES			
IV fluids			
Giving sets			
Gloves			
Cotton wool			
Suture materials			
Needles and syringes			
Lab. Reagents			
Lab. Supplies e.g. glass slides, culture plates, test tubes			

ESSENTIAL STANDARDS AND GUIDELINES

This inventory of essential standards may be used to assess availability and use of standards at any level of care. Te guidelines are in line with the National Minimum Health Care Package.

Standard or Guideline		Standard Available		Comments related to use of / compliance with the standard.
		Yes	No	
1. 0	**Integrated Support Systems**			
1.1	Guidelines for developing workplans			
1.2	Guidelines for PHC conditional grants			
1.3	Local Government accounting regulations			
1.4	Guidelines for user fees			
1.5	Guidelines for Health Unit or Hospital Management Committees			
1.6	Sub County Health Committee Guidelines			
1.7	Minimum staffing norms			
1.8	HMIS manual and data base			
1.9	QA manual for health workers in Uganda			
1.10	Standard Health Centre building Plans			
2. 0	Malaria control and Management			
2.1	Malaria control policy			
2.2	Practical guides for treatment of uncomplicated malaria			
2.3	Practical guides for laboratory of uncomplicated malaria diagnosis			
2.4	Guidelines for vector control			
2.5	Planning for malaria control at the District level			
2.6	Training guides for Insecticide Treated Materials Part 1 and Part 2			
2.7	Malaria control manuals for community leaders			
2:8	Malaria treatment manuals for CHWs			
2.9	New Treatment Guidelines for Malaria			

Standard or Guideline		Standard Available		Comments related to use of / compliance with the standard.
		Yes	No	
2.10	Intermittent treatment of malaria during pregnancy			
3.0	**STI, HIV and AIDS**			
3.1	Guidelines for syndromic management of STDs			
3.2	Guidelines for care of PLWA			
3.3	Infection Control Guidelines			
3.4	Guidelines for counsellors and counsellor assistants			
3.5	Strategy for monitoring and evaluation of HIV/AIDS in Uganda			
4.	**TUBERCULOSIS**			
4.1	Technical and Operational implementation of guidelines for DOTs			
4.2	Training manual for S/C health workers			
4.3	Guidelines for district review of TB activities			
5.0	**IMCI**			
5.1	IMCI guidelines			
5.2	Vitamin A schedule			
5.3	Guidelines for district level nutrition program planning and implementation			
5.4	Management of severe malnutrition in Uganda, a guide for Health Workers			
6.0	**Sexual and Reproductive Health, And Rights**			
6.1	RH Minimum Package			
6.2	Adolescent Health Policy			
6.3	Communication and counselling skills for adolescents			
6.4	Life saving skills manual			
6.5	Essential Obstetric Care Guidelines			

Standard or Guideline		Standard Available		Comments related to use of / compliance with the standard.
		Yes	No	
6.6	RH policy guidelines and service Standards			
6.7	Family Planning Procedural Manual			
6.8	Guide to use of Partogram			
7.0	**Immunisation**			
7.1	EPI manual for health workers (2000)			
8. 0	**Environment Health**			
8.1	National Sanitation Guidelines			
8.2	Guidelines for Sanitation in Schools			
8.3	Guidelines of Operationalising the Kampala Declaration on Sanitation			
9.0	**Health Education and Promotion**			
9.1	Guidelines for Community Mobilisation			
9.2	Guidelines for School Health			
9.3	Guidelines for use of the Mass Media			
9,4	Guidelines for Community Participation			
10.0	**Epidemic and Disaster Prevention, Preparedness and Response**			
10.1	Guidelines for epidemic preparedness and control.			
10.2	Guidelines for cholera control			
10.3	Guidelines for control of cerebral spinal meningitis			
10.4	Case definitions for Notifiable Diseases			
10.5	Guidelines for control of ebola			
11.0	**On Diseases targeted for eradication**			
11.1	On onchocerciasis, guinea worm			

Standard or Guideline		Standard Available		Comments related to use of / compliance with the standard.
		Yes	No	
12.0	**Mental Health (MH) Services**			
12.1	Guidelines for adult and children MH			
13.0	**Essential Clinical Care (plus injuries, disability, rehabilitation, dental care, and palliative care).**			
13.1	National Standard Treatment Guideline			
13.2	Hospital Performance Standards			
13.3	Guidelines for Casuality Services			
13.4	- Guidelines for disability on: Orthopaedic appliances and aids - Cerebral palsy, epilepsy, prevention of hearing and visual impairments			

ANNEX 5

CHECKLISTS FOR TECHNICAL SUPERVISION OF HEALTH SERVICES AND PROGRAMS

(Supervisors will select a checklist relevant to the program or service they intend to supervise. These checklists are applicable at any level providing the service in question).

INTEGRATED MANAGEMENT OF CHILD ILLNESSES (IMCI) CHECKLIST

(Based on observation of out patient care for children under 5 years).

Name of health facility ....

Answer Y for "Yes", N for "No" and NA if the provider has "Not Assessed" the condition in no3 below.

	DATE						
	SUPERVISOR (S):						
	SUPERVISEE (S):						
	Observe a provider manage a child seeking curative care						
1.	Does the health worker receive the patient / care taker politely?						
2.	Is the child weighed before or during the consultation?						
3.	Is the child correctly assessed for all danger signs? (NB. If not assessed write NA)						
a.	• Couch / difficulty in breathing						
b.	• Diarrhoea						
c.	• Fever						
d.	• Ear problem						
f.	• Anaemia: Is the child checked for palmar pallor?						
g.	• Immunization status						
h.	• Vitamin A supplementation status						
i.	• Other problems						
4.	Is the child assessed for all 3a - i above?						
5.	Is the care taker's own health assessed?						
6.	Are all illnesses classified correctly? If no, comment below on what mistakes were made.						

