

Approaches to an integrated supervisory system in Kyrgyzstan for better maternal and child health



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ABSTRACT

In 2009, WHO Regional Office for Europe and the WHO Country Office Kyrgyzstan organized a workshop with the Kyrgyzstan Ministry of Health. Its participants included policy-makers, other experts, managers and partners. The purpose was to consider how best to develop the Optimized MCH Integrated Supervisory System (OMIS) in Kyrgyzstan, to improve maternal and child health. This report analyses the origins and value of supervision, the different levels of supervision required, the key programmes and activities on maternal and child health in Kyrgyzstan, challenges on implementation, and suggestions. A list of recommendations for the development of OMIS was discussed and agreed.

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Introduction

"Supervision that is supportive and helps to solve specific problems can improve performance, job satisfaction and motivation"

World Health Report, 2006

Many countries in the European Region are scaling up delivery of essential health interventions aimed at reducing child and maternal mortality. However, progress is still rather slow and the efforts to address this disease burden have not always promoted linkages or synergy between the different disease control initiatives.

Integrating service delivery may improve the coverage of interventions and the efficiency of health systems in the European region. Integration of key child survival interventions is a viable approach to achieving the child survival goals.

The integrated package includes vaccine-preventable diseases, integrated management of childhood illnesses (IMCI), antenatal care (ANC), promotion of breastfeeding, nutrition, Vitamin A and other micronutrient supplementation. To demonstrate the outcome and impact of the integrated approach, there is a need to standardize monitoring and evaluation approaches, including use of comparable methodologies and protocols. The monitoring and evaluation system should cover all aspects of the campaigns and routine delivery systems and the information used for planning and documenting best practices. An integrated and optimized supervisory system should serve as a cornerstone of effective monitoring, and the evaluation of effective public health programmes aims to improve maternal and child health.

History of supervision

The immediate roots of what has come to be known as supervision lie in the development of social work and casework. In ancient China, Africa and feudal Europe, for example, there are numerous examples of people new to a craft or activity having to reveal their work to, and explore it with, masters or mistresses i.e. those recognized as skilled and wise. This process of being attached to an expert, of "learning through doing" allows the novice to gain knowledge, skill and commitment. It also enables them to enter into a particular 'community of practice' such as tailoring or midwifery. Such experts who were "looking over novices' shoulders" were the first supervisors.

Supervision can be found in the growth of charitable social agencies in Europe and North America during the nineteenth century. It involved the recruitment, organization and oversight of a large number of volunteers and, later, paid workers. The volunteers were commonly known as "visitors". Their task was to call on a small number of families to offer advice and support. The main concern was to foster self help, and the adoption of 'healthy' habits and behaviours. In addition, visitors were also often in a position to access limited funds via their agencies, although such monies were only given after a careful investigation of the family's circumstances. In other words, a decision had to be made as to whether they were "deserving".

The person assigning cases, organizing work and taking decisions on behalf of the agency was basically an “overseer” - and hence the growing use of the term 'supervisor'. (In Latin super means “over”, and videre, “to watch, or see”). Traditionally, part of the overseer's job was to ensure that work was done well and to standard. This can be viewed as an administrative task. However, overseers also had to be teachers and innovators. These were new forms of organization and intervention: “standards were being set, new methods developed”.

John Dawson (1926) stated the functions of supervision in the following terms:

- Administrative - the promotion and maintenance of good standards of work, co-ordination of practice with policies of administration, the assurance of an efficient and smooth-running office;
- Educational - the educational development of each individual worker on the staff in a manner calculated to evoke her fully to realize her possibilities of usefulness; and
- Supportive - the maintenance of harmonious working relationships, the cultivation of esprit de corps.

There are many supervisory models which are mainly based on the functions of supervision:

Administrative supervision – In administrative supervision the primary problem is concerned with the correct, effective and appropriate implementation of agency policies and procedures. The primary goal is to ensure adherence to policy and procedure.

Educational supervision - The primary goal of educational supervision is eliminating the ignorance of the worker and upgrading his or her skills. The classic process involved with this task is to encourage reflection on, and exploration of the work. Supervisees may be helped to: understand the client better; become more aware of their own reactions and responses to the client; understand the dynamics of how they and their client are interacting; look at how they intervened and the consequences of their interventions; and explore other ways of working with this another similar client situation

Supporting supervision - The primary goal is to improve morale and job satisfaction. Workers are seen as facing a variety of job-related stresses which, unless they have help to deal with them, could seriously affect their work and lead to a less than satisfactory service to clients.

