GUIDE FOR INTEGRATED SUPERVISION OF PERIPHERAL HEALTH CENTRE WORKERS ON CASE MANAGEMENT NEGLECTED TROPICAL DISEASES

(CM-NTDs)

To be used by district health management team members.

September 2015

TABLE OF CONTENTS

INTRODUCTION

Supervision is critical to performance enhancement of health systems staff, and contributes to effective planning towards improving logistics and performance optimization for better health outcomes. For effective conduct of this activity, the following are mandatory: Supervision guides; data collection grids and tools; preparation and monitoring of actions.
The guide will provide orientation on principles, objectives, methods, frequency and supervision grids so as to harmonize supervision of health staff at peripheral level for case management neglected tropical diseases (CM-NTDs). Supervision is important and beneficial for health systems, and has these advantages:

For the level conducting supervision:

- Situational analysis in real time and solution proposals, following reliable data collection and identification of problems and challenges;
- Contribution to health policy changes through relevant information input during supervision rounds.

For health facilities:

- Performance enhancement;
- Evaluation and adjustment of technical facilities;
- Identification of structural lapses and solution proposals.

For supervised health staff:

- Capacity building and in-service professional training;
- Scaling up staff motivation and incentives;
- Improving management of health services;
- Interactions with supervisors.

For effective supervision, there is need for a simple but well-grounded monitoring system that makes for systematic large data collection and good appraisal of the state of the system. The monitoring system must include:

- Well-defined functions of key supervision players, namely supervisors and those supervised;
- Required resources, such as facilitating logistics, funding and supervision tools.

This guide is meant for district health management teams to help them supervise peripheral health workers in charge of managing the five neglected tropical diseases: Leprosy, Buruli ulcer (BU), endemic treponematoses (yaws, pinta, endemic syphilis), leishmaniasis and human African trypanosomiasis (HAT). It offers a variety of supervision tools (task observation grid or form; checklist of resources or tasks; and interview guides) enabling frontline health workers to accomplish essential tasks. With this, every district health management team member should be able to carry out health worker supervision, without possessing complete expertise in methods of diagnosis and treatment of CM-NTDs cases.

I. Background information on supervision

1.1. Definition

One of the underlying causes of failure of most health programmes is the virtual absence of consistent and efficient supervision. Just as training, evaluation, information systems and logistics are support activities, supervision equally supports health workers and ensures that health-care services are of good quality and sustainable.

Operationally, "…supervision is a process which aims to appraise performance, incentives and working conditions of workers with a view to improving service delivery". It is a dynamic and holistic process that brings out all positive aspects in the human being, and is based on mutual trust.

The supervisor is to help in stimulating creativity in health workers and to assist them in situational analysis, assessing aspects of an issue and in proposing alternative solutions and identifying the most efficient one. In so doing, health workers acquire some self-confidence and maintain their self-esteem.

1.2. Aim of supervision

Supervision aims to guide, support and assist staff to enable them perform tasks that are assigned them.

1.3. Basic principles of supervision

The supervisor must remember some principles in order to come to terms with certain situations:

- Supervision must be done in an atmosphere of respect and consideration for the human being;
- Supervisors' authority emanates from their professional ability and not from their caprices;
- Supervision is a cooperative and participatory process;
- The individual, in the process, normally aspires to learning and self-development;
- The human being reacts physically and emotionally to supervision;
- Supervisors also bring on board their emotional burden;
- People have their own ideas of comportment that need to be respected;
- Attitudes change and prejudices are modified in the face of new experiences. This, however, is a slow and gradual process;
- For fear of innovations, people resist change but fear flees in the face of knowledge;
- Common sense tells us that supervision entails a huge responsibility, given that the supervisor works with human beings;
- Supervisors must know and always have in mind that each action of theirs (whatever their magnitude) contributes to developing in supervised workers a new attitude, with respect to their work;
- Supervisors are staff managers; this means they guide staff through supervision;
- The aim of supervision is to enhance efficiency of the institution or organization in question; it helps in providing services of better quality at lowest possible cost for the benefit of community. It also helps workers to attain exceptional carriers and derive from their daily work some personal satisfaction;
- The supervisor animates the organization, and gives orientation to accompanying strengths. The quality of supervision maintains and enhances the vitality of services;
- Supervisors must be innovators and also ensure that programme instructions are carried out. Supervisors without innovative qualities may create an atmosphere of unproductivity,

if their supervision is without inspiration, thereby forcing staff to work under restrictions and preconceived and rigid working relationships;

- Supervisors reduce the distance between administration objectives and aspirations of workers. They understand the desires and interests of both parties and try to reconcile them;
- Each institution needs to define its own philosophy of supervision, make it known to its workers and inculcate it into its supervisors;

1.4. Functions of supervision

Supervisors in their activities basically undertake three (3) functions:

1) Guidance;
2) Control;
3) Performance appraisal.

The importance of each supervision function depends on the level supervised: peripheral; intermediate; central.

1.4.1. Guidance as essential component of supervision

Supervisors are the immediate managers of health workers. As such, they have the day-to-day duty of ensuring guidance. For effective supervision, workers need to be trained and the list of tasks made available to them. While new information or instruction needs to be provided in writing to facilitate good communication among collaborators, it is equally essential to have direct and regular interaction with staff. Such interaction is, first of all, of utmost importance for knowing what actually goes on (in all aspects of work, particularly those that are never covered by any data); and secondly, to whip up working enthusiasm among staff. Direct interaction is important on two fronts: for ensuring effective functioning of programmes and stimulating staff morale and commitment.

