Managing programmes on reproductive, maternal, newborn, child and adolescent health

Module 3: Managing implementation
Managing programmes on reproductive, maternal, newborn, child and adolescent health

Module 3: Managing implementation

Adapted for the South-East Asia Region based on the WHO publication on “Managing Programmes to Improve Child Health (2009)”
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Managing programmes on reproductive, maternal, newborn, child and adolescent health
Foreword

The WHO South-East Asia Region has in recent years accelerated reductions in maternal, newborn and child mortality. Between 1990 and 2018 the Region’s estimated decline in under-five and neonatal mortality was around 72% and 62%, respectively. Between 2000 and 2017 the Region achieved a decline in the maternal mortality ratio of more than 57%, and between 2000 and 2019 reduced the stillbirth rate by 50%.

Member States are to be commended on the path-breaking change they have achieved. Progressive improvements in the coverage of evidence-based interventions for reproductive, maternal, newborn, child and adolescent health (RMNCAH) are responsible for the Region’s progress and must continue to be strengthened to ensure that no person or community is left behind.

To fill remaining gaps, well planned and managed programmes are needed. Such programmes will improve the population-based coverage of evidence-based interventions and thus reduce maternal, newborn and child morbidity and mortality. This will in turn facilitate the fulfillment of the Region’s Flagship Priorities and the achievement of the Sustainable Development Goal targets.

The technical programme planning and management cycle required to strengthen RMNCAH services has two parts: first, the strategic planning cycle at the national level; and second, the implementation planning cycle at the sub-national level. The training materials contained herein address the second part of the cycle – implementation planning – and include an introductory module which is followed by modules on planning and managing implementation, as well as a guide for facilitators. The draft materials have been pilot tested in countries in the South-East Asia Region, as well as some countries in African Region, and reflect the wisdom and input of participants from all countries and regions.
I am certain that these modules will help build the skills of programme managers at national and sub-national level across the Region, and will scale-up the provision of evidence-based interventions that will achieve lasting gains, in line with the Region’s Flagship Priority on accelerating reduction of maternal, newborn and child mortality. I urge all stakeholders to make full use of these modules as together we continue to drive real change in the lives of women and children across the Region, for a healthier, more equitable and sustainable future for all.

Dr Poonam Khetrapal Singh
Regional Director
Abbreviations

AIDS  acquired immunodeficiency syndrome
ANC  antenatal care
ART  antiretroviral therapy
ARV  antiretroviral
BEmONC  basic emergency obstetric and newborn care
CEmONC  comprehensive emergency obstetric and newborn care
EmONC–NA  emergency obstetric and newborn care – needs assessment
CHW  community health worker
DHS  demographic and health survey
EBF  exclusive breastfeeding
EPI  Expanded Programme on Immunization
ENC  essential newborn care
FP  family planning
Hib  haemophilus influenzae type B
HIV  human immunodeficiency virus
HMIS  health management information system
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>IMNCI</td>
<td>Integrated Management of Newborn and Childhood Illnesses</td>
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<tr>
<td>IPT</td>
<td>intermittent preventive therapy (for malaria)</td>
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<tr>
<td>ITN</td>
<td>insecticide-treated bednet</td>
</tr>
<tr>
<td>IYCF</td>
<td>infant and young child feeding</td>
</tr>
<tr>
<td>LBW</td>
<td>low birth weight</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goal</td>
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<tr>
<td>MICS</td>
<td>multiple indicator cluster survey</td>
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<td>MDR</td>
<td>maternal death review</td>
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<tr>
<td>MDSR</td>
<td>maternal death surveillance and response</td>
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<tr>
<td>MoH</td>
<td>Ministry of Health</td>
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<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
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<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
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<tr>
<td>ORS</td>
<td>oral rehydration solution</td>
</tr>
<tr>
<td>ORT</td>
<td>oral rehydration therapy</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission (of HIV)</td>
</tr>
<tr>
<td>PNC</td>
<td>postnatal care</td>
</tr>
<tr>
<td>RMNCAH</td>
<td>reproductive, maternal, newborn, child and adolescent health</td>
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<tr>
<td>RMNCH</td>
<td>reproductive, maternal, newborn and child health</td>
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<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children's Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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Managing programmes on reproductive, maternal, newborn, child and adolescent health
Managing implementation

Fig. 1. Steps to manage implementation are described in this module

Steps do not need to follow any direction. Can enter the cycle at any point, based on the needs.
Introduction

Managing implementation is the process of getting activities and tasks done according to an implementation plan. A number of different skills are important for managing implementation, and this module outlines some that are required to successfully implement reproductive, maternal, newborn, child and adolescent health (RMNCAH) programmes. Management skills are often general skills that cut across technical areas.

To ensure that activities are carried out according to the implementation plan, and that programmes are implemented effectively, managers should be able to:

- Advocate for RMNCAH to secure commitment from policy-makers, donors, staff and communities.
- Mobilize resources, including human, material and financial resources, so that activities can be implemented as planned.
- Manage effective use of human, material and financial resources.
- Organize supervision to ensure that health staff receive routine supportive supervision that motivates them, ensures quality and solves problems.
- Monitor progress in implementing activities by analysing data that are collected regularly.