Current view on supervision in public health programmes

The World Health Report (2006) entitled “Working together for health” stresses that supervision, especially when coupled with audit and feedback to staff, has been consistently found to improve the performance of many types of health workers, from providers to managers. It also shows that while the intent to supervise is almost universal, it often proves difficult to put into practice and becomes the first casualty in the list of priorities for busy and resource-constrained managers. Supervision often becomes more difficult but even more important in health systems that are decentralizing. Central managers in ministries, for example, may be perceived as no longer having the authority to supervise districts, or their posts may have been transferred. When it does take place, the nature of the supervision is important. If supervisory visits become sterile

administrative events, or are seen as fault-finding and punitive, they have little positive effect and may have negative effects. In contrast, supervision that is supportive, educational and consistent and helps to solve specific problems, can improve performance, job satisfaction and motivation. Good supervision makes a difference in staff motivation and performance. The key conclusion from the WHO report is that the most promising approach to effective supervision is to ensure its integrated nature when all key elements – administrative, educational and supportive are present and well equilibrated.

Components of programme supervision and strategies to improve it

There are several levels of supervision within public health programmes and depending on those levels there are different objectives and tasks for supervisors at these different levels:

National/ provincial level

- to plan and coordinate the programme implementation;
- to analyze data on the programme needs, service provision and programme management;
- to coordinate programme and systems plans with local and state partners;
- To recommend and assist in the implementation (establish schedules and methods for the delivery of health programmes, recommend and implement policies and procedures);
- to evaluate operations and programme activities and as a result to recommend improvements and modifications;
- to implement appropriate quality assurance and quality improvement systems for supervised programmes and to assure compliance with professional and state standards.

Health facility and community level

- to review selected administrative aspects related to the health facility. This includes staff matters, financial matters, infrastructural aspects of the clinic (building, water supplies, electricity, grounds), equipment, supplies and legal issues;
- to review a functioning information system at the health facility level;
- to review referral pathways functioning
- to evaluate active community participation in the programme activities and existence of outreach services;
- To conduct periodic in-depth programme review of selected programmes.

Health worker level

- to ensure that health care providers are updated, trained and appropriately coached;

- to receive information and another perspective concerning one's work;
- to ensure that as a person and as a worker one is not left alone to carry unnecessarily difficulties, problems and projections;
- to help a health worker to develop understanding and skills within the work;
- to provide a regular space for the supervisees to reflect upon the content and process of their work;
- to provide both content and process feedback to health care providers;
- to plan and utilize health workers' personal and professional resources better;
- to ensure quality of health providers work.

Current strategies to improve supervision tend to ensure two types of integration:

Vertical – between different levels of supervision – national/provincial, health facilities and health workers;

Horizontal – between public health programmes with similar objectives and target groups, as well as with similar implementation strategies.

Though there are still many debates in the literature on the benefits and disadvantages of integration in public health programmes, there is a common agreement that highly skilled and educationally sound supervision of clinical practice is one of the main ways of pursuing the excellence in health care practice which is demanded by both government and key professional bodies. Secondly it is also agreed that although supervision has become a key strategy in promoting an effective and efficient health service, it is often poorly understood by the health managers and the health care practitioners and lacks support in service settings.

Programme and activities focused on improvement of care for children and women in Kyrgyzstan and structure of primary health care

Currently in Kyrgyzstan primary care is defined as the first point of contact with the health care system. It is provided mainly by family doctors and paramedical staff (feldshers, midwives, nurses) who work mainly at family medicine centres (FMCs), group family medicine (GFM) and feldsher-obstetrical points (FAPs). In addition some of them work in ambulance and emergency care services.

At the top of primary health care (PHC) services are the FMCs. They are the largest outpatient health facilities and are situated in the main settlement at the oblast (region) and district (rayon) levels. They combine administrative functions as a leading coordinating institution at regional or district level, primary care and secondary outpatient care services. Their health services range from general medical care to specialized care and diagnostics. Family medicine centres provide care for children, minor surgery, rehabilitation, family planning, obstetric care, perinatal care, first aid, pharmaceutical prescriptions, certification, home visits, and preventive and health promotion services. Health personnel in FMCs usually comprise 10–20 specialists.