The main functions of guidance in supervision consist in helping workers to better carry out their work by making sure of:

- Orientation and training;
- Assistance in resources and logistics;
- Support, encouragement and defence of rights;
- Monitoring and Evaluation and feedback.

The role of the supervisor should be that of a resource person who lends support to subordinates to address issues, and not that of a censor who always criticizes them. Workers should be happy seeing supervisors, rather than trying to hide from them.

One of the essential qualities of the supervisor must be that of a teacher-adviser. Guidance is the most important approach available to the supervisor for assisting workers in recognizing their reasons for their own success or failure, and to encourage them to assume responsibility in achieving progress and attainment of their objectives.

The guidance process involves oral communication, using work assessment as basis of all dialogue. Open discussions between supervisor and worker bring about inspiration and individual needs. Also, common objectives are identified, and ways and means of achieving expected outcomes are discussed, while working methods and evaluation criteria are agreed on.

1.4.1.1. Prerequisites of effective guidance

Generally, supervision and particularly guidance, requires some skills and availability. Obstacles come up when these qualities are lacking. Following are some indispensable prerequisites for developing the guidance function:

- Knowledge of overall mission of the organization in question; its structure; its service delivery system; duties of workers on various posts and levels;
- Knowledge of technical standards of service delivery as well as administrative standards.
- Thorough job description of each employee;
- Effective team player; capable of recognizing the rights and needs of others; and accepting instructions and supervision of own supervisors;
- Communication skills;
- Readiness to request assistance from professionally more qualified people;
- Readiness to listen and consider points of view and ideas of the supervised person;
- Readiness to admit dynamic changes that affect supervisor and/or the supervised person in their work and status.

1.4.1.2. Obstacles to guidance

These obstacles come up when:

- Supervisors are afraid to share their authority;
- Supervisors find it difficult to praise supervised staff for their qualities and criticize their shortcomings without offending or frustrating them;
- Supervisors have difficulty in asking probing questions and responding adequately to questions;
- Supervisors see it as a sign of weakness when they allow supervised staff to set their own objectives and assume responsibility for addressing their own problems.

1.4.2. Control during supervision

In supervision, if guidance aims basically to improve output of each staff member, then control has to do with managing the institution and organizing health care, i.e. on the supervised staff's ability to carry out tasks assigned to them with maximum efficiency and effectiveness. Control means:

- Checking to ensure that policies, plans and procedures defined by health authorities are properly adhered to;
- Ascertaining whether tools and instruments validated by health authorities are properly used at required frequency;
- Ascertaining whether institutional policies established and enforced at the periphery level are in line with overall policies put in place by health authorities;
- Analysing strengths and weaknesses of service and assisting staff in question to adhere to overall policies, plans, standards and procedures put in place by health authorities.

1.4.3. Individual performance appraisal during supervision

It is an approach that helps to appraise aspects relating to quality and volume of work produced by a staff member within a given period. The primary purpose of performance appraisal is to help staff members to evaluate their own output with a view to improving their performance.

II- Organizing supervision

Supervisors must guide; support; provide assistance to staff; manage conflicts; and solve problems. Organizing good supervision calls for a set of rules, procedures to adhere to, and especially use of appropriate tools.

2.1. Supervision tools

Supervision tools are basically made up of:

- Critical task observation forms or grids;
- Checklists for activities and resources (material and financial);
- Interview guides or questionnaires for interviews.

These are instruments used to record observations, and are also used to draft the supervision report. Examples and models of supervision tools are in annexe.

2.2. Supervision protocols

There cannot be supervision without prior development of supervision protocols. The supervision protocol helps to answer the following questions:

- Who is to be supervised?
- On what tasks, aspects or functions should emphasis be placed?
- How should this be done?
- When should it be done?

- ‘Who’ refers to the supervision target, i.e. the supervised staff;
- ‘What’ refers to responsibilities of the staff to be supervised. It seeks to find out how tasks are performed out and their quality.
- ‘How’ relates to the resources used to execute these tasks. Resources may be observed or assessed through interview or analysis of personal records.
- ‘When’ has to do with the frequency and period when activities are implemented.

2.3. Frequency of supervision

This is the timetable and frequency of supervision visits.

3. Supervision stages

Three stages:

- Stage 1: Pre-supervision visit;
- Stage 2: During supervision;
- Stage 3: Post-supervision visit;

3.1. Stage 1: Pre-supervision

Two approaches are of importance:

3.1.1. Preparing a supervision timetable

It is the duty of the district management team to prepare a periodic supervision timetable indicating places to be visited, dates, time and professional groups to be mobilized. The timetable is forwarded

sufficiently in advance to departments concerned by the supervision in question. This approach enables officers of areas to be visited to get ready and ensure availability of their staff.

3.1.2. Preparing each supervision visit

1. Determine the aim of supervision.
2. Prepare visit as follows:
    a. Analyse previous supervision reports;
    b. Select specific areas and aspects to be investigated;
    c. Outline activities to be conducted during supervision (observatory visits; meetings; interviews, etc.) and specific tasks to be conducted.
    d. Decide on the time needed to successfully carry out these activities.
3. Mobilize needed resources:
    a. Human, financial, material resources or logistics;
    b. Distribute tasks to be executed during supervision among various selected team members, not forgetting the appointment of a team leader.
    c. Choose grids or checklists to be used during supervision.
    d. Identify reference documents needed for each area to be supervised.