Learning objectives

At the end of this module, you will understand the principles of:

- advocating for RMNCAH;
- mobilizing resources to help with implementation;
- administering supportive versus punitive supervision;
- monitoring the progress of programme activities.

You would have practised:

- preparing and giving an advocacy presentation;
- preparing a presentation to ask for support from a strategic/implementing partner;
- preparing a letter of intent for a donor;
- calculating quantities of medicines/materials needed;
- monitoring expenditures;
- analysing common problems found during supervision;
- giving feedback during supervision;
- analysing monitoring indicators to identify successes and problem areas.
Advocate for reproductive, maternal, newborn, child and adolescent health

Advocacy is essential for securing support – political, financial and material – for RMNCAH programmes. Support at all levels – from policy-makers, managers, health staff to communities – is required to implement programmes effectively. Advocacy includes all communication activities directed towards generating this support.

**Advocacy** is the act of presenting your case persuasively before a target audience

Advocacy is a set of targeted actions that aim to generate support for programme implementation at all levels
Advocacy aims to ensure:

- political will for the allocation of budgets and other resources towards RMNCAH;
- sharing of resources between ministries to assist RMNCAH programmes;
- community support for RMNCAH initiatives to enhance involvement of nongovernmental organizations (NGOs);
- more support from donors for RMNCAH activities.

Politicians and policy-makers respond to pressure from the public. Accordingly, one of the roles of advocacy is to raise the profile of RMNCAH activities among the general public.

Advocacy activities may include:

- conducting meetings with individuals and groups, e.g. groups of adolescent boys and girls;
- leveraging mass and print media;
- organizing workshops on particular issues with key stakeholders;
- circulating technical reports and data relevant to RMNCAH, including situation analysis reports, to identified audiences.

**Fig. 3. Examples of advocacy objectives**

**Examples of advocacy objectives**

- Campaign for strengthening the coverage and access to maternal, newborn, child and adolescent health services in order to reduce disproportionate burden of maternal, neonatal and child mortality among poor, rural and marginalized sections of the population.
- Promote better linkages between RMNCAH services.
- Emphasize the importance of eight antenatal care (ANC) visits and the importance of institutional delivery.
- Raise the profile of neglected aspects of RMNCAH, such as postnatal care, adolescent health, appropriate complementary feeding for infants, and cervical cancer screening for women.
- Encourage the participation of community groups in health education.
- Campaign for a human rights approach to RMNCAH.
1.1 Review policy and programme changes needed

Advocacy can be directed at any area of policy or programming where changes are needed. Decide on specific objectives for your advocacy. Consider the following points:

- What are the RMNCAH problems or issues that need to be addressed by advocacy?
- Which policy or programme changes will address the problem most effectively?
- What action should be taken, by whom and when?

Advocacy can aim for:

- general public support for RMNCAH or a particular component of it that has been neglected;
- additional financial resources for RMNCAH;
- allocation of more staff for RMNCAH, or training of new categories of staff;
- greater community involvement with primary health care activities;
- promotion of new areas of RMNCAH that have not received much attention, such as postnatal care, neonatal care, postpartum family planning, adolescent health and cervical cancer screening;
- promotion of technical policies in areas such as breastfeeding and complementary feeding;
- promotion of key family practices such as sleeping under an insecticide-treated bednet (ITN), care-seeking for illnesses, healthy eating habits, or keeping the environment clean.

1.2 Identify the target audience

When identifying a target audience, consider which group or groups are able to change current policies or practices, or to provide support. Decision-makers and the general public are important target audiences. Advocating to the public can create a favourable climate for RMNCAH policies and activities. Target audiences for advocacy can include:

- policy-makers at the national and subnational levels
- development partners
- health workers
- professional associations
• NGOs, civil society and private sector organizations
• media and other opinion leaders
• religious and community leaders
• communities and families.

To have a better understanding of the target audience, find out:
• What does the target audience know about RMNCAH?
• What does the target audience need to know?
• What can the target audience do to influence the objective?

Strategies to find out about current knowledge and attitudes include:
• speaking to members of the target audience or those familiar with the target audience;
• reviewing speeches and attending meetings that feature the target audience;
• reviewing reports;
• speaking to health workers;
• speaking to village leaders and community/women groups.

1.3 Decide on advocacy messages

Advocacy messages should provide a clear problem statement and recommendations for action. They should also be easy to understand. Different target groups will have different priorities and will respond to different messages. Consider:
• What will motivate the target group to change their views or take action?
• What messages will convince different audiences to take action?

Local data is particularly important. The audience is more likely to be interested in information about their own situation.

Arguments to obtain more support for RMNCAH could include:
• Burden of disease: National data on mortality and causes of death including inter-district disparities (e.g. maternal, neonatal and infant deaths and causes; data on stillbirths and cervical cancer deaths; and information on common causes of mortality and morbidity among adolescents) must be procured.
Effects on families: Maternal, neonatal, child and adolescent mortality and morbidity have serious emotional, social and economic impact on families. The demographic bonus of adolescents and young people can be realized only if their health and well-being is assured.

Sustainable Development Goals: The importance of achieving the Sustainable Development Goals (SDGs) of reducing maternal mortality, neonatal mortality, under-five mortality and ensuring universal access to reproductive health cannot be overemphasized. Cervical cancer prevention and treatment will lead to the achievement of SDG Targets 3.4\(^1\) and 3.8\(^2\).