An important responsibility of FMCs is coordination and control functions. They are responsible for controlling the organization, staffing of GFM and FAPs located in their oblast and rayons. The staff of FMCs carries out periodic (quarterly or annual) visits to GFM and FAPs to ensure proper reporting services, and to some extent quality of care. Owing to the frequent lack of personnel at peripheral level, doctors and other senior staff working at FMC are often sent to GFM and FAPs to carry out routine clinical services. This happens on a regular basis in most FMCs.

Lastly, FMCs serve as venues for various regular meetings of medical professionals working in a given area to discuss regional health issues and problems as well as to update health care providers on the latest orders from the Ministry of Health and various programmes and initiatives, including public health programmes like Integrated Management of Childhood Illness (IMCI), Promotion of Effective Perinatal Care (PEPC), Family Planning (FP) and many others. An intermediate level of PHC in Kyrgyzstan is the GFM. GFM are staffed by at least one physician in addition to nurses and midwives, and serve towns and villages with a population of more than 2 000 inhabitants. The number of staff depends on the size of the town or village. GFM are responsible for providing comprehensive primary care to their enrolled population. To guarantee quality of care family group practices usually consist of doctors representing the three specialties, of internal medicine, paediatrics and obstetrics/gynaecology, as well as midwives and nurses. By definition GFM provide integrated primary health services to the whole family. Because small family group practices began to encounter difficulties in rendering services, given their limited capacity, a recent trend is to merge small GFM to improve quality of care and make them more cost effective.

FAPs along with GFM are the first points of contact with the health care system for patients in rural areas. Feldsher-obstetrical points were established in the Soviet period to serve small villages and remote localities with populations between 500 and 2 000. They are staffed by at least one health worker – feldsher or midwife. In larger villages, they are staffed by two or three health workers, including a nurse. Services rendered by FAPs are limited to very basic curative, antenatal and postnatal care, immunization and health promotion. Deliveries are referred to the nearest hospital. FAPs report to either the GFM or the FMCs of their rayon. Currently many FAPs are severely understaffed or even closed, existing only on paper.

The reorganization of primary care in Kyrgyzstan is still being carried out. FMCs and GFM are taking on more and more responsibilities in the health care system. In particular, they are now responsible in addition to curative services for carrying out screening interventions, immunization and social patronage (including antenatal care). An increasing amount of time is also being spent on administration and paper work.

In addition to the PHC system at the oblasts and rayons, described above, secondary level child and maternal care is provided by the children and maternity hospitals at oblast level. and children and obstetrics/gynaecology departments at rayon hospitals. Health management of these institutions is done independently from PHC system management.

Key child and maternal health programmes in Kyrgyzstan

Implementation of the majority of programmes and activities focused on improvement of maternal and child care is done within the framework and under the umbrella of the national health reform programme Manas Taalimi 2005-2010. This programme is strongly supported by various donors through a sector-wide approach to programming and planning.

One of the main objectives of the national health reform programme Manas Taalimi 2005-2010 is an improvement in the efficiency and responsiveness of the health system, through development of the holistic and integrated health care services that meet the need of the population and individuals. This programme unifies many components; its key activities in relation to child and maternal care include:

- *Integrated management of childhood illness (IMCI)*

In 2000 the Government of Kyrgyzstan adopted the IMCI approach as a key child health strategy to reduce child deaths and improve child health and development. With WHO's assistance a national IMCI centre has been established, which plays a crucial role in the institutionalization of the IMCI strategy in the country. Training of health care providers in IMCI has now been carried out in all the oblasts in the country, with coverage reaching in some districts up to 90% of the target group of doctors. Training programmes include the IMCI clinical guidelines in pre-service and post diploma training of various categories of health workers in the country. In 2008, the national IMCI guidelines were revised to include neonatal IMCI (the first week of life), and IMCI compatible guidelines at the secondary level health facilities (small hospital IMCI) have been promoted by the national IMCI centre and local health authorities.