3.2. Stage 2: During supervision

3.2.1. Meeting with officer-in-charge and key staff for:

a. Introducing objectives of the visit and assuring staff;
b. Explaining process of visit and describing activities to be conducted;
c. Taking stock of application of recommendations made during previous supervision visit.

3.2.2. Supervising selected activity areas subject to implementation of visit plan, and using supervision tools (see annexes).

3.2.3. Organizing feedback meeting with main officer and key staff for:

a. Presenting supervision results;
b. Analysing problems and proposing solutions;
c. Drawing up a problem-solution plan with a specific timeline and assignment of specific duties for specific tasks.

3.2.4. Organizing of meeting with main officer for:

a. Determining resources to be mobilized, if necessary, for implementation;
b. Examining individual performance issues and deciding on required administrative and technical solutions.

3.3. Stage 3: Post-supervision visit

Three approaches are necessary:

- Evaluating supervision;
- Drafting and distributing supervision report;
- Organizing follow-up of supervision.

3.3.1. Evaluating supervision

This is an important stage that enables the supervision process and outcomes to be evaluated. This self-evaluation by the supervision team should be conducted within 72 hours following the supervision visit.

Following is a checklist for self-evaluation:

- Was supervision conducted in line with established plan? If no, what are lessons learnt for the future?
- Did each supervision team member play their role to the satisfaction of the team? Is there need for supervision competence of members to be strengthened?
- Were selected supervision areas exhausted in all aspects?
- Did the tools used (protocols, checklists, supervision grid) facilitate supervision? Or is there need for other instruments to be developed?
- Was each team member friendly and positive?
- Did the team examine problems, concerns and level of skills of staff in work performance?
- Did the team provide staff with immediate feedback of supervision results by emphasizing aspects to be improved?
- Did the team draw up a supervision follow-up plan with staff?
- Did the team congratulate staff on strengths identified?
- Did the team sum up major outcomes of the visit with main officer and plan future follow-up and support supervision visits?

3.3.2. Drafting supervision report

This report should be written within 15 days following supervision, with copies sent to:

- the area supervised;
- team members;
- regional/provincial directorates concerned;
- the national coordinator;
- the Director General;
- the office of the minister

Outline proposed for writing supervision report (see annexes).

3.3.3. Organizing supervision follow-up

There are issues supervisors may be able to address just after returning from the facility supervised (or even during the supervision visit), while other problems may be solved within a reasonable time frame. For others, their solution approaches depend on a higher level. Each supervisor, following analysis of preliminary data, must communicate issues to a higher level and follow up until a solution approach is applied. The supervisor should inform the area supervised of the steps taken and the outcomes expected.

CONCLUSION

This guide is part of a set of documents developed by the WHO Regional Office for Africa and includes: The regional integrated strategy for managing cases of neglected tropical diseases; the revised version of terms of reference and mode of operation of the regional review group of the NTD Programme; the manual for integrated management of CM-NTDs to be used by peripheral

health centre workers; the monitoring and Evaluation guide for CM-NTDs control programmes, and this guide for supervision of health workers at peripheral level for managing NTD cases.

This set of orientation documents aims to strengthen integration and/or pooled activities and interventions for controlling five CM-NTDs, which are priority diseases in the African Region: Leprosy; Buruli ulcer; endemic treponematosis; leishmaniasis and human African trypanosomiasis. This supervision guide is meant for use by members of district health management teams in supervising health workers dealing with management in peripheral health centres.

This guide, as well as other strategic and orientation documents, will be distributed in all countries under the WHO African Region that are endemic for CM-NTDs, in order to make the documents available in all health districts. It is our hope that district health management team members and national officers of control programmes of the five CM-NTDs will find this supervision guide useful for enhancing control of CM-NTDs, and that it will help them contribute to reducing the burden of these NTDs, thereby reaching the objectives of control, elimination and eradication of NTDs by 2020.

ANNEXES: Supervision tools and report

List of CM-NTDs supervision tools

1. General dermatological examination
1.1. Critical tasks to be observed for diagnosis
1.2. Critical tasks for treatment

2. Leprosy
2.1. Critical tasks to be observed for diagnosis
2.2. Critical tasks to be observed for treatment

3. Buruli ulcer
3.1. Critical tasks to be observed for diagnosis
3.2. Critical tasks to be observed for treatment

4. Yaws
4.1. Critical tasks to be observed for diagnosis
4.2. Critical tasks to be observed for treatment

5. Cutaneous Leishmaniasis
5.1. Critical tasks to be observed for diagnosis
5.2. Critical tasks to be observed for treatment

6. Visceral Leishmaniasis
6.1. Critical tasks to be observed for diagnosis
6.2. Critical tasks to be observed for treatment

7. Human African Trypanosomiasis
7.1. Critical tasks to be observed for diagnosis
7.2. Critical tasks to be observed for treatment

8. Checklist of resources

9. Interview guide
9. 1. Interview with other health workers
9. 2. Interview with health services clients
9. 3. Interview with community