7.	Does the health worker ask about treatment prior to presentation?						

Comments and date when made:

IMCI Checklist continued

Answer Y for "Yes", N for "No" and NA if Not Applicable

8.	Does the health worker prescribe the correct treatment? If no, comment on mistakes made on prescription with respect to antibiotics, antimalarial, ORS, or any other treatment.						
9.	Is the first dose of the drug given in the health facility?						
10.	Is correct immunization recommended? If no, comment below on mistakes made.						
11.	Is the correct dose of vit. A recommended according to MOH guidelines?						
12.	Is correct deworming recommended according to guidelines?						
13.	Does the health worker counsel the care taker appropriately? Does this cover:						
a.	Description of what is wrong with the child?						
b.	Description of how to take any drugs prescribed?						
c.	When to return?						
d.	Checking that the mother has understood?						
e.	Is child < 2 years assessed and counseled for feeding?						
f.	Is the IMCI mother's card used / given out?						
14.	Does the health worker ask if the caretaker has any questions?						
15.	Does the health worker use the IMCI chart booklet or laminated patient recording form during the consultation?						

Comments and date when made:

IMCI Checklist continued

Answer Y if correctly done and N if incorrect and make comments below:

15.	If not covered during the observation, ask the health worker to demonstrate/describe						
a.	• Chest in-drawing.						
b.	• Skin pinch for dehydration						
c.	• Oedema						
d.	• Stiff Neck						
e.	• Severe wasting						
16.	In your assessment: Does the health worker know how to treat malaria i.e.						
a.	• Correct knowledge and practice about first and second-line antimalarial drug prescription. Is it in accordance with national guidelines?						
b.	• Correct knowledge about danger signs for severe complicated malaria?						
c.	• Appropriate knowledge and practice about preventive practice counselling for						
17.	Does the health worker know when to refer the patient?						

Comments and date when made:

IMCI Checklist continued:

Interview with Caretaker of a child < 5 years of age treated at the facility (Ask at end of the case observation in the presence of the health worker)

If caretaker's answer was correct write "C:, "W" if wrong and DK if she/he doesn't know

	Ask the Caretaker as appropriate and judge whether she understood correctly						
1.	**Drugs:**						
	Did the health worker give you or prescribe any medicines for your child today?						
	If an antibiotic						
	How much will you give your child each time?						
	How many times a day will you give it?						
	For how many days will you give the medicine?						
	If an antimalarial						
	How much will you give your child each time?						
	How many times a day will you give it?						
	For how many days will you give the medicine?						
	IF ORS						
	How much will you give your child each time?						
	How many times a day will you give it?						
	For how many days will you give the medicine?						
2.	**When to return**						
	When should you bring your child back to the health facility?						
3.	**Feeding**						
	Did the Health Worker talk you about how to feed your child today?						
	Please describe how you should feed your child. (Judge by the age of the child and the recommendations on the IMCI mother's card).						
4.	**Care taker's view on care provided**						
	How do you feel about the care you received for your child today? (Put answer in comment space below)						

5.	**Review registry book for the last 10 malaria cases** (write proportion e.g. 5/10)						
	Proportion receiving first line antimalarial.						
	Proportion receiving injection.						
6.	**Review registry books for the last 10 pneumonia cases** (write proportion e.g. 5/10)						
	Proportion receiving first line antibiotic.						
	Proportion receiving injection.						

Comments and date when made:

IMCI Checklist continued:

Answer Y for "Yes", N for "No" and NA if Not Applicable

1.	**Number of health workers who manage children (including nurse-aides)**						
	Number of them trained in IMCI.						
	Number trained in management of severe malaria.						
2.	Needed equipment and supplies available?						
	• Functional weighing scale						
	• Functional watch or other timing device						
	• Outpatient Register						
	• HMIS forms						
	• Mother's Cards (for IMCI)						
	• Child Health Cards						
	• Laminated IMCI recording form						
	• IMCI Chart Booklet						
3.	Are there functional facilities for diagnosis of Malaria?						
	• A functional microscope						
	• Staff trained to use it						
	• Supplies for blood smear						
	• Others (specify)						
4.1	Note if the following immunization facilities are available.						
	• Functioning fridge						
	• (2) gas cylinders						
	• Correct vaccine temperatures (4-8						
	• Sufficient needles and svringes						
	• Functioning sterilizer						
	• Adequate Ice packs						
	• Vaccine carriers						
	• Vaccine monitors						
	• Other problems (please specify)						
4.2	Does the facility immunize daily? If no please specify in comments space below why not						
5.	ORT: is there evidence that the unit is providing ORT daily?						

5.1	Is there clean water to mix ORS?						
5.2	Are there supplies to mix ORS?						
5.3	Are there ORS containers?						
5.4	Others (please specify)						
6.	Are there diagnosis and treatment guidelines and/or wall charts for Malaria and IMCI?						
7.	Are there any problems with management drugs and supplies? Check for these of problems Answer Y or N						
	• Drugs in locked cabinet / room.						
	• Drug packets not in dry place.						
	• Stock cards not available.						
	• Stock cards not updated.						
	• Others, please specify:						

Comments and date when made:

IMCI continued.