Other global commitments: These include the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) and Convention on the Rights of the Child (CRC), which many countries have ratified, and Articles 7.2 and 7.3 of the Plan of Action formulated by the International Conference of Population and Development (ICPD), which provides the definition of reproductive health and rights (please see Sections 3.3, 3.4 and 3.5 in Module 1: Introduction).

Economic burden: A high level of disease among women, children and adolescents, and maternal and child mortality, pose an economic burden on the country and impact economic development.

Implication for population growth: Improved child survival is important for transitioning from high to low fertility and stabilizing population growth.

Design advocacy messages for a specific target audience and provide:
- a clear statement of the problem
- justification and benefits
- recommendations for action

Examples of key messages on RMNCAH targeted at policy-makers and communities are shown in Fig. 4.

Fig. 4. Key messages for policy-makers and communities

- Maternal mortality is everyone’s problem. Maternal health is essential for family health as well as for the well-being of family members, especially children, and finally, for the development of the country.

- Each country needs to achieve by 2030 the SDG target on maternal mortality ratio (MMR): ‘two third reduction of MMR from the 2010 baseline or no country with an MMR of more than 140 per 100 000 live births’.

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\(^1\) Target 3.4: reduce by one third premature mortality from NCDs through prevention and treatment, and promote mental health and well-being.

\(^2\) Target 3.8: achieve universal health coverage (UHC), including financial risk protection for access to quality health-care services, and access to safe, effective, high-quality and affordable essential medicines and vaccines for all.
Reducing maternal mortality is not totally dependent on socioeconomic development. Most maternal deaths can be prevented with cost-effective interventions that do not require sophisticated equipment or highly trained specialists, and which can be implemented even where health services have limited capacity and resources.

Ending preventable neonatal and under-five deaths is essential for future improvements in child health as well as for the development of the country.

By reducing under-five mortality to 25 per 1000 live births, and neonatal mortality to 12 per 1000 live births, the country will be able to meet the SDG targets.

Adolescent pregnancy is associated with higher risk of complications and higher neonatal mortality. It also interrupts the education of the girl and impacts her future employability.

If all women who want to avoid pregnancy use modern contraceptives, and if all pregnant women and neonates receive standard care, there would be a reduction in unintended pregnancies by 70%, abortions by 67%, maternal deaths by 67%, and neonatal deaths by 77%, compared with the situation in 2014. The return on investment would be an estimated USD 120 for every USD 1 spent.

Investing in early childhood care is cost-effective. For every USD 1 spent on early childhood development (ECD) interventions, the return on investment can be as high as USD 13. Early childhood development is also key to upholding the right of every child to survive and thrive.

Many interventions can be effectively implemented by strengthening or expanding existing RMNCAH services and programmes such as Safe Motherhood, family planning and community-based Integrated Management of Newborn and Childhood Illnesses (IMNCI), and home-based neonatal care.

Key messages for communities

- Communities can help improve the survival and health of mothers and children by doing a few simple things during the pregnancy, childbirth, postnatal and early childhood periods.
- Couples can ensure the health of the family by spacing out children, seeking skilled care during pregnancy, planning the childbirth in an institution, and opting for skilled care following the birth of the baby.
- Many infants die due to common childhood illnesses such as diarrhoea and pneumonia in their first year of life. In addition to providing ideal nourishment, breastfeeding provides infants with protection from many infections, including diarrhoeal diseases.
- Families should seek timely care from an appropriate health provider for mothers and neonates exhibiting danger signs. This is critical for preventing maternal and newborn deaths.
- To reach their full potential, a child needs good health, adequate nutrition, responsive caregiving, security and safety, and opportunities for early learning.
Despite being a resource-constrained country, Sri Lanka has succeeded in reducing maternal mortality drastically owing to unequivocal advocacy efforts led by public health experts and obstetricians. Advocacy targeted almost all stakeholders from the highest political leadership to the village communities, and always used real-time data and true stories of women dying during pregnancy and childbirth. These advocacy efforts led to favourable policies and systemic changes within and outside the Ministry of Health (MoH).

The issue of maternal deaths was given considerable prominence, thus reducing maternal deaths became a social responsibility. Maternal death notification was made a legal requirement a few decades ago, and the maternal death surveillance and response system (MDSR) is in operation. As part of the response to maternal death reviews, timely steps were taken to address inequalities of access to services, including emergency obstetric and newborn care services. Free health services at the point of delivery, high female literacy rate, well-distributed health facilities, and the strong, preventive health system, which provides domiciliary health care that is interlinked with the health institutions, also contributed immensely to reduce maternal mortality in Sri Lanka.

### 1.4 Decide the best way to deliver messages

- Advocate for RMNCAH
  - 1. Review policy and programme changes needed
  - 1.2. Identify the target audience
  - 1.3. Decide on advocacy messages
  - 1.4. Decide how to best deliver messages
  - 1.5. Develop a plan to monitor effectiveness of advocacy
Consider which channels and methods will be most effective in reaching and delivering messages to different audiences. Channels and methods can include:

- **mass media**: Assess the potential of TV, radio and press coverage to reach different audiences. Target influential and opinion-leading journalists and provide regular briefings, articles and press releases to highlight issues.

