WEEKLY EPIDEMIOLOGICAL REPORT

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Ministry of Health, Nutrition & Indigenous Medicine

231, de Saram Place, Colombo 01000, Sri Lanka
Tele: + 94 11 2695112, Fax: +94 11 2696583, E mail: epidunit@sltnet.lk
Epidemiologist: +94 11 2681548, E mail: chepid@sltnet.lk
Web: http://www.epid.gov.lk

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Supportive Supervision (Part I)

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

Supportive supervision is a process of helping staff to improve their own work performance continuously. It is carried out in a respectful and non-authoritarian way with the focus of using supervisory visits as an opportunity to improve knowledge and skills of the health staff. Supportive supervision encourages open twoway communication and builds team approaches that facilitate problem-solving. It focuses on monitoring performance towards goals, using data for decision-making and depends on regular follow-up with staff to ensure that new tasks are being implemented correctly. Supportive supervision is helping to make things work, rather than checking to see what is wrong.

Traditionally, many countries have used an authoritarian, inspection or control approach to supervision. This approach is based on the thinking that health workers are unmotivated and need strong outside control to perform correctly. However, it has been shown that a supportive approach, where supervisors and health workers work together to solve problems and improve performance, delivers improved results for the programme. Table 1 compares the characteristics of the control approach and the supportive approachThe three main Rs for an effective supportive supervision system are:

1) **Right Supervisors**- a core set of supervisors, well trained on supportive supervision techniques and with updated information and skills.
2) **Right tools-** availability of training materials and job aids to update skills of health workers during supervision visits, checklists and forms for re-cording recommendations and follow up
3) **Right resources-** sufficient vehicles, time for supervision and follow-up.

Training a core of supportive supervisors

As the supervisors will be providing on-the-job training to health workers, it is important that the supervisors themselves are well informed and trained. The initial step will be to provide refresher training for the core set of supervisors.

To identify the training needs of supervisors, start by asking the following questions:

- Have there been major changes in the system which requires training (e.g. introduction of new vaccines, new policies or reporting procedures)?
- Do the supervisors require training on supportive supervision techniques and participatory approaches (e.g. problem identification, problem-solving, time management, two-way communication, coaching, on-site training etc.)
- Are there areas that can be strengthened by supportive supervision and will therefore require supervisor training? You may, for instance, decide that the country's disease surveillance needs to be enhanced and therefore supervisors themselves need training.

Control approach	Supporting approach
Focus on finding faults with individuals	Focus on improving performance and building relationships
Supervisor is like a policeman	More like a teacher, coach, mentor
Episodic problem solving	Use local data to monitor performance and solve problems
Little or no follow-up	Follow-up regularly
Punitive actions intended	Only support provided

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Right tools

Preparing a supervisory checklist

The supervisory checklist is a list containing priority issues that must be observed and recorded by the supervisor. The checklist helps the supervisor to focus on priority issues and reminds him/ her to observe and record them. **The information collected should help the supervisor to decide what corrective action can be taken during the visit and what issues need to be followed up for action in the longer term.**

A checklist contains items to be checked at EVERY site visit. How-ever, it should not deter the supervisor from recording and following up on other critical issues that he/she has observed but that are not included in the checklist.

Three 'S's for a good quality checklist are:

- **Short-**should include only priority areas to observe and re-cord during supportive supervision visits. If the list is too long, filling it will become a mechanical exercise.
- **Specific-**Items should be specific, with details on what ex-actly needs to be observed. For exaample, a question such as "Does the health worker dispose of used syringes appro-priately?" is not specific, but "Does the health worker dis-pose of used syringes in the safety box?" is more specific. The information collected should be critical and should help in taking managerial decisions.
- **Simple-**Additional observations or comments should be easy to record.

e.g. Vaccine and cold-chain management Is there an up-to-date stock recording system? Is the Vaccine Vial Monitor (VVM) be-ing used?

Monitoring and use of details the monitoring chart used regularly to track immunization performance? What does it tell you about access, drop-outs and completion of the schedule? Include re-view of monitoring charts.

Communication with parents and links with the community Are parents informed about the next visit and about side effects of drugs and vaccines?

How many meetings are held per year with the community to discuss/plan services?

Immunization safety- Observation of injections/ are all used sy-ringes disposed of in safety boxes?