1. GENERAL DERMATOLOGICAL EXAMINATION

1. 1. Critical tasks to be observed for diagnosis

Tasks to be performed	Appraisal criteria	HF1:		HF2:	
		YES	NO	YES	NO
Interviewing a patient with skin lesion	**Key questions asked:** Beginning; evolution; pains; pruritus, contact and treatment received;				
Clinical examination of a patient with skin lesion					
Close and distant examination	Good lighting (day light) and respect for privacy				
	Inspection of entire body				
	Description of lesions: macule, papule, pustule, number, dimension, adenopathy…				
Palpating lesions	Look out for induration, nodule, scaling, heat and pain				
Test of sensitivity of cutaneous lesions	Conducted in three phases: Explanation to patient (1), followed by test with eyes open (2) then test with eyes closed (3) with cotton wick				
	Cotton wick-suspect finger dialogue				
Examining superficial nerve trunks, sensitivity and motor testing of eyes, and limbs;	In event of sensitivity disorders on skin lesions				
Sampling of skin tissue for lab examination	In case of suspected BU lesion, cutaneous leishmaniasis or yaws				
Search for osteoarticular damage	In case of suspicion of Buruli ulcer				
Blood sampling and CSF for lab examination	In case of suspicion of HAT (sleeplessness, mental disorders) and visceral leishmaniasis				

1.2. Critical tasks to be observed for treatment

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Prescription on basis of lesion category					
Explanation on treatment					
Administration of medication	Dosage; duration; frequency; completeness				
Choice of treatment supervision strategy	Different options proposed to patient (monthly supervision, flexible, advanced strategy, accompanied MDT; community MDT, etc.…)				
Counsel during treatment	Adverse events, allergy to medication;				
What to do in case of complications …	Leprosy reactions; inconsistent reaction in BU Skipping daily dose; Travel; Stay in another health zone.				
Supervision of treatment					
Questions asked about previous treatment	Regularity, side effects, leprous reactions, empty strips (e.g. leprosy)				
Hand treatment to patients	Appropriate PB/MB strip; adult/child (e.g. leprosy)				
Supervise absorption of RMP, DDS (et CLO)	Help patient in removing tablets; give water (e.g. leprosy)				
Supervise treatment administration	Injection around ulcer (leishmaniasis)				
Indicate administration of drugs in information handouts	Treatment form; patient card				
Recall for remaining treatment	Number of months/strips remaining to be taken				
Recall date of next appointment	Next appointment date				

2. LEPROSY

2.1. Critical tasks to be observed for diagnosis

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Interviewing a suspected leprosy case or reactions	Key questions asked				
Clinical examination of suspected leprosy					
Close and distant examination	Good lighting (day light) respect of privacy				
	Entire body examined				
Sensitivity test of clear cutaneous patches	Conducted in three phases				
	With cotton wick				
	Cotton wick-suspect finger dialogue				
Palpation of superficial trunk nerves					
PCS	Head turned in opposite direction of examined side				
	Palpation to eliminate blood vessel				
Ulnar	MS at right angle				
	Palpation above elbow duct				
	Bilateral comparative palpation				
SPE	MI at right angle				
	Palpation at the popliteal fossa, at the back of the fibular head				
Posterior tibial	Palpation behind and above the MI				
Tests of sensitivity and nerve ends					
Eyes	Look out for reddening, reduction of eye-blinks				
	Search for lagophthalmos				
	Test for forced opening of eyelids				
	Visual acuity test				
Hands	Use of ballpoint pen and blocking of the hand				
	Conducted in three phases on at least four sites				
Feet	Use of ballpoint pen; comfort of patient				
	Conducted in three phases on at least four sites				
Disability scale, WHO	Correct degree 0, 1 or 2; eyes, hands and feet				
	Maximum degree indicated (0, 1 or 2)				

2.2 Critical task observation form for leprosy treatment

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Prescription of PCT/MDT					
Classification into PB or MB	Adhering to criteria 1 - 5 and more than 5 lesions				
Explaining principle of PCT/MDT to patient	Dosage, duration, frequency, completeness				
Choice of strategy for supervising PCT/MDT	Different options proposed to patient (monthly supervision, flexible, advanced strategy, accompanied PCT/MDT; community PCT/MDT, etc.…)				
Counsel during PCT/MDT	Side effects, allergy to drugs				
What to do in case of …	Leprous reactions Skipping daily dose Travel, stay in another health zone				
Supervision of PCT/MDT treatment					
Questions asked about previous treatment	Frequency, adverse events, leprous reactions, empty strips.				
Handing PCT strip to patient	Appropriate PB/MB strips; Adult/child				
Supervise absorption of RMP, DDS (and CLO)	Help patient to remove tablets; give water				
Record PCT/MDT administration in information forms	Treatment form; patient card				
Recall for remaining treatment	Number of months/strip remaining to be taken Next appointment date				
Prescription of Prednipac					
Appraisal of severity of reaction	Adherence to of severity criteria				
Ignore contra indications (CI) of treatment	Questions about CI of corticosteroid therapy				
Explaining corticosteroid therapy to patient	Aim, dosage, frequency, decreasing doses				
Handing Prednipac	Strip handed according to frequency of supervision				
Recalls of advice during corticosteroid therapy	Diet, once morning dose				
Record taking of Prednipac in information forms	Treatment form; patient card				
Recall of next visit date	Next appointment date				