- *Promoting effective perinatal care (PEPC)/Making pregnancy safer (MPS)*

A special programme to improve perinatal health has been developed within the framework of the national health reform programme Manas Taalimi 2005-2010. This programme aims to improve perinatal mortality during 2008-2017.

There are six main directions of work for this programme:

1. Introduction of effective technologies in maternity work
2. Regionalization of perinatal care and use of evidence based medicine approaches for the organization of care
3. Creation of mobile consultative services to provide on-site quality care to mothers and newborns, or organization of speedy referral if needed
4. Strengthening pre-service and in-service training of health professionals who provide care to mothers and newborns, based on evidence-based medicine
5. Creation of an appropriate monitoring and audit system for maternal and neonatal health
6. Creation of effective financing of perinatal care.

- *Infant and young child feeding and mother's nutrition*

In Kyrgyzstan, 13.7% of children under five years have stunted growth; for some regions, the prevalence is as high as almost 30%. In addition the prevalence of anaemia is 50% or higher in children and approximately 38% in women. To address these problems, the Ministry of Health jointly with major partners (UNICEF, WHO, the Asian Development Bank and others) are implementing a number of programmes and projects which aim to improve nutrition and micronutrient status by improving nutrition during pregnancy, breastfeeding habits, and the frequency of complementary feeding.

- *Baby-friendly initiative*

In 1994 Kyrgyzstan adopted the WHO/UNICEF programme on the protection, encouragement and support of breast feeding. The National Committee on Support and Encouragement of breast feeding was created in 1996. The main aim of the baby-friendly hospital initiative (BFHI) is to protect and encourage the practice of breast feeding through adopting “10 principles of breast feeding” and to put an end to the delivery of free or reduced cost breast milk substitutes.

During the period from 2000-2006, 31 medical facilities received the name of “Baby friendly Hospital”. In 2006, 12 more medical facilities were conferred this title. As a result of BHFI, the situation on breast feeding in the republic has improved dramatically. Today, 95.3% of infants who are discharged from maternity houses are on exclusive breast feeding. 88.5% of infants less than 3 months are on breast feeding only according to the reports of 2000-2004, 81.2% infants at the age of 6 months.

The average duration of breast feeding is about 12 months. According to research in Kyrgyzstan, 97.3% of children less than 2 years old received breast milk at this or that age. Out of this number 61% of infants of 0-3 months were on breast feeding only, 32% at the age of 4-6 months.

- *Expanded programme on immunization*

Currently Kyrgyzstan has nationally acceptable Immunization calendars which include the type of vaccinations, frequency and timing of vaccination. The vaccination coverage, in general, is satisfactorily high and drop-out rates are very low. However, the maintenance of this high level is a constant challenge, especially in view of a more mobile population, the internal migration around Bishkek and the need to expand the national immunization scheme in the future. Vaccination is free of charge. The vaccines are financed from several sources. In 2007, the Kyrgyz Government and the Asian Development Bank (ADB) each funded 50% of the vaccine purchases. In 2008, the ADB will stop funding its share. However, for the period 2007-2010 the country will receive well over one million USD from the Global Alliance for Vaccines and Immunization (GAVI).

Challenges for sustainable implementation of national priority programmes

Despite significant positive results in the implementation of maternal and child health programmes, the national health system still faces a number of important challenges which may interfere with provision of quality care especially at primary health care level. These include:

- a continuous outflow of medical staff from the system, including those services providing care for mother and children, especially in rural areas;

- insufficient level of financing for the services providing care for mothers, pregnant women and children
- the fact that the quality of maternity and child health services is still at suboptimal level;
- insufficient support by the health administrators for priority programme implementation, especially in the area of regular monitoring;
- low adherence by health workers at all levels to existing protocols and guidelines;
- low motivation of health staff at primary care level due to the financial situation, lack of supportive supervision and lack of incentives;
- insufficient coordination between different levels of the health system, and particularly weak links between the first and secondary levels of health care; and unclear division of tasks and responsibilities between these both levels;
- health staff overloaded with unnecessary administrative procedures and reporting;
- a heavy and ineffective reporting system, often implemented on programme by programme basis, often with the results not used at the peripheral level. Individual health professionals do not see the need for collected information;
- no links between the quality of health worker performance and remuneration of labour;
- poor physical infrastructure and working conditions in the primary care facilities especially in the rural areas; and
- often ineffective management at health facility level, leading to inadequate organization of work and ineffective use of the existing resources.