- **social media**: The use of social media has increased in the recent past, and it provides a suitable platform to create discussions/opinions and share views.

- **supportive individuals**: Identify “champions” who can advocate with their peers and develop strategic collaborations with professional and other groups.

- **meetings with groups and individuals**: Bring together policy-makers and opinion leaders, including politicians, programme managers, professional societies, researchers, media professionals, NGO leaders, donor representatives and others who could influence policy.

- **conferences**: Highlight the issue at national and subnational events and forums attended by policy-makers.

- **presentations**: Ensure presentations are customized for the audience, clear and easy to understand, and credible and appealing. Presentations need to highlight problems, ways to tackle them, and actions that need to be taken.

### Advocating to decision-makers

Decision-makers (at all levels) influence decisions on policies that affect RMNCAH. When approaching decision-makers, it is important to:

- Keep the message simple: include only one or two messages; too many messages are confusing.

- Tailor the message to the skills and responsibilities of decision-makers.

- Ensure that there is enough time for them to focus on the issue; be brief.

- Think strategically; for example, advocate before the budget is decided for the next year, not afterwards.

- Remember that information from multiple channels can help change the attitudes and opinions of decision-makers. For example, follow a key newspaper article or public event that has highlighted the problem with a face-to-face meeting.

- Consider involving key partners in meetings. For example, if a significant local donor is committed to RMNCAH, ask them to contribute to a meeting with decision-makers.
Advocating to the general public

There are multiple ways the public can be informed about health issues such as maternal and reproductive health. Possible channels include:

- Mass media: newspapers, radio and TV;
- Social media: web pages, Facebook and social media platforms such as WhatsApp, Viber, etc.;
- Community meetings and groups (mothers’ groups, village committees and health committees) and community theatre;
- Health facilities and health workers through counselling, health education meetings and posters and information hand-outs;
- Religious leaders and groups, who can disseminate information or present information at group gatherings;
- Teachers who can provide children with information that they can take home;
- Women’s groups.

Communication methods for advocacy

The two main methods are face-to-face contact with individuals or groups to obtain support for RMNCAH programmes and mass media or social media to create awareness of the importance of RMNCAH issues and the need for action.

Advocacy: face-to-face with individuals

When arranging meetings to advocate for RMNCAH, consider the following:

- Is the meeting arranged with the right person/s? Are they likely to be interested in any area of RMNCAH? Do they have the power to take the necessary action?
- Think about the person who is being approached. How do they stand to benefit by supporting RMNCAH activities? People are more likely to lend support if their own organization will benefit in some way, for example, by achieving their own organization’s goals, earning respect from senior policy-makers and generating increased support within the community.
- Who is the best person to make the approach? Are they senior enough? Do they have the right technical skills?
Advocacy: face-to-face with groups

This generally means making a public presentation. The following principles are important:

- **Design the presentation** to be appropriate for the educational background, interests and position of your target audience.

- **Time presentations strategically**, for example, soon after the release of key survey data, at the beginning of a new donor-funded project on RMNCAH, after the publication of a key newspaper article, or reporting the death of a mother or a child due to a preventable cause.

- **Prepare high-quality material** to hand out at the meeting that summarizes the key points.

- **Make it clear** how the target audience can be involved and what they can do. Be specific.

- **Execute follow-up**. The type of follow-up will depend on the target audience. For a group involved with policy decisions, it may be important to follow up with key individuals about concrete proposals for policy revisions or additions. For those involved with funding, it may be appropriate to follow up with funding proposals.

Advocacy: using the mass media

The mass media (TV, radio, newspapers and digital media) is effective in creating awareness. There are two main approaches to using mass media:

- **Buying time on mass media to promote messages**. This can be through advertising, public service announcements, TV soap operas, radio programmes, etc. The advantage of this approach is that messages can be carefully developed, tested and controlled for maximum impact. The disadvantage of this approach is that it is often expensive.

- **Encouraging the media to cover activities and promote causes**. Journalists can be encouraged to write articles about key RMNCAH issues, or to report on significant events, such as workshops and meetings, new projects, public meetings or rallies, the release of new RMNCAH data, and so on.

In addition, digital media channels such as mass messaging, social media sites, and Internet-based television and radio can be used to further a cause (refer to Annex 1).

Become familiar with the media that are popular in the local community. A useful starting point is to buy copies of newspapers and magazines that are in circulation there, and to listen to and view radio and television news to get an idea of how health topics are usually covered. Choose media that will reach the target audience. If television ownership and use is low, it would not be a useful medium for reaching a wide population. Print media is not useful for a largely illiterate audience; radio may be more effective in such a case. In case of high mobile phone penetration, text messages (SMS) or social media may have a wider reach. Household survey data are often available to determine the local availability of media channels in communities.
Planning a media event

The media will only cover a topic if it is newsworthy and makes for a good story. Journalists may have a long list of possible topics to cover and will choose ones that are new, interesting or unusual. One way of getting coverage is to plan a “media event” or seminar that will attract journalists, film crews and photographers. The principles of organizing and conducting a good media event include:

- Time the activity properly so that journalists can meet deadlines.
- Make the event interesting, so that it does not just have speeches, but includes dances, music, short plays, quizzes, street marches or other innovative activities, and case histories.
- Involve well-known personalities such as politicians or local opinion leaders, or maybe a survivor of a “near miss” situation, such as a patient who survives due to availability of comprehensive emergency obstetric care (CEmOC) services.
- Send a media advisory in advance of the event to attract journalists to attend the event.
- Provide a “press packet” of basic information and key points about the issue.