2.2 Critical task observation form for leprosy treatment (cont'd)

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Neurological follow-up examination					
Receiving patient	Welcome address; comfortably seated				
Guidance on neurological functions	Questions on sensitivity motor ability of nerve ends (eyes, hands and feet)				
Interviewing on self-care (at home or in groups)	Questions asked on self-care and outcomes				
Ascertain neurological status of patient during previous examination	verifying follow-up records and patient card				
Palpation of main superficial trunk nerves					
PCS	Head turned in opposite direction of side examined				
	Palpation to eliminate a blood vessel				
Ulnar nerves	MS at right angle				
	Palpation above E-O duct				
	Bilateral comparative palpation				
SPE	MI at right angle				
	Palpation at popliteal fossa, behind fibular head				
Posterior tibial	Palpation behind and above MI				
Sensitivity and nerve ends motor ability test					
Eyes	Look out for reddening, reduction in eye-blinks				
	Search for lagophthalmos				
	Test of forced opening of eyelids				
	Visual acuity test				
Hands	Use of ballpoint pen and blocking of hand				
	Conducted in 3 phases on at least 4 sites				
Feet	Use of ballpoint pen, comfort of patient				
	Conducted in 3 phases on at least 4 sites				
Scale of disabilities, WHO	Correct degree 0, 1 or 2 on eyes, hands and feet				
Scale with YMP score	Degree by site 2Y, 2M and 2P (0 - 12)				

3. BURULI ULCER

3.1. Critical task observation form for diagnosis

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Guidance a suspected Buruli ulcer case	Identity				
	Profession				
	Coming from an endemic region				
	Reason for consultation				
	History of patient				
	Related signs:				
	Characteristics of living environment				
Clinical examination of Buruli ulcer suspected case	Examine whole body under good lighting				
	Examine suspected lesions attentively				
	Height				
	Wounds with peeled edges yellow-looking, necrotic and relatively not painful; absence of satellite lymph nodes				
	Locating lesions				
	Look out for limited movement at the joints				
	Check temperature (normally, absence of fever in BU), blood pressure, weight.				
Conclusions of clinical examination	Lesion categorisation				
Biological confirmation of Buruli ulcer	Sampling conducted				
	Each lesion is sampled twice				
	Packaging samples				
	Transporting samples				

3.2. Critical task observation form for treating Buruli ulcer

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Treatment					
Antibiotic therapy	Availability of antibiotics				
	Adherence to prescription conditions				
	Advice on regularity of taking drugs				
	Adherence to injection conditions (IM, asepsis…)				
	Correct filling out of treatment form				
	Monitoring side effects				
Dressing/bandaging	Availability of bandages				
	Determining ulcer evolution phases				
	Adherence to aseptic conditions				
	Compliance with appropriate care type according to ulcer evolution				
	Compliance with dressing frequency				
Prevention of joint movement limitation	Joint movement during dressing of wounds				
	Putting limbs and joints in functioning position, if necessary, using splints				
	Advice to patient on joint movements				
	Passive and active movement of limbs immediately wound-healing process starts				
	Referring at-risk cases for complementary physiotherapy				

4. YAWS

4.1. Critical tasks to observe for yaws diagnosis

Tasks to perform	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Interviewing a suspected yaws case	Age				
	Community				
	Painful lesions				
	Itching				
	Bone pains at night				
	General signs: fever, uneasiness etc.				
	Similar case at home, school or in community				
Clinical examination of a suspected yaws case					
Close examination	Good lighting (daylight)				
	Respect of privacy				
	Whole body examined				
Detailed examination of lesion	Determine:				
	Consistency of papilloma				
	Softening of bones and joints				
	Base not hardened on upturned edges and crusty floors in ulcer				
	Scales on macules				
	Sole and palm hyperkeratosis				
General clinical examination	Palpate to determine hypertrophy and Softening of lymph nodes				
Determination of clinical form of lesion	Early phase:				
	Papilloma				
	Ulcer				
	Macule				
	Papule				
	Maculo-papule				
	sole/palm				
	Mixed form				

Tasks to perform	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
	Late phase				
	Chronic osteitis and periostitis				
	Tibia saber				
	Juxta-articular nodules				
	Gangosa				
Observation of serological test procedures (place of treatment if test is available)	Gathering of test kit				
	Observation of asepsia				
	Test procedure				
	Correct interpretation of test results				
	Correct disposal of used kit				
Correct diagnosis of yaws	Was diagnosis correctly carried out?				
	Is the clinical form correct?				
	Were lesions classified into “early” and “late” forms?				

4.1. Critical tasks to be observed for yaws treatment

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
TRAITEMENT					
Prescription of Azithromycin oral/benzathin penicillin					
	Does the health worker at the centre give the right dose?				
	Is information on side effects/allergy given?				
	Management of side effects/allergy				
Follow-up of treatment	Did patient have a follow-up appointment?				
	Does worker evaluate failure of treatment				
	Is benzathin penicillin administered in case of treatment failure?				
	Is PCR swab used in case of treatment failure?				

