WEEKLY EPIDEMIOLOGICAL REPORT

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Ministry of Health

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Supportive Supervision (Part II)

This is the second in a series of three articles on supportive supervision. The first article described the differences between control and supportive supervision, the requirements and where to conduct supportive supervisions. The next article will describe the feedback to the health care staff concerned.

The most common criteria used for selecting priority areas

- Highest no. of unimmunized children
- High dropout rates (e.g. gradually reducing number of children are coming for subsequent vaccines)
- Poor reports from previous supervision visits

Other criteria

- Areas with few or no visits in the past
- Areas with recent outbreaks of vaccine preventable diseases/AEFI
- Frequent stock problems (out of stock/ overstock)
- New staff that may need monitoring/training on immunization practices
- Problems identified by the health staff or the community
- Good coverage earlier but drop in coverage or low coverage now
- High risk districts for disease outbreaks
- Coverage rates above 100% or negative drop-out rates
- Prioritized areas ear marked for new vaccine introduction
- Areas submitting no reports or incomplete reports

When to conduct a supportive supervision visit

Once the prioritization of the areas has been done for the next quarter/year, a supportive supervision schedule should be prepared. The annual/quarterly work plan should be consulted when scheduling supportive supervision visits.

The following issues should be considered

- Visits should preferably be on days when there is a planned important event (e.g. an immunization session)
- Routine as well as mobile and outreach sessions should be supervised
- The health worker concerned should be informed regarding the schedule
- The schedule should be feasible and practical, taking into account the distance, transportation difficulties or constraints due to weather and travel conditions.
- The supervisor should schedule enough time to cover the site completely and if possible, provide on-site training.

It is important to conduct the visit according to the plan. If the visit cannot take place as planned, the health worker concerned should be informed in advance. It is important to monitor planned visits versus held visits and record the reasons for not holding any visit as planned (e.g. lack of transport, competing priorities, etc.).

The frequency of supervisory visits will vary with the situation. Problem solving and motivation of staff will demand frequent supervision if they are to result in improved performance. New Health centers or major changes in existing health centers (new staff, new responsibilities) will require frequent visits. As the center become more firmly established, the staff gain more in experience and confidence, supervisions can be reduced or reprioritized. It will be necessary, however, to undertake **at least** two visits per year to each health facility. When planning the schedule, ensure that adequate time is available; for example, it may take two hours or more to meet the needs of a single supportive supervision visit.

What to cover during the visit

It is important to have a clear understanding of the main objectives of the visit. This could include main tasks to observe or main topics on which training should be given etc. A review of previous supervision reports, checklists or data analysis can assist in identifying which topics to cover during supportive supervision visits.

Contents	*Page*

Always be prepared to use data
- Review the local data on site during the visit;

- Bring summary data, monthly reports etc. as reference material.

Although certain topics can be planned in advance, some training needs may become evident during the visit or during discussions with health staff

Supervision plan

The supervision plan should contain the name of the health-facility, when and where the supervision is to be conducted and Main topics to be covered during the supervision.

Conducting a supervisory visit

During a supervisory visit to the health facility, the supervisor should complete following main steps.

1) Collect information.
2) Problem-solving and feedback.
3) On-the-job training.
4) Recording the results of supervision

Collecting information

Supervisors can collect information using a number of methods/ tools including observing the health facility environment and the health worker giving immunizations, listening to health workers, reviewing the records, using a checklist, talking with parents and community members, reviewing recommendations from past visits and by conducting a rapid community survey etc.

Observing the health facility environment and the health worker giving immunizations.

Supervisors can obtain a lot of information by simply observing the health facility environment. For example, they may observe the following.

- Is the health facility clean?
- Are IEC posters, monitoring charts displayed on the walls?
- Are there any used syringes or open safety boxes lying around that can pose a threat to the community?
- Are there frozen or expired vaccines in the refrigerator?
- Is the health worker integrating well with the community and informing them about the services provided?

As a supervisor, you should watch the health worker doing the work, rather than simply listen to health staff talking about what he/she usually does. When observing the health worker, watch how he/she load the refrigerator, screen the infants, prepare vaccines, immunize children, complete tally sheets and immunization registers, handle used needles and syringes and communicates with parents.

Important-Do not intervene or correct the health worker while he/she is working (unless you feel that harm will be done to the visiting child or mother without your intervention).

Listening to the health staff

Listening to health workers' concerns is critical in providing appropriate support. During discussions with health workers, you should explain the purpose of your visit and offer them the opportunity to share their concerns. If possible, try to meet with each staff member individually, and explain the reason for the visit.