Suggestions for optimized MCH integrated supervisory system (OMIS)

Analysis of the current challenges shows that considerable improvement of mother and child health programmes will be essential to attaining the 4th and 5th Millennium Development Goals (MDGs). All these programmes require urgent and effective interventions. One feasible and effective solution would be developing the Optimized MCH Integrated Supervisory System, which would include key maternal and child health programmes.

The key direction at different levels of the health system should include the following steps:

National (oblast level)

- to strengthen effective use of local information
- to create a sustainable system of internal supervision, establishing close links between external and internal supervisory components
- to develop national policy on supervision and supervisory skills reinforcement

- to use integrated supervision as a tool for improving quality of maternal and child care

Health facility level

- to develop a system in which the supervisors (internal and external) will provide a vital link between service management and service delivery. The key areas of such integrated MCH supervision should include:
 1. administrative review: this review should include certain administrative aspects related to the implementation of MCH programmes (staff matters, infrastructural aspects of the facility (building, water supplies, electricity, grounds), equipment and supplies.
 2. information system review: the key objective will be to ensure the accuracy and validity of the information system, the proper use of the existing registers, the correct completion of the regular reports, and the use of data for health service planning and monitoring accomplishments at the health facility level.
 3. referral system review: this will include review and dealing with any problems with referrals, both in terms of patient movement as well as communication between health facilities and higher levels.
 4. quality of clinical care review: the correct application of standard treatment guidelines and use of the approved list of essential drugs is of great importance to ensuring high quality care. The review should concentrate on the correct use of the standard treatment guidelines by all levels of health professionals, reinforcing correct practice and insuring adherence to established standards.
 5. community involvement review will strengthen community involvement into the work of health facilities.
 6. in-depth programme review: periodically supervision should focus on the details of implementation of key maternal and child health programmes. Standard review lists will be provided by the individual programmes.
 7. capacity building: the key function of the supervisory system is to ensure that clinical staff is updated, trained and appropriately coached.
 8. problem solving: solving problems related to all aspects of the clinic is an integral part of the supervisory process.

Recommendations

During the meetings with Ministry of Health staff, relevant programme managers and partners which took place in May 2009, a list of recommendations for the development of Optimized MCH Integrated Supervisory System OMIS was discussed and agreed.

- I. It is recommended to create a national coordination committee on the quality of maternal and paediatric care and supervision.**

1. The proposed committee should be led by the Deputy Minister of Health and should include the representatives of the following key stakeholders : representatives of the relevant departments of MOH (strategic planning, medical care and MCH, Human resources, pharmaceuticals, quality care), national centre of mother and child care, National State Health insurance foundation, national coordinators of the key programmes (IMCI, EPI, BFHI, EPC/MPS, Nutrition etc.), medical attestation commission, and the national association of family doctors as well as the representatives of PHC from selected rayons and oblasts.
2. The key objective of the proposed committee will be development, coordination and support of the Optimized MCH Supervisory system (OMIS). The OMIS will use modern approaches of external and internal supportive supervision of the key MCH programmes which will be defined in the national policy on integrated supervision in Kyrgyzstan.
3. The main functions of the Committee will include: on-going analysis of the needs and challenges for the key MCH programmes in the country, development of national policy and the key documents to be used by OMIS, development of structure and main terms of reference for OMIS, and planning integrated supervisory system activities. In addition the Committee will be responsible for reviewing the existing MCH monitoring indicators in order to prepare a consolidated list of the essential indicators for routine monitoring of MCH programmes progress and quality of care at PHC level.
4. During the process of OMIS implementation the Committee will play supervisory role for the whole process. This will include monitoring the effective implementation of national policy, the tools that have been developed, and necessary follow-up on the main activities by OMIS, aiming to ensure sustainability of the system.

II. It is recommended to develop a comprehensive national policy on supportive supervision in the country. The proposed policy should include the following elements:

1. Vision and key objectives of the optimized supervisory system. OMIS should promote and support the ongoing process of reforming the health system, integration of provision of health care to the mothers and children in PHC, and ensuring quality of care at all levels with a focus on primary health care.
2. The structure of the supportive supervisory system
 - i. Who takes responsibility for supervision at different levels of the system, including the internal supervisors? Where are supervisors drawn from – external and internal? What authority do they have at different levels? What is the nature of their designation as a supervisor (external and internal)? How is the authority designated, delegated and accounted for?