An example of press information about an important event is in Annex 2.

Preparing a press release

A press release is usually a one-page typed document which is used to inform the media of a forthcoming event or to update them on new information. It should provide the following information:

- WHAT will be happening? Describe the event. Give the names of important participants and details of activities that may make for a good photograph.
- WHY will it take place? Give background details. Supply some facts and figures that can be quoted in a story. For example, when describing the importance of reducing unwanted pregnancies, give the number of women who died of induced abortions the previous year in that community.
- WHERE will it take place? Give precise details of how to get there.
- WHEN will it take place? Give the date and time of day.
- WHOM to contact? Give contact details for more information.
**Giving an interview**

Sometimes programme managers are asked for interviews about a topic or activity. It is very important to do this well as thousands and even millions of people may be influenced positively or negatively by what is said and how it is said. Ideally, only people who have had media training should talk directly to the media. Fig. 6 provides some guidelines for making an interview interesting and effective.

**Fig. 6. Tips for being interviewed on radio and television**

- Be prepared. Know facts and figures or have details handy, and prepare answers for anticipated questions.
- Before the interview, if possible, discuss with the interviewer the questions and issues.
- Be clear and concise. Keep to the point. Plan three or four key points and make sure that these are mentioned.
- Make it interesting! Sound enthusiastic. Have notes to refer to but avoid reading directly from them. Build in personal examples or stories (but be careful about revealing names and breaching confidentiality).
- Keep the language simple and avoid technical words. Give statistics in ways people will find easy to grasp (for example, rather than saying 830 women die from pregnancy- and childbirth-related complications every day, try to say one woman dies every two minutes from preventable causes related to pregnancy and childbirth).
- Keep calm! If a question is difficult, do not refuse to answer, but change the subject or ask a question back.
- If the interview is being broadcast ‘live’, choose your words carefully. If it is being recorded, do not be afraid to ask to repeat part of the interview.

**Presentation skills**

The performance of managers is often judged most critically when they are making a presentation in front of others. So, it is particularly important that presentations meet a high standard. Practise and refine your presentation beforehand!

---

**A good presentation does not simply depend on preparing a number of interesting slides (although this can help)**

---

**Fig. 7. Principles of developing a presentation**

**Give it a structure, including a beginning, a middle and an end:**

- An introduction – what will be covered and why.
- Clear overall messages – no more than a few sentences.
- A final summary – review the points that have been made.
- Limit the amount of data or information – too much is confusing.
- An end-point – ‘My conclusion is that we need three more health clinics built in district X.’

**Keep it short**

- Attention spans vary. Very busy people such as ministers may only have five minutes to give you. Students may be able to focus for 30 minutes. Don’t expect anyone to listen to you for more than 30 minutes.
- As a general rule, plan to talk on one slide per minute. A five-minute presentation needs no more than five slides. Make each one count!

**Keep it simple**

- Complicated graphs do not impress audiences. It is difficult to study a graph and listen at the same time. Give the title of the graph and explain what it demonstrates. Explain anything that is not immediately obvious: ‘This slide shows the increasing cost of providing the service over the past five years.’
- Limit the amount of information on any one slide. Do not use more than five bullet points on any one slide. Do not over-fill the page or screen.
- It is easier to read simple fonts such as Arial that do not have serifs (extra lines at the tips of the letters). Use large letters such as in 28 or 32 font size that can be seen from the back of the room. Make fonts consistent throughout the presentation. Switching between fonts makes text difficult to read.
Make it interesting

- Try to tell a story with your slides – with a beginning, a middle and an end.
- Keep the visual message interesting. Illustrations or pictures can be more powerful than words. But choose them carefully because they may distract attention from your message. Using a digital camera, it is now possible to take photographs yourself and incorporate them into a presentation.
- Share something new. Describe new developments such as new outbreaks, research, newly released data or new initiatives to control a disease or to tackle a health problem.
- Use powerful language. Personalize statistics and give the problem a human face.
- Modulate your voice. Monotonous presentations put everyone to sleep.
- Slow down! Until you are experienced, everyone tends to talk too fast in a presentation. You do not transmit more information by talking faster.

1.5 Develop a plan to monitor effectiveness of advocacy

What can be measured to assess the effectiveness of advocacy? Approaches to assessing effectiveness can include:

- Measuring activities successfully completed, such as meetings held and materials produced.
- Measuring results of activities, such as changes in budget, expenditure, personnel availability or effort; changes in the use of health services (demand); changes in the availability of community-level resources or community-based activities; or knowledge or attitudes before and after advocacy (such as the proportion of pregnant mothers who say breast milk is the best food for the baby).