Planning- review of session plan and work plan

Preparing learning materials and job aids

As supervisors will be providing on-the-job training, it is impor-tant to have standard materials available that are specific to the skills that need to be improved. These can be used to prepare for training; supervisors can refer to these during Unittraining sessions and health workers can use them for practice and ref-erence. For health-facility staff, materials with clear explanations on how to do a particular task, preferably with drawings, worked examples and practice exercises are the most useful. The su-pervisor needs to be well prepared and fully knowledgeable about the topic and materials

Different training methods that a supervisor could use to help on site training

- Participatory exercises
- Group discussion
- Small group work
- Case study
- Practical exercises
- Demonstrations/ presentations
- Role playing
- Question and answer sessions

Job aids

A job aid is a learning product available for on-the-job training which is designed to facilitate correct performance of the task by extending the performer's capability to retain and utilize information. It is also called quick or easy reference. Often these are paper-based and posted on the wall in plain sight or in a small reference notebook. They can also take the form of posters, cards, manuals etc. **It might be useful to carry a known accurate thermometer along with other job aids.**

Job aids are useful as they target specific tasks or skills and allow the health worker to quickly refer to them without having to search through long training manuals.

Some examples of job aids:

1. National immunization schedule.
2. Checklist of things to carry to an outreach site.
3. One-page sheet with pictures showing how to administer different vaccines.
4. Poster put on the refrigerator showing how different vac-cines should be stored.
5. Poster showing methods to prevent freezing.
6. Poster with standard case definitions and disease pic-tures.

When setting up a supportive supervision system, you need to en-sure that adequate resources are available. In addition to scheduled visits, supervisors should be able to interact with staff at opportunities such as monthly or quarterly meetings.

Planning regular supportive supervision visits

Planning for supportive supervision visits should be an integral part of the annual/quarterly work-planning exercise. It is impor-tant to look at the data when planning for supervision visits.

The plan should indicate: Where to conduct visits When to conduct visits

What are the objectives to cover during the visit Where to con-duct supportive supervision visits

Prioritizations of the areas need to be done. Peripheral areas will generally need more supportive supervision visits. Immuni-zation data and information from previous supervision visits can be used to select priority areas for supervision.

Source :

Supportive supervision, available from

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

Compiled by Dr. Madhava Gunasekera of the Epidemiol-

to be continued….

Table 1: Selected notifiable diseases reported by Medical Officers of Health 24th - 30th Sep 2016 (40th Week)

RDHS Division	Dengue Fever		Dysentery		Encephalitis		Enteric Fever		Food Poisoning		Leptospirosis		Typhus Fever		Viral Hepatitis		Human Rabies		Chickenpox		Meningitis		Leishmaniasis		WRCD	
	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	A	B	T*	C**
Colombo	143	13427	1	135	0	11	0	51	22	57	6	237	0	7	0	38	0	0	6	366	0	51	0	0	88	100
Gampaha	16	5519	1	120	0	14	0	23	0	34	0	269	0	15	0	35	0	1	0	335	0	37	0	7	20	80
Kalutara	27	2855	1	85	0	9	1	30	0	29	2	362	0	7	0	24	0	1	4	233	4	78	0	0	79	100
Kandy	51	3448	2	138	0	16	0	20	0	33	1	108	2	84	1	46	0	0	3	183	0	35	0	9	83	100
Matale	5	840	0	49	0	1	0	12	0	4	2	83	0	19	0	16	0	1	1	31	0	52	0	17	62	92
NuwaraEliya	6	359	2	87	0	3	1	53	0	36	2	53	1	63	0	34	0	0	1	119	1	37	0	0	100	100
Galle	55	1865	3	120	0	8	0	7	0	8	6	228	0	98	0	9	0	0	0	242	1	34	0	3	60	90
Hambantota	7	665	1	60	0	1	0	5	0	58	0	92	1	58	3	94	0	0	1	193	0	14	6	274	83	100
Matara	15	1023	1	105	1	14	0	7	0	38	3	158	1	47	4	37	0	0	4	157	0	22	6	172	100	100
Jaffna	26	1801	21	256	0	6	0	74	2	56	3	15	4	587	0	8	0	0	2	148	1	53	0	1	100	100
Kilinochchi	2	70	1	37	0	1	0	36	0	9	0	13	0	24	0	1	0	0	0	10	0	10	0	0	100	100
Mannar	0	117	1	34	0	4	0	22	0	9	1	10	0	39	0	0	0	0	0	7	0	3	0	0	60	80
Vavuniya	1	215	0	13	0	4	2	86	0	33	0	13	0	10	0	6	0	0	0	26	0	10	0	6	75	75
Mullaitivu	3	155	1	25	1	3	0	17	0	40	0	24	0	6	0	2	0	1	0	20	2	9	0	6	80	100
Batticaloa	3	454	14	263	0	3	0	41	6	98	1	42	0	6	0	11	0	0	4	92	1	14	0	1	71	93
Ampara	1	220	0	47	0	2	0	0	0	21	0	26	0	0	1	10	0	0	5	141	0	4	0	7	57	86
Trincomalee	1	354	0	50	0	2	0	11	0	24	0	30	0	24	0	33	0	2	3	132	0	11	0	11	83	92
Kurunegala	12	2101	3	261	0	11	0	4	1	14	2	138	0	40	2	24	0	3	6	289	1	50	6	88	83	93
Puttalam	5	921	2	76	0	4	0	6	1	1	0	38	0	61	0	3	0	1	0	77	1	51	0	4	57	71
Anuradhapura	16	607	4	85	0	3	0	6	1	27	0	252	0	25	0	15	0	1	6	206	1	37	2	203	42	79
Polonnaruwa	3	389	2	37	0	4	0	12	0	13	1	86	1	3	0	3	0	0	1	111	0	16	1	106	43	57
Badulla	30	722	1	107	0	13	1	11	0	27	3	114	2	99	2	109	0	0	8	203	2	169	0	3	82	94
Monaragala	4	347	2	76	0	1	0	3	0	11	1	156	2	114	1	119	0	2	3	64	1	20	0	33	82	100
Ratnapura	15	2489	4	305	0	29	0	25	1	24	5	467	0	32	3	160	0	0	3	192	0	133	0	1	61	83
Kegalle	7	1212	0	71	0	19	0	32	0	52	5	159	1	29	1	23	0	0	5	273	2	46	0	2	64	100
Kalmune	0	436	0	84	0	3	0	5	1	44	0	18	0	0	0	3	0	4	2	80	0	22	0	0	46	92
SRILANKA	454	42611	68	2726	2	189	5	599	35	800	44	3191	15	1497	18	863	0	17	68	3930	18	1018	21	954	72	92