AVAILABILITY OF VACCINES, DRUGS AND SUPPLIES

Indicate in columns marked A if available today, and in columns B, if was available some time during last month

Date							
Supervisor(s)							
Supervisee(s)							
		A	B	A	B	A	B
	VACCINES:						
	Polio						
	DPT						
	TT						
	Measles						
	BCG						
	FIRST LINE DRUGS:						
	Cotrimoxazole						
	Chloroquine						
	Paracetamol						
	Iron						
	Folate						
	Vitamin A						
	Mebendazole						
	ORS						
	Tetracycline eye ointment						
	Gentian violet						
	SECOND LINE DRUGS						
	Fansidar						
	Amoxicillin						
	Nalidixic acid						
	Erythromycin						
	Procaine Penicillin						
	PRE-REFERRAL DRUGS						
	Quinine						
	Chloramphenicol						
	Benzypenicillin		,				
	Rectal Diazepam						
	Gentamycin						

Comments and date when made:

IMMUNIZATION CHECKLIST

Answer Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S):							
	Does the health worker:						
1.	Know the catchment target population of 0 - 11 months and women of 15 - 44 years old?						
2.	Have a drawn static and outreach immunizations programme?						
	COLD CHAIN MAINTENANCE						
1.	Is there a vaccine refrigerator at the unit?						
	If there is one, is it in good working condition, door / lid closes well, seal is tight and clean?						
2.	Is there sufficient gas or functioning electrical connections?						
3.	Is the refrigerator well positioned, out of sun or draught?						
4.	Are there adequate icepacks, in good condition?						
5.	Does the refrigerator freeze ice packs in the required time?						
6.	Are the vaccine vials properly packed and spaced in fridge?						
7.	Are there opened vials of vaccine in the fridge, protected from being contaminated (OPV, DPT, TT)						
8.	Is the refrigerator used for EPI vaccines only?						
9.	Is there a thermometer in the fridge, located in the centre?						
10.	Is the interior refrigerator temperature read and recorded on a temperature chart daily both in the morning and afternoon?						
11.	Is the storage temperature maintained between 0 and +8 deg. cent?						

12.	Is the quality of vaccines in the fridge being monitored including use of 3M cold chain monitor or WM?						
13.	Is there a vaccine control book and up to date?						
14.	What method is used to estimate vaccine requirements? Write below						
15.	What is the storage duration of the vaccine stock at the unit (in days)?						
16.	Is there a vaccine carrier, in good condition at the unit?						

Comments and date when made:

Immunization checklist continued.

	IMMUNIZATION SESSION PROCEDURES						
	Does the health worker						
1.	Explain to the mothers what immunization is all about?						
2.	Tell the mothers/clients the date of next visit and what to do in case of reaction after immunization?						
3.	Use the education materials during H/E talks?						
4.	Review the child's health card / TT cards and determine whether the child/mother needs immunization or not?						
5.	Correctly interpret the information on the Child Health Card (CHC)?						
6.	Record the immunization data in the health record?**						
7.	Record the date of the next immunization visit and comments?						
8.	Observe injection safety techniques? i.e. Does the H/worker:						
	a) Wash her hands with soap and clean water before immunizing the children?						
	b) Keep the immunization materials clean?						
	c) Clean the work area where the vaccine carrier and injection materials are to be placed?						
	d) Clean the injection site with clean cool water?						
	e) Dispose of used materials according to MOH regulations and standards?						
	f) Introduce the needle in the appropriate body site?						
	g) Aspirate and inject the vaccine slowly? (Intramascular - OPT, TT)						
	h) Withdraw the needle and apply pressure using clean dry cotton swab?						

	i) Take a vaccine vial antigen from the vaccine carrier only when a client is ready to receive immunization?						
	j) Are the opened vaccine vials being used placed in a sponge in the vaccine carrier?						
	k) Discard reconstituted BCG and Measles vaccine after six hours of reconstitution						
	I) Use precooled not frozen diluent of same consignment of vaccine? the						
9.	Carry out outreach immunization services?						
10.	Have transport for outreach services - bicycle.						

Comments and date when made:

STERILIZATION AND INFECTION CONTROL CHECKLIST (FOR EPI)

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE:							
SUPERVISOR (S) :							
SUPERVISEE (S) :							
	DOES THE HEALTH WORKER:						
1.	Make sure the sterilizer is working?						
2.	Make sure there is a spare kit '8' in stock?						
3.	Make sure there is a complete immunization kit?						
4.	Make sure there is fuel (paraffin) for sterilization?						
5.	Wash the instruments before sterilization?						
6.	Sort, soak and clean re-usable syringes and needles before sterilization according to MOH guidelines and standards?						
7.	Count the instruments and injection equipment before sterilization and ensure adequate enough syringes and needles for each antigen in the steriliser racks?						
8.	Put enough water in the steriliser base before sterilization?						
9.	Cover the steriliser properly?						
10.	Separate the curative and prevention injection equipment both in storage and during sterilization						
11.	Sterilize the cheatle forceps? What method is used?						
12.	Sterilize the instruments and injection equipment for the proper duration?						
13.	Use TST spots for to confirm complete sterilization process and keep records on use of TST spots?						
14.	Keep the instruments sterile in chlorhexidine?						
15.	Ensure that immunization injection equipment are not cleaned with any disinfectant at all?						
16.	Keep record of both instruments and injection equipment stock?						

Comments and date when made:

HEALTH EDUCATION CHECKLIST (GENERAL)

This is applicable to any HED session at a Health Facility, out reach program or any other service delivery point.