Sample questions to ask individual health workers

- Are they able to get their work done? If not, why?
- Do they have any particular interest in any particular aspect of their job?
- Do they have any ideas about how the health facility can be organized better to give a better service to the community?

Try to ask questions that require more than a "yes" or "no" answer. For instance, ask open-ended questions.

Example of a closed-ended question-"Do you know how to use the VVM?"

Example of an open-ended question-"How would you know if the vial should to be discarded?"

Reviewing data and using a supervisory checklists

Reviewing can provide useful information about health worker's performance. It may also provide information on any gaps in the knowledge and skills of health workers or alternatively any lack of equipment.

Talking to the parents and community members

Talking with parents and members of the community is the only way supervisors can learn how community members view the health services provided. It is especially useful to talk to women as they leave the health centre (exit interviews) and to visit members of the community associations.

Problem solving and feedback

Problem solving with staff

Step 1: Describe the problem and its impact

- Focus on the problems, not individuals
- Be sure and identify if the problem is due to lack of skills or due to an external factor that prevents the health worker from doing his/her job
- Explain the impact (long term/short term) of the problem.
- Tackle one problem at a time.
- Be specific in explaining the problem.
- If possible, back it up with facts rather than judgment alone

Step 2: Discuss the causes of the problem with health staff

- Discuss the causes of the problem with health staff
- "Ask why" repeatedly.
- This should not be an opportunity to blame others or blame the system
- It may sometimes be necessary to seek causes in other sources (e.g. community members, data etc). Prioritize causes according to those that can be addressed more easily.

Step 3:Implement solutions and monitor regularly

- Suggested solutions should reach a common consensus regarding what needs to be done and by whom.
- Solutions that can be implemented easily should be implemented first
  e.g. training on how to assemble a safety box
- Develop an implementation plan that details what, how, who and when
- Follow up progress

Compiled by Dr. Madhava Gunasekera of the Epidemiology Unit

Supportive supervision, available from

whqlibdoc.who.int/hq/2008/WHO_IVB_08.04_eng.pdf

to be continued

Table 1: Vaccine-preventable Diseases & AFP

07th – 13th April 2012 (15th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2012	Number of cases during same week in 2011	Total number of cases to date in 2012	Total number of cases to date in 2011	Difference between the number of cases to date in 2012 & 2011
	W	C	S	N	E	NW	NC	U	Sab					
Acute Flaccid Paralysis	00	00	00	00	00	00	01	00	00	01	00	25	24	+ 04.2 %
Diphtheria	00	00	00	00	00	00	00	00	00	-	-	-	-	-
Measles	00	00	00	01	00	0	00	0	00	01	00	18	33	- 45.4 %
Tetanus	00	00	00	00	00	00	00	00	00	00	00	03	05	- 40.0 %
Whooping Cough	01	02	00	00	02	00	00	00	00	05	00	29	12	+ 141.6 %
Tuberculosis	16	00	00	01	02	00	00	10	00	29	00	2531	2243	+ 12.8 %

Table 2: Newly Introduced Notifiable Disease

07th – 13th April 2012 (15th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2012	Number of cases during same week in 2011	Total number of cases to date in 2012	Total number of cases to date in 2011	Difference between the number of cases to date in 2012 & 2011
	W	C	S	N	E	NW	NC	U	Sab					
Chickenpox	10	03	07	05	07	09	05	02	05	53	23	1684	1507	+ 11.7 %
Meningitis	00	00	00	00	03 KM=1 AM=1 TR=1	00	00	01 BD=1	01 RP=1	05	04	204	289	+ 29.4 %
Mumps	14	01	02	01	18	10	06	04	10	66	17	1543	603	+ 155.9 %
Leishmaniasis	00	00	02 MT=2	00	00	00	07 PO=7	00	00	09	04	206	218	+ 05.5 %

Key to Table 1 & 2

Provinces: **W**: Western, **C**: Central, **S**: Southern, **N**: North, **E**: East, **NC**: North Central, **NW**: North Western, **U**: Uva, **Sab**: Sabaragamuwa.

DPDHS Divisions: **CB**: Colombo, **GM**: Gampaha, **KL**: Kalutara, **KD**: Kandy, **ML**: Matale, **NE**: Nuwara Eliya, **GL**: Galle, **HB**: Hambantota, **MT**: Matara, **JF**: Jaffna, **KN**: Killinochchi, **MN**: Mannar, **VA**: Vavuniya, **MU**: Mullaitivu, **BT**: Batticaloa, **AM**: Ampara, **TR**: Trincomalee, **KM**: Kalmunai, **KR**: Kurunegala, **PU**: Puttalam, **AP**: Anuradhapura, **PO**: Polonnaruwa, **BD**: Badulla, **MO**: Moneragala, **RP**: Ratnapura, **KG**: Kegalle.