- ii. What is the relationship between various levels of the supervisory system?
The relationship, authority and responsibilities of the supervisor to other institutions and the district should be defined in writing.
 - iii. How do other visiting personnel (persons from specific programmes, MOH, specialists or other occasional visitors) relate to the supervisor? What are the relations between individual programmes and supervisors?
 - iv. Roles, responsibilities and division of tasks and authorities between external and internal supervisory branches
3. The regularity of supervisory encounters and visits
 - i. Ensure that health professionals have regular encounters (meetings) with internal supervisors and visits to health facilities by external supervisors, in a regularly scheduled and planned manner. This will enable optimal use of the supervisors' time and assure that facility personnel have adequate opportunity to interact with the supervisors and participate in the various activities for which he or she is responsible.
 - ii. Define the obligation and rights of health staff in preparing for these encounters (meetings) and visits: expectation of participation, reducing patient load during scheduled hours set aside for supervision activities such as staff training etc.
 - iii. Indicate the duration of the encounters (meetings) and visits and how best this is to be done. Frequency and duration should be defined, along with the various options allowable (timing, the nature, and objectives)
4. The activities and components of a supervisory encounter (meeting) or visit
 - i. Understand and define the activities and components of an encounter/visit.
 - ii. Allocate time to prepare for the encounter/visit - follow up of previous meetings, prepare coaching and mentoring, paperwork for the meeting/visit, check with individual programme managers to determine their inputs.
 - iii. Allocate time for follow-up after encounter/visit for problem solving, contacting various services on behalf of health staff and preparing written reports.
 - iv. Link to activities the necessary responsibility and authority in writing to act on behalf of the health staff. A clear statement of the authority of supervisors will enable the supervisor to source the resources required to support the health professional and health facilities.
5. The responsibilities and functions of oblast and rayon authorities to ensure effective supervisory practises

- i. Ensure reliable availability of transport to carry external supervisors to health facilities, if needed.
 - ii. Ensure both internal and external supervisors have enough time to supervise. They require adequate time for preparation, and clinic visit follow-up and report writing to enable them to carry out the responsibilities to their health facilities and to report to their own higher authorities in an orderly way.
 - iii. Consider capacity building of supervisors in order to enable them to understand, carry out their work and to carry on quality improvement activities in their health facilities.
 - iv. Ensure that supervisors have adequate tools - including current clinical guidelines and national standards and guides to provide to clinic staff, and the authority necessary to arrange for remedial action for problems identified.
 - v. Ensure that supervisors have the necessary tools/instruments to guide, facilitate, and document supervision work. These should be used, recorded and kept in an orderly file to document supervisory activities and be available for evaluation of outcomes.
 - vi. Develop an effective system to ensure active follow-up of the findings and recommendations made during previous supervisory encounter/visit.
6. Effective use and dissemination of the results and information received during supervisory encounters/visits.
- i. Define appropriate mechanisms of dissemination and use of information received.
 - ii. Link up the outcomes of supervisory encounters/visits with existing systems of accreditation and attestation of health professionals and individual health facilities.
 - iii. Ensure that results of supervisory encounters/visits are effectively used in quality improvement activities and measures to motivate quality services provision.
 - iv. Ensure that the above results are appropriately used for monitoring and evaluation of the national policies and programmes implementation.

III. It is recommended to develop appropriate tools and guides to carry out effective supervisory encounter/visits.

1. **Supervisory manual or handbook.** This manual/handbook should serve as a main working document for supervisors at all levels of the health system. It should include key policy decisions with regard to support supervision in Kyrgyzstan; provide guidance on the organization of encounters by internal supervisors and the content of

the supervisory visits by external supervisors. In addition it will include all instruments used during encounter/visit, as well as key clinical guidelines and national standards. The supervisory manual should focus on a number of key areas and provide all necessary forms and guidelines. These areas include:

- i. **Key principles of national policy** on the optimized integrated MCH supervisory system
- ii. **Supportive supervision techniques.** Every supervisor should use and follow the key principles of supportive and encouraging interaction with the health professionals. This section will describe the definition of supportive supervision and main aspects of good communication with health staff, examples of mentoring techniques and other important communication and management tools, including guidance on how to motivate and encourage health staff in daily work.
- iii. **Health facility administration review.** The supervisor should review certain administrative aspects related to the health facility. This would include staff matters, financial matters, and infrastructural aspects of the health facility (building, water supplies, electricity, and grounds), equipment, supplies, including necessary forms, guidelines and MOH health policy documents and legal issues.
- iv. **Information system review.** A functioning PHC information system is essential for effective management. The supervisor plays a very important role in ensuring the accuracy and validity of the information system. The supervisor concentrates on ensuring the proper use of the health facility recording forms and document, the correct completion of the regular reports, the correct use of data for health service planning and monitoring accomplishments at the health facility level.
- v. **Referral pathways review.** Dealing with referral at the appropriate higher level within the system is an important element of the supervisory encounter/visit. Any problems with referrals, both in terms of patient movement as well as communication between health facilities and higher levels, will be investigated and facilitated.
- vi. **Quality of clinical care review.** The correct application of standard treatment guidelines and use of the approved list of essential drugs is of great importance to ensure high quality care. The supervisor will concentrate on the correct use of standard treatment and counselling guidelines by the health professionals, reinforcing correct practises and insuring adherence to established standards.
- vii. **Community involvement review.** Periodically the supervisor should ensure community involvement in the appropriate health facility activities. Concerns

of the community should be brought to the attention of the relevant authorities and any community problems which need urgent attention (malnutrition, disease outbreaks, etc) will be noted. The supervisor should also encourage health staff to plan and conduct specific community outreach activities on a regular basis.

- viii. ***In-depth programme review.*** During the course of the year the supervisor will conduct in-depth reviews of main important health programmes. Key programmes for review include - EPI, IMCI, care for development, maternal and perinatal care, nutrition. Standard review lists will be provided by the relevant programmes.
- ix. ***Effective use and dissemination of information*** received during supervisory encounter/visit. The manual will describe appropriate mechanisms of dissemination and use of information received. As well as how to link the outcomes of supervisory encounters/visits with existing system of accreditation and attestation of health professionals and individual health facilities. It will provide necessary guidance that can be used for monitoring and evaluation of the national policies and programmes implementation.
- x. ***Coaching and mentoring.*** The supervisor carries a major responsibility to ensure that health staff are updated, trained and appropriately coached. The supervisor will conduct coaching sessions during each encounter/visit designed to address specific needs of the health staff, covering elements of clinical service provision (updating and implementing programmatic changes), staff management (new rules and regulations related to government service) and general administration.
- xi. ***Problem solving.*** Solving problems related to all aspects of the health staff/health facility is an integral part of the supervisory process. The supervisor should engage with health staff around problems which are being experienced. Many problems can be dealt with on the spot at the health facility whilst others will have to be taken to the responsible levels. A note will be made of problems requiring solutions at a higher level and actions taken will be reviewed at the subsequent encounter/visit. The supervisor will be authorized to contact relevant authorities.
- xii. ***Personal issues.*** Health facility staff often have personal issues/problems which need to be addressed. The supervisor should be available to listen to these issues sympathetically and support and assist staff as far as she can in dealing with personal problems/issues.
- xiii. ***Set of job aids for supervisors.*** This set will include the profiles for each individual programme. These profiles are intended to help the supervisor to carry out his/her activities. They should cover: goals and objectives of the

programme, current status of implementation, key programme activities, core programme indicators and quality standards.

xiv. **Set of all forms** necessary for internal and external supervision.

IV. It is recommended to develop a consolidated list of essential indicators and monitoring key programme activities and quality of care provision

1. Review and collect all indicators currently used (or proposed) by the individual priority programmes included into the optimized MCH supervisory system (for example EPI, IMCI, maternal and neonatal health, child and maternal nutrition etc).
2. Prepare suggestions for monitoring indicators for ROUTINE monitoring of the national priority programmes to be used during supervisory encounter/visits.
3. Develop suggestions for quality indicators; these will be used at different levels of the health system for operational situational analysis.
4. Define the periodicity of the indicators' use to monitor programme implementation and quality of provided care.