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S):							
	DOES THE HEALTH WORKER:						
1.	Have a plan for the Health Education sessions?						
2.	Select an appropriate site for health education?						
3.	Appear clean and presentable?						
4.	Arrive on time for the HED session?						
5.	Explain the topic for HED for the day?						
6.	Use clear language?						
7.	Use appropriate teaching aids?						
8.	Make the session interesting and participatory?						
9.	Clarify doubts and use relevant examples?						
10.	Have knowledge about the subject matter?						
11.	Arrange for demonstrations where necessary?						
12.	Seek other people's views?						
13.	Summarize key points?						

Comments and date when made:

GROWTH MONITORING CHECKLIST

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S):							
	DOES THE HEALTH WORKER:						
1.	Welcome the mother?						
2.	Check when the child's weight was last measured?						
3.	Calibrate the scale prior to using it to weigh the child?						
4.	Assist the mother to remove all clothing from the child prior to weighing?						
5.	Determine that the child is not moving or holding to any object before measuring the child's weight?						
6.	Weigh the child properly ensuring that the scale is accurately balanced before reading the weight?						
7.	Say the weight aloud in a tone audible to the mother?						
8.	Record the weight of the child on a health card?						
9.	Plot the weight in the correct location of the growth chart?						
10.	Connect the weight points?						
11.	Explain to the mother the significance of the weight?						
12.	Others (specify)						
13.							

Comments and date when made:

REPRODUCTIVE HEALTH CHECKLISTS

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR(S):							
SUPERVISEE (S):							
A.	**COMMUNITY ASSESSMENT OF PRIMARY HEALTH CARE RH SERVICES (OVERALL)**						
	Does the health worker						
1.	Register all children <5 on the family health card?						
2.	Register all women over 16 on the family health card?						
3.	Vaccinate or arrange for vaccination of children who need to be immunized?						
4.	Check to be sure that nutritional counseling, food supplementation and/or medical attention are being received (if there are malnourished children in the house).						
5.	Recommend **ORT** and help the mother to prepare and administer it?						
6.	Ask if she is receiving prenatal care and arrange for prenatal visit if necessary?						
7.	Refer interested women or couples for family planning services?						
8.	Discuss water, hygiene, and sanitation, if indicated?						
9.	Establish a good report with the mother?						

Comments and date when made:

RH checklists continued.

Write Y for "Yes", N for "No" and NA if Not Applicable

Date							
Supervisor(s)							
Supervisee(s)							
B.	**ADOLESCENT SEXUAL AND REPRODUCTIVE HEAL TH**						
	Does the health worker						
1.	Ensure privacy & confidentiality while providing service?						
2.	Determine participants' knowledge, attitudes, practice, about topic						
3.	Determine participants' general level of knowledge?						
4.	Explain the topic and focus the discussion?						
5.	Discuss all relevant aspects of the topic?						
6.	Use appropriate discussion techniques to encourage active participation.						
7.	Use appropriate educational materials during the presentation?						
8.	Distribute any available educational materials?						
C.	**HEAL TH EDUCATION IN RH**						
	Does the health worker						
1.	Determine participants' knowledge, attitudes, practices, about topic?						
2.	Determine participants' general level of knowledge?						
3.	Explain the topic and focus the discussion?						
4.	Discuss all relevant aspects of the topic?						
5.	Use appropriate discussion techniques to encourage active participation?						

6.	Use appropriate educational materials during the presentation?						
7.	Distribute any available educational materials						
D.	**ANTENATALCARE / RH**						
	Does the health worker						
1.	Review and update obstetric record or family health card?						
2.	Ask at least two questions about reproductive history risk facilitators?						
3.	Ask at least two questions about risk factors associated with this pregnancy?						
4.	Perform at least 1 physical exam activity?						
5.	Immunize or arrange for immunization against tetanus?						
6.	Do a blood test (glucose, Hb, heamatocrit and malaria) if medically indicated?						
7.	Discuss the importance of having the delivery attended by a trained health						
8.	Explain danger signs, which require immediate attention?						
9.	Tell pregnant women when and where to go for the next prenatal visit?						
E.	**SAFE DELIVERY/RH**						
	Does the health worker						
1.	*Before Birth* Sterilize needles, syringes, cord ties, scissors / razor blades?						
2.	Prepare a clean birthing place?						
3.	Take labour history?						
4.	Review reproductive history for high-risk factors if necessary?						
5.	*During birth:* Conduct physical exam and monitor women throughout labour?						
6.	Assist the progress of labour?						
7.	Assist with delivery?						
8.	Seek help for obstetric problems and emergencies?						

9.	Tie the umbilical cord with threat in three places and cut with blade/scissors?						
10.	Determine APGAR score at 1 minute and 5 minutes after birth?						
11.	Deliver placenta?						
12.	*After birth:* Monitor mother and provide the needed care immediately after birth?						
13.	Examine infant?						
14.	Insert antibiotic eye ointment or silver nitrate drops into eyes within one hour after birth						
15.	Give BCG vaccination?						
16.	Administer vitamin A?						
17.	Discuss postnatal cleanliness and provide related instructions?						
18.	Give advise about breast feeding?						
19.	Give advice about well-child care?						

Comments and date when made:

RH checklists continued.