Plan how the effectiveness of advocacy will be monitored, who will collect the information, and a schedule for monitoring. Also, plan for the materials, skills and financial resources needed to monitor the effectiveness of advocacy. Examples of some items to monitor appear in the far-right column of Table 1.
Table 1. Summary of an approach to RMNCAH advocacy intervention package: improve exclusive breastfeeding of infants under six months of age

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<tbody>
<tr>
<td>Increase the maternity leave period for employed women</td>
<td>Policy-makers</td>
<td>Increasing the maternity leave period will enable mothers to exclusively breastfeed their infants, which in turn will save more lives.</td>
<td>One-on-one meetings. Small group meetings.</td>
<td>Low (time to write the justification with evidence; prepare short presentations; and</td>
<td>Government policy changes to increase the maternity leave period.</td>
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<tr>
<td>Increase awareness about the importance of supporting women with young babies and encourage families to do so</td>
<td>General public, health workers and decision-makers</td>
<td>Exclusive breastfeeding is a simple way to reduce deaths, improve health and improve bonding between mother and child. Breast milk is all that a baby needs for nutrition.</td>
<td>Mass media: Radio and TV Social media: SMS, Facebook group presentations.</td>
<td>High costs of developing and broadcasting; (group presentations require time and venue).</td>
<td>Number of sessions/broadcasts. Proportion of caregivers/families hearing broadcasts or attending meetings. Number of views of social media messages and positive comments. Correct knowledge in target groups</td>
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<tbody>
<tr>
<td>Implement baby-friendly hospital initiatives</td>
<td>Decision-makers, programme managers</td>
<td>Health facilities also recommend and support exclusive breastfeeding.</td>
<td>Small group meetings.</td>
<td>Low (time for small meetings).</td>
<td>Baby-friendly hospital initiatives adopted by the Ministry of Health and budgeted.</td>
</tr>
<tr>
<td>Decrease the use of formula</td>
<td>General public, professional colleges, health workers, pharmacists</td>
<td>Formula should not be given. Breast milk is best for babies.</td>
<td>Mass media; technical updates.</td>
<td>High (mass media costs; costs of training).</td>
<td>Correct knowledge in target groups. Broadcasts/training conducted.</td>
</tr>
</tbody>
</table>
EXERCISE A: Advocate for RMNCAH

In this exercise, you will develop an approach to advocacy for an intervention that will be implemented in your area. You will then develop a short advocacy presentation (five minutes) and present it to the group. Your facilitator will divide you into pairs or small groups for this exercise.

Part 1: Plan an approach for advocacy of an intervention or intervention package

1. Before deciding what to achieve, it is important to write down the problem statement and list down various solutions to address it. Then you can decide which ones to take up for advocacy (the advocacy objectives). Do you want to raise awareness? Do you want more funds? Are there particular elements needed for implementation that you do not have? Are there policies or guidelines that you would like to change? Write a few objectives in the left column.

2. Decide on the target audiences for your advocacy objectives. Each target audience should be one that can make the needed change or influence the change specified in your advocacy objective.

3. Work out your advocacy messages. Keep them simple and appropriate for each target audience.

4. Describe what methods (or channels) you will use to deliver your message.

5. Estimate the resources you will require to develop and deliver your advocacy messages.
6. Decide how you will measure if your advocacy has been effective.

Worksheet: Summary of approach to RMNCAH advocacy

Interventions/packages:

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Part 2: Prepare an advocacy presentation

1. Prepare a **five-minute** advocacy presentation for **one** of the selected target audiences. The message should include:
   - A problem statement;
   - What would you like the target audience to do (the action)?

2. One person from the group makes the presentation to all the other groups. After each presentation, the entire group will discuss the following questions, so that you can learn ways to make a better advocacy presentation:
   - Did the presentation convince you as a member of the audience?
   - Was the action desired of the audience clear?
   - What was done well? What was not done as well? (Consider content, format, timing, simplicity, overall message, organization and the body language and style of the presenter.)
   - What could have been done to improve the presentation?

When you are ready for the presentations, tell your facilitator
Resource mobilization is the process of obtaining the resources needed to implement the planned activities. Resources are the elements needed to carry out your work and can include:

- **Human resources**
  - People who can help in the planning and management of activities;
  - People who can help in the implementation of activities;
  - Full-time staff, community volunteers and consultants.

- **Material resources**
  - Equipment for short- or long-term use;
  - Supplies of consumables, e.g. vaccines, medicines, injection supplies, training materials, cards, logbooks and recording and reporting forms;
- Offices or buildings;
- Vehicles or other forms of transportation.

- Financial resources
  - Funds for programme activities;
  - Funds for essential system supports;
  - Funds for staff.

### 2.1 Form strategic partnerships

Strategic partners are groups, organizations or individuals who participate in the implementation of activities by contributing human and material resources and, in some cases, funding. Some of these may be stakeholders who were involved in planning (donors are a particular type of strategic partners who provide only financial resources).

The sub-steps of this step are shown in Fig. 9. Strategic partners can include any groups or individuals active in communities, districts, states/regions or nationally. Potential partners must be convinced that supporting the effort will directly benefit their own constituencies. It must be remembered that partnerships are not built overnight.