+Test Kit, gloves, lancet, and alcohol swab gathered on a clean surface

5. CUTANEOUS LEISHMANIASIS

5.1. Critical tasks to be observed for diagnosis of cutaneous leishmaniasis

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Interview a suspected cutaneous leishmaniasis case	Key questions asked				
Clinical examination of a suspected cutaneous leishmaniasis case					
Close and distant observation	Good lighting (day light), respect privacy				
	Complete body examination				
Description of skin lesions (mention existence or not of following characteristics)	Papule, nodule or plate				
	Central crust covering ulcer				
	Ulcer with edges surrounded by variable induration				
	Painless lesion				
	“Dry” or “wet” ulcer (severe inflammation)				
	Duration of state (date or when patient noticed lesion)				
	Satellite papules				
	Swelling of lips or nose				
	Nodular lymphangitis				
Collect clinical information on five aspects of skin lesions in order to determine treatment to prescribe	Size of lesion (cm)				
	Number of lesions				
	Location of lesions on body				
	Evolution of lesions: duration, aggravation (active lesion), improvement (self-healing)				
	Immunological or general health status of patient: immune-compromised or not, diabetic, heart/kidney/liver disorders; pregnant or not.				
Other aspects of clinical diagnosis	Past history of CL events				
	CL cases in the family				
	Previous treatment received for current lesions				
	History of travels in last 6 months				
Categorization of situation according to WHO algorithm	Situation 1, 2 or 3 is correct				

5.2. Critical tasks to be observed for treatment of cutaneous leishmaniasis

Tasks to be performed	**Evaluation criteria**	**HF1:**		**HF2:**	
		YES	NO	YES	NO
Prescription for treatment					
Categorization in situation 1 - 3	Criteria are correctly applied. Treatment is compatible with the "Situation "				
Explanation to patient of treatment options	Advantages and disadvantages, dosage, duration, completion.				
Advice given to patient to opt for antimony (or other drugs against leishmaniasis)	Side effects, allergy				
What to do in the event of ...	Omission of scheduled injections; Travel outside or absence from health area				
Quality of intra-lesional injection	Product is withdrawn aseptically				
	Antimony is injected into lesion and the edge whitened until lesion is entirely swollen				

6. VISCERAL LEISHMANIASIS

6.1. Critical tasks to be observed for diagnosis of visceral leishmaniasis

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Interviewing a suspected visceral leishmaniasis case (LDPK included)	Key questions asked Fever for more than two weeks; Abdominal swelling; Weakness and weight loss; Exclude malaria; Living in an area endemic for VL or travel history; History of treatment for VL; For how long? Other symptoms: cough, diarrhoea?				
	Skin lesion (LDPK: no itching; no loss of sensitivity; traditional medication; old treatment for VL				
Clinical examination of a suspected VL case					
General health status of patient; check for fever; BMI (body mass index)	Good lighting (day light), respect of privacy				
	Record vital signs of patient (temperature, pulse, blood pressure) Record weight of patient and calculate BMI				
	General health status of patient: cachexia/wasting, cannot walk, etc.				
Physical examination: head, eyes, ears, throat, nose: pallor, mouth infection	Examine the conjunctiva, tongue, palm paleness				
	Examine the oral mucous for mouth infection				

Tasks to be performed	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Palpation of lymph nodes	Palpate the axillary and inguinal lymph nodes Measure size of palpable lymph nodes				
Abdominal examination for splenomegaly and hepatomegaly	Hypertrophy of the spleen? size				
	Hypertrophy of the kidney? size				
Examination of the tegumentary and lower extremities	Skin rash, wound, oedema of the feet				
	Characterize the lesion: type, extension, sensation, secondary infection Characterize the lesion: type, extent, sensitivity, secondary infection Grade de LDPK				

6.2. Critical tasks to be observed for treatment of visceral leishmaniasis

Tasks to perform	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Diagnosis tests done					
Malaria excluded	TDR/microscopy, treatment with antimalarial drugs				
Criteria met for definition of VL case	Patient meets definition of VL case				
TDR for VL For patients whose diagnosis of VL is not confirmed at first visit and are selected for follow-up (clinical and repetition of TDR for VL)	Run test with correct procedure Correct interpretation of test results				
Referral of suspected or confirmed cases to VL treatment centre	Good use of referral forms Referral of suspected VL relapse cases All relevant information is documented in referral folder Register for referral cases Follow-up of referred cases				

7. HAT

Critical task observation form for diagnosis and treatment of HAT

Tasks to be performed	Evaluation criteria	Replies		Observations
		YES	NO	
Interview of a suspected HAT case	Identity			
	Profession			
	Usual place of residence			
	Reason for consultation			
	Notion of stay or residence in an endemic area			
	Past history of HAT in individual or family			
	General signs or symptoms considered to be revealing of HAT			
Clinical examination of suspected HAT case	Is nodal palpation systematically done?			
	Is nodal palpation well done?			
Serological testing of suspected HAT case	Is serology test correctly performed?			
Confirmation of HAT case	Is lymph node puncture well performed?			
	Is nodal fluid correctly examined?			
	Are unconfirmed suspected cases referred?			
Treatment	Are 1st stage patients managed?			
	Were patients correctly treated?			
	Is treatment form correctly filled out?			