Write Y for "Yes", N for "No" and NA if Not Applicable

Date							
Supervisor(s)							
Supervisee(s)							
F.	**POSTNATAL CARE / clinic (RH)**						
	Does the health worker						
1.	Ask the mother at least two medical history Questions?						
2.	Examine the mother?						
3.	Examine the infant child?						
4.	Record findings of history and physical examination health record?						
5.	Refer the mother for special treatment if necessary?						
6.	Refer the infant for all physical conditions which need medical attention?						
7.	Give BCG or verify that child received vaccination at birth?						
8.	Give first DPT and OPV?						
9.	Tell the mother to feed the infant with breast milk only, for the first 4 - 6 months?						
10.	Discuss family planning with the mother and tell her how she can obtain FP services?						
11.	Encourage the mother to enroll child in well-child clinic?						
G.	**FAMILY PLANNING / RH**						
	Does the health worker						
1.	Ask at least three medical and reproductive history Questions?						
2.	Take blood pressure of the client?						
3.	Examine breast for lumps?						
4.	Examine the client for signs of anemia?						
5.	Recommend a method that was free of contra-indications for this client?						
6.	Discuss side effects?						

7.	Ask the client to explain how to you use the contraceptive received?						
8.	Ask the client to repeat the possible side effects?						
H.	**BREAST FEEDING/RH**						
	Does the health worker						
1.	Ask about mother's knowledge and practice concerning breast feeding?						
2.	Instruct mothers on the health benefits (to mother and child) of breast feeding?						
3.	Recommend how long to breast feed and encourage continued breast feeding during illness?						
4.	Instruct mother on method of breastfeeding?						
5.	Explain warning signs that indicate the mother should seek help?						
6.	Provide counseling, as appropriate, on FP methods and contraceptive benefits of breast feeding?						
7.	Provide appropriate counseling on diet during lactation, nutrition supplements, and important locally available foods?						
8.	Advise mother on weaning practices and food preparations.						
I.	**SEXUAL TRANSMITTED DISEASE / RH**						
	Does the health worker?						
1.	Ask about symptoms of infection?						
2.	Ask about previous exposure to STD and any treatments administered?						
3.	Ask about exposure to other potential sources of infection, ego Blood, non-sterile instruments etc.,						
4.	Ask about possible risk behaviours associated with STD?						
5.	Examine patient for signs of infection?						
6.	Diagnose and treat STDs testing according to established guidelines?						
7.	Provide health education on the modes of transmission and prevention of STD?						
8.	Instruct the client on the correct and consistent use of condoms?						

9.	Provide appropriate counseling on testing procedures, confidentiality and meaning of test results?						
10.	Provide appropriate counseling to STD cases on available treatments, complications of diseases or any long term effects, and possible risks to partners and/or children?						

Comments and date when made:

CLINICAL SERVICES: CHECKLIST FOR MANAGEMENT OF COMMON CONDITIONS, DISABILITIES AND INJURIES.

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR ·(S):							
SUPERVISEE (S):							
	DOES THE HEALTH WORKER						
1.	Make the patient comfortable?						
2.	Ask important questions?						
3.	Carry out physical examination?						
4.	Record relevant information?						
5.	Request for relevant and appropriate investigations?						
6.	Make a correct diagnosis?						
7.	Explain the findings and treatment plan to the patient?						
8.	Prescribe appropriate drugs in correct doses (or rehabilitation procedures) for the condition diagnosed?						
9.	Give clear instructions to the patient?						
10	Give appropriate health education messages?						
11	Refer the patient appropriately						
12	Handle emergencies appropriately?						
13	Others (please specify)						
14							

Comments and date when made:

CLINICAL SERVICES: CHECKLIST FOR MANAGEMENT OF DENTAL CASES

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S):							
	DOES THE HEALTH WORKER						
1.	Make the patient comfortable?						
2.	Record past Medical history?						
3.	Record past dental history?						
4.	Record the chief complaint?						
5.	Request for other investigations?						
6.	Carry out a full mouth examination?						
7.	Make the correct diagnosis?						
8.	Record his treatment plan and explain to the patient?						
9.	Explain to the patient what is to be done?						
10.	Carry out the correct treatment procedures?						
11.	Observe infection control procedures?						
12.	Give post-treatment instructions and Health Education?						
13.	Prescribe the correct drugs when necessary?						
14.	Keep patient records?						
15.	Refer cases where applicable?						

Comments and date when made:

CLINICAL SERVICES: CHECKLIST ON WOUND DRESSING

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S):							
	DOES THE HEALTH WORKER						
1.	Assemble all the necessary equipment?						
2.	Make the patient comfortable?						
3.	Explain the procedure to the patient first?						
4.	Protect fresh wounds from contamination?						
5.	Use sterile instruments?						
6.	Clean the wound correctly?						
7.	Apply the dressing and bandage correctly?						
8.	Clean the instruments after use?						
9.	Dispose dirty dressings properly?						
10.	Re-sterilise the instruments after use?						
11.	Keep the room clean?						
12.	Others (please specify)						

Comments and date when made:

CLINICAL SERVICES: CHECKLIST ON DISPENSING DRUGS

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S):							
	DOES THE HEALTH WORKER						
1.	Welcome patients?						
2.	Interpret the prescription correctly?						
3	Count the medication correctly?						

4.	Explain adequately to the patient how to take the drugs?						
5.	Explain the need to complete the treatment (finish the drugs)?						
6.	Ask the patient to repeat the instructions?						
7.	Label the medicine container correctly?						
8.	Others (please specify)						
9.							
10.							