**Fig. 9: Strategic partnerships**

- 2.1.1 Decide on potential strategic partners
- 2.1.2 Initiate a possible partnership
- 2.1.3 Agree on the terms of collaboration
- 2.1.4 Negotiate a partnership with other government departments
- 2.1.5 Negotiate collaboration with communities
- 2.1.6 Plan collaborative activities with the community
2.1.1 Decide on potential strategic partners

Possible partners could include:

- government departments/ministries;
- NGOs, both local and international;
- international donors or relief/humanitarian organizations;
- UN agencies;
- community groups, Lions Club, Rotary, women’s groups, groups of adolescent girls and boys, etc.;
- professional groups or societies of professionals, such as physicians, nurses, pediatricians and midwives;
- universities and research institutions;
- school teachers;
- religious groups or organizations, including local churches or mosques;
- traditional healers;
- pharmacists;
- local medicine sellers or medicine vendors;
- media;
- the private sector.

Factors for assessing the suitability of possible strategic partners include:

- The human, material and technical resources that they can contribute. These should complement the resources that already exist, either in size, geographical focus, flexibility or skill.
- Their personal interests and objectives. Examine a potential partner’s history of involvement with public health. Are they likely to support any area of RMNCAH?
- Their potential for long-term involvement. Leaders of religious organizations may be asked to participate in a single activity, in the hope that they will see RMNCAH as an important area to be involved.

2.1.2 Initiate a possible partnership

a) Clarify your goals for the partnership

Determine the desired outcome. What will you ask for from this partner? Can your goals be modified, if possible, if partners have slightly different goals?
b) Prepare to clearly state the case for collaboration

Gather the relevant facts and information. Identify the most persuasive way to present this information. Clearly articulate the positive health effects (and medical effectiveness) of RMNCAH programme activities. Provide economic data supporting the cost-effectiveness of such programmes. State the potential political benefits of displaying leadership on an issue and the potential political consequences of failing to act. Give concrete examples of what the potential partner could do to support implementation.

c) Arrange a first meeting with the potential partner

Make contact. Introduce your department/organization through phone calls and letters. Do not focus on gaining support at this stage. Listen carefully to the interests of possible partners. You should state your case and, if necessary, provide short summary documents. Identify the “first step” – an activity they could do to kick-start their participation. In most cases, the first step should be an activity that is easy to undertake. At the end of the meeting, the next steps should be clear.

A useful first step is to invite potential partners to meet for a proposal development workshop. This might last one or two days, depending on the nature of the activity that is being planned. A workshop allows each partner to understand the other’s perspectives, build trust and develop a shared understanding of the problem and possible solutions.

d) Maintain the relationship through regular communication

Make follow-up visits. Find legitimate ways to follow up on the original conversation and keep the partner informed. Be generous with thanks and ask for further involvement. Help the partners achieve their particular self-interest.

2.1.3 Agree on the terms of collaboration

Once partners have agreed to participate, the terms of collaboration need to be negotiated. Examples include:

• The partner provides staff or other resources using their own funds to support programme activities. The partner may ask, “What benefits are there for our organization?” They will need to be convinced that the best way for that organization to achieve its own objectives is to work collaboratively. Offer something in return for their collaboration. If the collaboration offers mutual benefits, the organization will be more willing to collaborate.

• The partner is included on a joint funding bid with another donor. In this situation, the partner organization needs to be involved closely in the development of the proposal so that it can identify what its role will be, and what resources will be required.
The partner provides a specific service that is paid for by the RMNCAH programme. Usually, a formal request for services needs to be made, which states the costs and scope of the activity. Then, a letter of agreement (or contract or memorandum of understanding) is developed, spelling out the details of the agreement.

Remember that some donor agencies have very precise definitions of partnership as well as well-defined criteria for the types of organizations that are eligible for funding. This needs to be taken into account when selecting strategic partners.

2.1.4 Negotiate a partnership with other government departments

Sometimes, resources for RMNCAH can be released from other government departments, especially when there is an overlap between different ministries that may be working with the same target groups in the field. For example, the following departments may be willing to provide support for special activities:

- The Ministry of Education may provide support for child health promotion activities in schools, pre-school facilities and adult education programmes.
- The Ministry of Youth may provide support for activities targeted at adolescents and youth such as education on HIV and reproductive health.
- The Ministry of Women may cover health as a topic when working with women’s groups.
- The Ministry of Rural Development may provide field staff and community groups to carry out health education activities.
- RMNCAH is a subject for most local government institutions.

There are many possibilities to explore when looking for ways to collaborate with other departments. For example:

- **Consider offering something to collaborating departments**, such as health education and counselling materials or links with health facilities.
- **Use existing structures for intersectoral coordination**, such as district management committees. Sometimes, it may be easier to obtain support by approaching community and district-based field staff and working through existing committees or groups. In other cases, some clearance at the national level is needed to obtain support.
- **Consider collaboration on short-term activities such as immunization campaigns.** These may be more feasible for departments that cannot commit resources on an ongoing basis, and can provide an opportunity to build a working relationship that can be used in the future.
2.1.5 **Negotiate collaboration with communities**

**Mobilizing resources from the community is particularly important because it**

- draws upon expertise and talents that exist within communities (such as traditional birth attendants or TBA, traditional healers, artists, musicians and actors) and is, therefore, more likely to be accepted and be appropriate for local social and cultural norms. For example, TBA can be employed to accompany mothers to hospitals for their deliveries.
- results in a greater sense of ownership of the programme by the community and greater participation in activities because they have contributed to implementation.
- leads to programmes that are less dependent on external inputs and have long-term sustainability.