8. CHECKLIST FOR RESOURCES AND TASKS

8.1 Leprosy

RESOURCES	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Items for information collection					
Patient clinical forms	1 clinical form per patient under treatment and 5 forms reserved				
PCT treatment notebook	Available with blank sheets of paper				
Patient cards	5 blank cards reserved				
Periodic report forms	QS until end of year				
Stock form	At least 1 per type of strip of PCT and Prednipac boxes				
Neurological follow-up register (Pod register)	Use of YMP score, quarterly or bi-yearly				
Medicines					
MBA	1 box of 6 + strips of MBA cases in Ttt				
MBE	1 box of 6 + strips of MBE cases in Ttt				
PBA	1 box of 6 + strips of PBA cases in Ttt				
PBE	1 box of 6 + strips of PBE cases in Ttt				
Prednipac	1 box + strips of treated reagents				
IEC material					
Content of images	Early signs, signs of reaction				
Message content	Positive message: healing; free treatment				
PoD demonstration material					
Steeping basin, pumice stone, mineral oil, shoes, gloves	Availability of kit for hands and feet				
Mirror, eye glasses, eye drops, etc.	Availability of kit for eyes				
TASKS: Filling out various forms/documents					
Clinical forms	1 well filled out form for each patient				
Treatment notebooks	Complete list of cases under PCT, notebook updated				
Leprosy register	Updated				
Neurological follow-up register (PoD register)	1 updated register for followed-up patients				
Stock form (PCT and Prednipac)	1 updated stock form by type of strip				
Copy of periodic report (quarterly, annual)	Presence of copies of dispatched reports				

8.2. Buruli Ulcer (BU)

RESOURCES	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Information collection material					
Clinical and treatment forms of new cases (BU 01)	1 clinical form per patient under treatment and 5 forms reserved				
Register of new BU cases (BU 02)	Available				
	Correctly filled out				
Request form for lab confirmation (BU 03)	Available				
	Correctly filled out				
Post-antibiotic treatment follow-up form	Available				
	Correctly filled out				
Stock form	Available for each product				
	Updated				
Medicines					
Rifampicin	Stock available for complete treatment				
	Emergency stock				
	Expiry date				
Streptomycin	Stock available for complete treatment				
	Emergency stock				
	Expiry date				
Clarithromycin	Stock available for complete treatment				
	Emergency stock				
	Expiry date				
Bandages/dressing					
	Availability of boxes of bandage				
	Sterilisation material available and functional				
	Consumables available				

8.3 Yaws

RESOURCES	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Information collection material					
Recording of yaws cases in HF (clinical evaluation form)	Available				
Recording from register	Available with one blank copy				
Summary of treatment form (large scale)	Available with one blank copy				
Monthly report form of centre	12 forms available				
Individual case card	Available with one blank copy				
Stock management card for Azithromycin/benzathin Benzyl Penicillin	Available				
Medicines					
Azithromycin	Quantity to treat 5 patients and 10 contacts at centre at all times				
Benzathin benzyl penicillin	Availability of 5 bottles in stock				
IEC Material					
Image book for recognizing yaws in the community	Early signs and symptoms				
Posters and working tools on yaws.	Attractive; information messages encouraging				
TASKS: Filling out various documents					
Personal patient card	One is correctly filled out by patient				
Health centre register	Treatment recorded; up-to-date				
Summary of large-scale treatment form	Up-to-date				
Monthly report form of centre	Up-to-date				
Stock of cards	Up-to-date				

8.4. Cutaneous leishmaniasis

RESOURCES	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
Data collection forms					
Patient medical file (Clinical evaluation form)	1 form per patient under treatment and 5 new ones in reserve				
Treatment register of CL	1 with pages available				
Treatment cards	5 new ones in reserve (quantity to be adapted according to number of patients per month)				
Forms for monthly report	Sufficient until end of year				
Stock card	At least 1 for each drug and medical equipment				
Injection drugs and material					
Derivatives of pentavalent antimony	Sufficient ampoules for 3-month period				
Injection material	Sufficient ampoules for 3-month period				
IEC material					
With photos	Different types of lesion and charts to help in differential diagnosis				
Content of messages	Positive message: treatable and free				
TASKS: Fill out patient files, forms and notebooks					
Medical file of patient and treatment cards	1 report and 1 card duly filled out by patient				
Treatment register	All patients are registered, and up-to-date				
Register (district or regional level)	Updated				
Stock cards	At least 1 for each drug and medical equipment/material				
Monthly report forms	Copies of reports dispatched				

8.5. Visceral leishmaniasis

RESOURCES	Evaluation criteria	HF1:		HF2:	
		YES	NO	YES	NO
TDR					
	Where do you find TDR?				
	Right brand of TDR of VL available				
	Expiry date of TDR for VL				
	Regular follow-up of stock with stock cards				
	Algorithm of TDR pasted in laboratory				
	1 test per patient				
Data collection forms					
Patient clinical record	1 clinical evaluation record per patient				
Lab test	1 lab test record per patient				
Referral	1 form per patient for referral				
IEC Material					
Content	Definition of VL case Photos of signs of advanced VL Photos of LDPK				
Content of messages	Positive message: treatable and free, information on VL treatment centre Periodic health education for the community in health facility				
TASKS: Fill out patient records, forms and notebooks					
Patient medical record and treatment cards	1 records file and 1 card duly filled out by patient				
Referral notebook	Referral notebook duly filled out				
VL register (district or regional level)	Updated and duly filled out				
Case report is in order	Quarterly report on suspected LV/LDPK cases/referrals duly filled out				
Stock cards for TDR	Stock cards duly filled out				

8.6. HAT

RESOURCES	Evaluation criteria	Response		Observations
		YES	NO	
Data collection material				
Consultation register	In stock			
	Correctly kept			
Record of new HAT cases	Available			
	Correctly filled out			
Laboratory register	Available			
	Correctly filled out			
Patient treatment card	Available			
	Correctly filled out			
Drug stock form (Pentamidin)	Available			
	Updated			
Reagent stock card	Available			
	Updated			

9. INTERVIEW GUIDES

9.1. Generic guide for interview with a health worker

People to be interviewed	Questions	HF1:		HF2:	
Other health staff		YES	NO	YES	NO
	What is your role in patient management?				
	Who performs diagnosis and treatment?				
	Who confirms diagnosis?				
	Who prescribes treatment?				
	Who takes care of?				
	Who fills out management documents in your centre?				
	How many cases have been seen in your centre during the quarter?				