Comments and date when made:

CLINICAL SERVICES: CHECKLISTON GIVING INJECTIONS

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S)							
	DOES THE HEALTH WORKER:						
1.	Assemble all the necessary equipment properly?						
2.	Explain the procedure to the patient/client first?						
3.	Counter check the prescription of the patients?						
4.	Counter check the drug to be administered?						
5.	Identify the correct injection site properly?						
6.	Clean the injection properly?						
7.	Administer the injection properly?						
8.	Keep the instruments and injection equipment sterile throughout the procedure?						
9.	Dispose off used injection materials according to the MOH set guidelines and standards?						
10.	Keep a disposal container for the sharps?						
11.	Portray positive attitude towards the clients / patients?						

Comments and date made:

EPIDEMIC AND DISASTER PREVENTION, PREPAREDNESS AND RESPONSE CHECKLIST

The priority diseases for MOH for integrated disease surveillance system:
Diseases targeted for eradication or elimination: Guinea work, AFP/Polio, NNT and Leprosy.

Epidemic prone diseases: cholera, B. dysentary, Plague, Measles, Yellow fever, M. meningitis, Rabies and Viral haemorrhagic fever .

Diseases of Public health importance: Diarrhoea in under fives, HIV/AIDS, Malaria, STIs, Trypanosomiasis, Tuberculosis, injuries, and Schistosomiasis.

Write Y for "Yes", N for "No" and NA if Not Applicable

DATE							
SUPERVISOR (S):							
SUPERVISEE (S):							
	In the health facility, is there						
1.	A person responsible for disease surveillance?						
2.	A known catchment area of the health unit?						
3.	A known catchment population of the health unit?						
4.	Case definitions for priority diseases?						
5.	Case confirmation for suspected epidemics clinical/laboratory?						
6.	Reporting mechanism for cases of priority diseases to the next level?						
7.	Analysis of data collected on priority diseases?						
8.	Utilization of data collected for action?						
9.	Feedback to the lower level on data collected?						
10.	Investigation of disease outbreaks?						
11.	An epidemic preparedness mechanisms?						
12.	A Mechanism to respond to epidemics?						
13.	Supervision on Integrated Disease Surveillance (IDS)?						

14.	Guidelines on outbreak investigations?						
15.	Guidelines on epidemic response?						
16.	Guidelines on epidemic preparedness?						
17	Guidelines on mass casualty management?						

Comments and date when made:

ANNEX 6

CHECKLIST FOR INTEGRATED SUPPORT SUPERVISION OF COMMUNITY HEALTH SERVICES AND PROGRAMS

CHECK LIST FOR SUPERVISION OF COMMUNITY HEALTH SERVICES

1. MANAGEMENT OF COMMUNITY LEVEL HEALTH SERVICES.

1.1 Does the subcounty have an active Sub County Health Committee (SCHC) headed by a secretary for health and children welfare?

1.2 Does the subcounty have in place an Environment Health Officer or Assistant?

1.3 Are there Community Based Health Care Organisations?

1.4 Is there a Sub County (S/C) Annual Health Plan and quarterly plans? Specify.

1.5 Did the S/C implement at least 75% of the planned activities during the last quarter?

1.6 What cadres of Community Based Providers exist e.g. CHWs, TBAs, PDCs, CBDAs, VHCs, Local Vaccinators, etc?

1.7 Is there inter-sectoral collaboration for community health programs at the S/C level?

1.8 In the past quarter, was there supervision of the SCHC by the members of the District council?

1.9 In the past quarter, were the Community Health Care Providers (e.g. TBAs, CHWs, etc) supervised by the Health Sub Districts and the Health Facility in the community?

1.10 Is there a Community Based HMIS for registration of births, deaths, and disabilities, in the community?

2. ENVIRONMENTAL SANITATION AND HYGIENE.

2.1 Do at least 60% of households in the community have latrines?

2.2 Do at least 60% of households have adequate housing with separate houses for animals and kitchen?

2.3 Do at least 60% of households have access to safe water?

2.4 Are there adequate latrine facilities in public places e.g. markets, schools, fish landing sites, and bars?

2.5 Is there pollution of water sources by small industries including pollution by car washers?

3. INTEGRATED MANAGEMENT OF CHILD ILLNESSES.

3.1 Do CHW s provide education on home based care and care seeking behaviour for sick children?

3.2 Are there any CBDA who distribute ORS in the community? If so, do have adequate ORS supplies?

3.3 Have the CBDA of ORS been given on job training or any in service training to realise the different degrees of dehydration especially cases requiring referral to the health facility at least in the last one year?

4. MALARIA.

4.1 Do CHWs keep records of patients who have received antimalarial drugs?

4.2 Do CHW correctly identify patients with malaria who need to be referred to a health facility?

4.3 Is there a program in the *SIC* work plan for sensitising the community on Malaria control measures e.g. use of bed nets, elimination of stagnant water etc.?

5. FOOD AND NUTRITION.

5.1 Has the SCHC got in place a program for promoting food security and community awareness on nutritious foods especially for children, mothers and the sick?

5.2 Is growth monitoring being carried out by community health providers?

6. IMMUNISATION.

6.1 Are there local vaccinators who have been active in the last quarter?

6.2 Have the local vaccinators in your catchment area received any formal training course at the district, HSD or health facility level?

6.3 Is there an immunisation outreach at every Parish level (HC II)?

6.4 Are local councils and other opinion leaders involved in community mobilization for EPI? Discuss how they involved and how they can mobilise the community.

7. REPRODUCTIVE HEALTH (RH) SERVICES.

7.1 Is there an adequate supply of contraceptives (Oral contraceptives and condoms) among CBDAs to last them at least one month?