Data Sources:

Weekly Return of Communicable Diseases: Diphtheria, Measles, Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps.

Special Surveillance: Acute Flaccid Paralysis.

Leishmaniasis is notifiable only after the General Circular No: 02/102/2008 issued on 23 September 2008.

Dengue Prevention and Control Health Messages

To prevent dengue, remove mosquito breeding places in and around your home, workplace or school once a week.

Table 4: Selected notifiable diseases reported by Medical Officers of Health

07th – 13th April 2012 (15th Week)

DPDHS Division	Dengue Fever / DHF*		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Returns Received
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	%
Colombo	47	2486	2	39	0	5	3	69	0	24	3	49	0	2	0	18	0	1	**77**
Gampaha	43	1960	0	29	1	3	1	27	0	9	4	67	0	5	5	88	0	0	**60**
Kalutara	13	679	0	33	0	2	0	16	0	3	1	80	0	1	0	6	0	1	**46**
Kandy	17	608	1	28	0	1	0	9	0	10	0	23	2	58	2	10	0	0	**87**
Matale	1	145	0	27	0	4	0	7	0	4	1	14	0	2	0	5	0	0	**58**
Nuwara	2	110	2	49	0	1	1	17	0	1	0	10	0	27	0	7	0	0	**54**
Galle	10	403	0	34	0	3	0	6	0	4	4	57	0	17	0	1	0	0	**68**
Hambantota	1	174	0	16	0	0	0	2	0	7	1	24	0	20	0	4	0	0	**42**
Matara	19	528	3	28	0	4	0	9	4	15	5	59	0	32	0	47	0	0	**100**
Jaffna	9	189	7	76	0	5	6	163	5	18	0	2	1	227	0	2	0	0	**100**
Kilinochchi	1	16	0	6	0	1	0	12	0	39	0	3	0	21	1	2	0	1	**75**
Mannar	0	65	0	9	0	2	0	11	0	13	0	15	2	33	0	1	0	0	**60**
Vavuniya	1	25	0	5	0	17	0	2	0	3	0	14	0	0	0	1	0	0	**100**
Mullaitivu	0	4	1	7	0	1	0	3	0	1	0	2	0	4	0	0	0	0	**50**
Batticaloa	9	481	0	43	0	1	1	10	6	11	0	4	0	0	0	3	0	1	**86**
Ampara	4	34	2	36	0	0	0	2	4	5	0	14	0	0	0	1	0	0	**86**
Trincomalee	1	71	2	55	0	1	0	15	0	1	0	18	1	3	0	1	0	0	**83**
Kurunegala	14	422	2	44	0	6	1	35	0	8	3	53	0	14	1	23	0	1	**74**
Puttalam	4	312	0	22	0	2	0	2	0	1	1	18	1	8	0	1	0	0	**50**
Anuradhapu	5	123	1	24	0	1	1	3	0	1	0	38	0	16	0	25	0	0	**58**
Polonnaruw	1	77	0	11	0	0	0	1	0	0	0	17	0	2	2	26	0	1	**86**
Badulla	2	76	2	29	0	2	1	13	0	1	1	15	2	21	2	18	0	0	**76**
Monaragala	2	70	2	26	0	3	1	8	0	0	2	35	2	36	7	82	0	0	**91**
Ratnapura	9	472	3	80	1	19	0	19	0	2	0	104	1	16	0	45	0	0	**56**
Kegalle	5	456	1	24	0	6	1	12	0	5	1	42	0	18	3	186	0	0	**64**
Kalmune	0	112	0	71	0	1	0	5	0	13	0	1	0	0	0	5	0	1	**62**
SRI LANKA	**220**	**10098**	**31**	**851**	**02**	**91**	**17**	**478**	**19**	**199**	**27**	**778**	**12**	**583**	**23**	**608**	**00**	**07**	**71**

Source: Weekly Returns of Communicable Diseases WRCD).
***Dengue Fever / DHF** refers to Dengue Fever / Dengue Haemorrhagic Fever.
****Timely** refers to returns received on or before 13th April, 2012 Total number of reporting units 329. Number of reporting units data provided for the current week: 234
A = Cases reported during the current week. **B** = Cumulative cases for the year.

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Comments and contributions for publication in the WER Sri Lanka are welcome. However, the editor reserves the right to accept or reject items for publication. All correspondence should be mailed to The Editor, WER Sri Lanka, Epidemiological Unit, P.O. Box 1567, Colombo or sent by E-mail to **chepid@sltnet.lk.**

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