9.2. Guide for interview with recipients of health-care delivery

Care recipients		HF1 Replies	HF2 Replies
	How many days of treatment did you receive, and how many days more do you have for treatment?		
	Has your state of health improved since you started treatment?		
	How much do you pay for your treatment?		
	Have you got information on the disease?		
	Are you satisfied with services received thus far from the health centre?		

9.3 Guide for interview with community

People to be interviewed	Questions	HF1:		HF2:	
Local authorities and leaders		YES	NO	YES	NO
	What are the working hours of your health centre?				
	Are there cases currently being treated in your centre?				
	Is active surveillance carried out in your district?				
	How much do diagnosis and treatment cost?				

9.4. Specific Interview Guides

9.4.1. On leprosy

People to be interviewed	Questions	HF1:		HF2:	
Leprosy case with reaction		YES	No	YES	No
	Is your current status related to the strips of PCT you took?				
	How many times a day and at what time do you take medicine against your state of reaction?				
	Can you stop treatment if your condition improves before the end of prescribed treatment?				
	How much did you pay for treating reaction?				
Person affected by leprosy (PAL) with disability degrees 1 or 2					
	What were you told to arrest worsening of your health status?				
	Are you a self-care group member?				

9.4.2. On yaws

People to be interviewed	Questions	HF1:		HF2:	
Other health staff		YES	No	YES	No
	How many contacts were treated in your centre in the last quarter?				
	What is the importance of latent yaws in eradicating yaws?				
Local authorities and leaders					
	Do health workers follow up on cases to treat contacts in your community?				
	Has the school in your community been visited by health workers with respect to yaws?				

9.4.3. On cutaneous leishmaniasis

People to be interviewed	**Questions**	**HF1:**		**HF2:**	
Health staff		YES	NO	YES	NO
	What is your role in management of CL patients?				
	Who ensures CL diagnosis and treatment are done?				
	Who prescribes treatment?				
	Who fills out CL reports or cards in your facility?				
Local authorities and leaders					
	What time does your health centre open?				
	Are there currently CL cases being treated in your health facility?				
	What day do CL patients come for injection?				
	How much do CL diagnosis and treatment cost?				
Other health staff					
	Who requests for RDT test for suspected VL cases?				
	Who runs the RDT test for suspected cases?				
	How many VL/PKDL cases were suspected/confirmed in your centre in the last 3 months?				
	How many patients were referred for VL/PKDL treatment?				
	What is the part PKDL plays as a reservoir for transmission?				
Local authorities and leaders					
	Is the VL RDT test free? If it is not, how much does it cost?				
	What vector control measures are generally applied to prevent VL?				

9.4.4. On visceral leishmaniasis

People to be interviewed	**Questions**	**HF1:**		**HF2:**	
Health staff		YES	NO	YES	NO
	What is your role in management (diagnosis and referral) of VL patients?				
	Who ensures diagnosis and referral are done for treating VL cases?				
	Who requests for testing of VL suspected cases?				
	Who performs TDR for suspected VL cases?				
	How many VL/LDPK cases were suspected/confirmed in the last three months in your facility?				
	How many patients were referred for treatment for VL/LDPK?				
	Who fills out report forms or VL cards in your facility?				
	What is the involvement of LDPK as transmission reservoir?				
Local authorities and leaders					
	What are the working hours of your health centre?				
	Are there any VL cases currently under treatment in your health facility?				
	Is TDR for VL free? If no, what is the cost of this TDR?				
	Is active surveillance part of the programme of VL control in the municipality?				

9.4.5. On HAT

People to be interviewed	**Questions**	**Replies**
Other health workers of centre		
	Who performs serological suspicion of HAT?	

10. SUPERVISION REPORT

SUPERVISION REPORT MODEL

Names of supervisor(s):……
Qualification of supervisor(s)…….
Date of supervision ……..
Health facility: ……
Names of persons supervised ……
……
Qualification of persons supervised……
……
Supervision activities carried out:
Observations made on critical tasks:…(score of correctly performed tasks)
……..……
……
Control of resources and tasks ……..
……
……
People interviewed: ……
……

POSITIVE ASPECTS
……
……
…….

ASPECTS TO BE IMPROVED
……
……
……
……
……
……

RECOMMENDATIONS, ACTION POINTS, PROPOSED MEASURES FOR IMPROVING SERVICE DELIVERY
……
……
……

Agreed date for next supervision:

SIGNATURE(S) OF SUPERVISOR(S): SIGNATURE(S) OF PERSONS SUPERVISED

NB: Report to be prepared in at least 3 copies; 1 for the person supervised; 1 for the supervisor; and 1 sent to the immediate supervisor.