7.2 Do CBDAs, TBAs and CHWs have sufficient IEC materials on Reproductive Health?

7.3 Have the CBDAs, TBAs and CHWs received supervision in RH services in the last 3 months?

7.4 Do CHWs or CBDAs give iron to pregnant women? Are they keeping records of mothers who get these tablets?

7.5 Have the CBDAs, TBAs and CHWs received training and refresher courses in the last year?

7.6 Do CBDAs, TBAs and CHWs have the required registers in place, and being

used?
Are they up to date and accurate? Do they use the data they collect routinely for planning and monitoring the services they provide?

7.7 Are TBAs able to recognise and refer complicated pregnancies?

7.8 Do the TBAs deliver mothers in Hygienic environment at home?

7.9 Are clients treated in privacy and with respect to confidentiality?

8. AIDS / STI

8.1 In the past quarter, has there been active distribution of condoms through CBDAs?

8.2 Are there functional community counselling aides?

8.3 Are there home based care providers for HIV patients?

9. HEALTH EDUCATION AND IEC.

9.1 Do community health providers have adequate and relevant IEC materials for the speciality areas?

9.2 Are the Community Health Providers able to give relevant health education talks in their speciality programs?

9.3 Have there been any health education sessions carried out in the community by the community providers?

10. MENTAL HEALTH AND MEDICAL REHABILITATION.

10.1 Are there community own resource persons (CORPS) involved III rehabilitative activities of people with disabilities in this catchment area?

10.2 Are the established health committees e.g. VHC, PDC, SCHC, etc. addressing issues of PWDs.

10.3 Are the artisans making appropriate local appliances for PWDs?

ANNEX 7

REPORTING FORMAT

REPORTING FORMAT

Date

Supervisor(s)

Supervisee(s)

POSITIVE FINDINGS
(Also acknowledge actions taken following the last supervision recommendations)

"
WEAKNESSES / GAPS OBSERVED.

RECOMMENDA TIONS / ACTIONS TO BE TAKEN.

ANNEX a

MEMBERS WHO PARTICIPATED IN DIFFERENT CONSULTATIVE WORKSHOPS DURING THE DEVELOPMENT PROCESS.

Representatives who attended the first stakeholders' workshop of 10 -12 December 1998 that proposed the format, content and tools for the NSG

1. Jay Anderson — Health & Population Officer USAID.
2. Martha Bekiita — Training Co-ordinator CARE Kabale .
3. H.W. Kakande — National Coordinator, AVSC International.
4. G. Jagwe — MS Moroto Hospital
5. Rezaul Haque — Health Prog. Co-ord. CARE - UFHP Mbale.
6. M.Oteba — Ag. CHS (Pharm) MoH
7. J.M. Zziwa — M/S Kawolo Hospital
8. M.F. Semambo — Secretary Social Services, Mbarara
9. G.W. Wopuwa — Ag. CAO Mbale.
10. Anders Jeppsson — Management Advisor DHSP/MoH.
11. Peter Thompson — Health Pop. Field Manager DFID
12. Jessica Nsungwa — Ag. Prog. Manager CDD/ARI.
13. Issa Tamale — Clinical Officer Mukono.
14. D. Yiga — for DDHS Masaka
15. R. Najjemba — Lecturer IPH
16. F. Tirwomwe — CHS (C) MoH
17. S. Sebudde — Research IPH
18. G.L. Kinimi — CHS(N)MoH
19. G.W. Pariyo — Lecturer IPH *I* Field Coordinator MPH program
20. J. Mugume — Program Manager Sexual/Rep. Health WHO
21. J. Namboze — Disease Prevention & Control. coordinator,WHO
22. B. Wanume — MS Jinja . Hospital.
23. T. Rubale — Team Leader GTZ FortPortal.
24. Musoke Byenkya — Project Leader AMREF
25. V. Sebagereka — Secretary Social Affairs Mukono
26. Lynn Atuyambe — Lecturer IPH
27. P. Waibale — ACP/STI MOH
28. G. Kasirye — Clinical Officer Buikwe H/C Mukono.
29. Francis G. Omaswa — Head QAU
30. Peter Sovesnik — Chief of Party / DISH
31. Michael Igune — Chief Health Training Officer HMDC, Mbale
32. Godfrey Magumba — Deputy DDHS / Mukono
33. Tembi Matatu — Clinic Services Advisor / DISH
34. H. G. Mwebesa — SMO / QAU.
35. Gilbert Burnham — Associate Professor, JHU / Baltimore.
36. V. Ojoome — CHS (T&E)MoH

Representatives of stakeholders who revised the final draft that was Pilot tested in 8 districts.