Source: Weekly Returns of Communicable Diseases (WRCD).

*T=Timeliness refers to returns received on or before 30th September, 2016 Total number of reporting units 339 Number of reporting units data provided for the current week: 316 C**-Completeness

A = Cases reported during the current week. B = Cumulative cases for the year.

Table 2: Vaccine-Preventable Diseases & AFP

24th - 30th Sep 2016 (40th Week)

Disease	No. of Cases by Province									Number of cases during current week in 2016	Number of cases during same week in 2015	Total number of cases to date in 2016	Total number of cases to date in 2015	Difference between the number of cases to date in 2016 & 2015
	W	C	S	N	E	NW	NC	U	Sab					
AFP*	00	00	00	00	00	00	00	00	00	00	00	53	56	-5.3%
Diphtheria	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Mumps	01	00	00	01	01	00	00	00	00	03	06	304	303	+0.3%
Measles	00	02	01	00	01	00	00	06	00	10	29	340	2278	-85.0%
Rubella	00	00	00	00	00	00	00	00	00	00	00	08	08	0%
CRS**	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Tetanus	00	00	00	00	00	00	00	00	00	00	00	08	14	-43.1%
Neonatal Tetanus	00	00	00	00	00	00	00	00	00	00	00	00	00	0%
Japanese Encephalitis	00	00	00	00	00	00	00	00	00	00	00	15	07	+114.2%
Whooping Cough	00	01	00	00	00	01	00	00	00	02	00	56	77	-27.2%
Tuberculosis	81	14	13	06	02	03	08	09	18	154	274	7167	7609	-6.1%

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.

RDHS 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, Neonatal Tetanus, Whooping Cough, Chickenpox, Meningitis, Mumps., Rubella, CRS,

Special Surveillance: AFP* (Acute Flaccid Paralysis), Japanese Encephalitis

CRS** =Congenital Rubella Syndrome

AFP and all clinically confirmed Vaccine Preventable Diseases except Tuberculosis and Mumps should be investigated by the MOH

Number of Malaria Cases Up to End of September 2016,

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All are Imported!!!

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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. **Prior approval should be obtained from the Epidemiology Unit before publishing data in this publication**

ON STATE SERVICE

Dr. P. PALIHAWADANA
CHIEF EPIDEMIOLOGIST
EPIDEMIOLOGY UNIT
231, DE SARAM PLACE
COLOMBO 10