1.	Mr. S. Kasoro A.	For DDHS Kabarole
2.	Dr.Okoth	M/S Fort Portal Hospital, Kabarole
3.	Mr.H. Kagaba	Secretary for Health, Kabarole
4.	Dr. M. Nsubuga	Physician Kitovu Hospital, Masaka
5.	Dr. Musisi	DDHS Masaka
6.	Dr. T. Rukundo	M/S Masaka Hospital, Masaka
7.	Dr. E Kyomugisha	M/S Villa Maria Hospital, Masaka
8.	Mr. A.K Serunjogi	Secretary for Health, Masaka
9.	Dr. F. Abwaimo	Ag. DDHS, Mbale
10.	Dr. J.M. Masaba	M/S Mbale Hospital
11.	Dr. F. Nabende	M/S Bududa Hospital, Mbale
12.	Mr. S. Wakwaba	Secretary for Health, Mbale
13.	Dr.Oonyo Etaabon	DDHS Kumi
14.	Dr. P.Otim Nape	M/S Ngora Hospital, Kumi
15.	Dr. J. Opolot	M/S Kumi Hospital, Kumi
16.	Dr. B. Odu	M/S Atutur Hospital, Kumi
17.	Ms. C.R Tino	Secretary for Health, Kumi
18.	Dr. G. Magumba	Deputy DDHS, Mukono
19.	Dr. M. Marembwe	M/S Nyenga Hospital, Mukono
20.	Dr. J.M Zziwa	M/S Kawolo Hospital, Mukono
21.	Dr. A. Nagujja	M/S Naggalama Hospital, Mukono
22.	Dr. D. Musisi	M/S Kayunga Hospital, Mukono
23.	Dr. P. Kyamanywa	M/S Nkokonjeru Hospital, Mukono
24.	Mrs. V. K. Sebagereka	Secretary for Health, Mukono
25.	Dr. D.M. Muzira	Ag. DDHS, Kamuli
26.	Dr. J. Nyolia	M/S Kamuli Mission Hospital
27.	Mr. D.T Katongole	Secretary for Health, Kamuli
28.	Dr. Amooti B. Kaguna	SMO/DDHS, Mbarara
29.	Dr. R. Isabirye	M.O Itojo Hospital, Mbarara
30.	Dr. V.M. Owarwo	EDF/RHP, Mbarara
31.	Dr. A. Twinamasiko	Ag. M/S Mbarara University Teaching Hos
32.	Mrs. M.F Semambo	Secretary for Health Mbarara
33.	Dr. J. F. lmoko	DDHS Arua
34.	Dr. N. Mande	M/S Yumbe Hospital, Arua
35.	Dr. K. Neudeck	M/S Kulva Hospital, Arua
36.	Dr. J. Amandua	M/S Arua Hospital
37.	Mrs. R. Popo	Secretary for Health, Arua
38.	Dr. K.M Rezaul Haque	UFHP, Care Mbale
39.	Dr. Martin Ejerfeldt	Health Management, UNICEF
40.	Dr. A.L. Abongomera	ACHS (QA), MOH
41.	Mr. Jay Anderson	Head Health Population, USAID
42.	Dr. P. Savosnick	Chief of Party, DISH
43.	Mrs. Stembile Matatu	Clinical Services Advisor, DISH
44.	Dr. H.G Mwebesa	Ag. PMO, MOH/QAD
45.	Ms. Harriet Aisu	Administative Assistant QAU
46.	Ms. Sarah Muledhu	Secretary QAD

Participants in the workshop to review and finalize the NSG - May 2000

	Name	Station	Title
1.	Amodoi A. Joseph	Bukedea (HSD) Kumi	Clinical Officer
2.	Dr. Otim P. Nape	Ngora HSD Kumi	Medical Officer
3.	Dr. Bobby Hultberg	EDF/RHP, Mbarara	Co-ordinator
4.	Dr. Nyehangane W	Itojo Hosp. - Mbarara	Med. Superintendent
5.	Dr. Byaruhanga P.	Mbarara district	DDHS
6.	Pamela H. Zaninka	UNEPI - Entebbe	For Program Manager
7.	Dr. Kirunda Ibrahim	Kinoni HSD, Masaka	Medical Officer
8.	Dr. Driwale Alfred	Koboko HSD, Arua	Medical Officer
9.	Dr. C. K. Kyobutungi	Mbarara University	CHD - Co-ordinator
10.	Dr. Jakor Oryema	Kuluva Hospital, Arua	Medical Superintendent
11.	Joseph Agondua	Mbale- HMDC	Asst. Tech Advisor HRD.
12.	Dr. V. Ojoome	Mbale Hospital	Senior Consultant, Pead.
13.	E. Karozi	Kabarole, Kibale HSD	Clinical Officer
14.	Bingi Christopher	Kabarole, Kyegegwa HSD.	Clinical Officer
15.	Dr. Julius Balinda	Kabarole district	For DDHS
16.	Dr. H. Balidawa	Fort Portal Hosp, Kabarole	Medical Officer
17.	Dr. David Tigawalana	Kamuli district	DDHS
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23.	Dr. D. Musisi	Kayunga Hospital	Medical Superintendent
24.	Dr. G. Magumba	DISH II	IMCI specialist
25.	Dr. S.W. Wandera	DDHS's Office Mukono	Ag. DDHS
26.	Prof. E.M. Kaijuka	Ministry of Health	CHS/QA
27.	Dr. H.G. Mwebesa	MOH, QAD	Ag. ACHS
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29.	Dr S Barry	DISH II	Chief of Party
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34.	Dr. J. Imoko	Arua	DDHS
35.	James Mugisha	MOH/IMCI	IMCI Specialist
36.	Dr. J.M. Zziwa	Kawolo Hospital	Senior Medical Officer
37.	Dr. Sentumbwe Olive	MOH/WHO	RH coordinator
38.	Dr. Sentongo M	MOH/UNFPA	Senior Medical Officer
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46.	Dr. Twinamasiko Amos	Mbarara University Hosp.	Medical Superintendent
47.	Dr. Lwandwa	Bubulo East HSD, Mbale	Medical officer
48.	Dr. M. Igune	HMDC Mbale	Member SWG
49.	Dr. Desmet M	MOH/HPD	Planning Advisor
50.	Dr. Wyne Stinson	DISH II/ MSH Boston USA	QA Advisor