Programme managers can work with community leaders and community groups to help them understand RMNCAH problems, the types of activities that may be useful, and how these can be implemented with local support. Creating an inventory of resources available in the community is useful. For example, the inventory could include rooms for meetings or for health education; a volunteer health worker from the community with some training in RMNCAH; nutrition groups or mothers’ groups; and traditional healers who are willing to collaborate.

Individuals and groups that are often involved in health include:

- village health committees
- local authorities
- village elders or leaders
- women’s groups and adolescents’ groups
- school teachers
- religious leaders
- faith-based groups
- community support groups
- mother support groups
- community-based NGOs
- volunteer health workers.
2.1.6 Plan collaborative activities with the community

A group of community leaders, such as a village health committee, should work with health staff to plan the collaborative RMNCAH activities. This group can help develop simple action plans that specify what will be done and when and by whom, and then discuss the plans further with the community. Community planning needs to describe how the community will benefit from participation in maternal and reproductive health programmes, and how responsibilities will be shared between the community and the programme staff.

There are a number of ways that communities can contribute to programme activities. Some options that are described below include:

a) self-help
b) use of volunteers
c) financial contributions by the community
d) commercial or business sponsorship.

a) Self-help

Communities help themselves by contributing time and skills to make changes or improvements that have a health impact. Self-help approaches mobilize the energy and enthusiasm of a community. Experience has shown that communities are willing to contribute time and effort to activities if they believe that real benefits will ensue. It helps if some of the costs or expertise is provided by the health programme, so that the effort is collaborative.

Examples of projects for which a community has contributed labour include:

- construction of a health centre;
- preparation of a school garden;
- cleaning of a communal area;
- maintenance of a public latrine;
- digging and protection of wells;
- construction of latrines for individual households;
- arranging transport for mothers and babies in emergencies;
- preparing hot meals for pregnant women and young children;
- establishing mother support groups.
b) Use of volunteers

Many communities have a tradition of volunteering. **Volunteers must be trained and organized, and a key group or individual in the community should assume the role of coordinator.** Programme managers or others with technical expertise need to ensure that volunteers use information and methods that are technically sound and should provide materials and supplies when required.

Examples of the ways in which community volunteers have been used include:

- health education on particular topics;
- nutrition/mother support groups;
- case-finding and follow-up; notification of maternal deaths;
- community-based distribution activities (for example, distributing bednets, vitamin A, iron supplements);
- mobilizing the community for immunization days.

c) Financial contributions by the community

Financial contributions by the community can help sustain RMNCAH programme activities in the longer term, and can help build local commitment to the programme. Local funds have been provided for a variety of purposes, including:

- building health centres, latrines and wells;
- medicines that are distributed by community health workers;
- salaries of community health workers and allowances of volunteers;
- transportation costs for sick mothers, neonates and children to referral centres.

Fundraising and cost-recovery are two mechanisms of local funding. Fundraising means that a community raises money for health activities. The funds need to be collected, stored and managed by a coordinating committee that is accountable for the money. Fundraising may include activities such as fairs or community gatherings or local festivals that sell donated food or goods; produce sales of donated goods; and community theatre for which contributions are collected.

**Cost-recovery** systems charge for goods and services such as medicines, insecticide-treated mosquito nets, soaps, chlorine for disinfection of water, services of community health workers, and services of facility-based health workers. The challenge is to find a price that will cover enough of the real cost of the item or service, while not deterring people from spending the money.
d) Commercial sponsorship

Commercial companies, businesses and shops in the community may be willing to sponsor RMNCAH activities. Some companies do have corporate social responsibility (CSR) budgets set aside for contributions that will have a positive impact on society. Sponsors have often contributed to health education activities (such as the production of posters, vinyls, community dramas, video equipment, and establishing mobile phone message systems) as well as for supplies such as safe delivery kits or weighing scales or vitamin supplements. Sometimes, this is done without conditions. Usually, however, sponsorship is in exchange of increased visibility for their business or for the products they sell. It is important to ensure that businesses offering sponsorship do not produce or market products that are unhealthy or inappropriate.

Examples of non-desirable corporate sponsorships include:

- Sponsorship by tobacco or alcohol companies.
- Sponsorship by companies promoting breast milk substitutes, breast-milk supplements and other related products.
- Sponsorship by companies promoting inappropriate medicines for mothers and children such as anti-diarrhoeals or some traditional remedies.
EXERCISE B: Assess potential strategic partnerships and ask for support

In Part 1 of this exercise, you will review potential strategic partners for the implementation of the intervention package that you planned in Module 2: Planning Implementation. You will assess their interests and objectives and the resources they can offer. In Part 2, your small group will prepare a presentation for one of the potential partners. Finally, in a role play, one person will make the presentation for the rest of the group.

Part 1: Review potential strategic partners who could help with the implementation of the intervention package in your programme

A. Answer key questions for potential strategic partners.

Complete the following worksheet:

Worksheet: Key questions for potential strategic partners

<table>
<thead>
<tr>
<th>Key questions</th>
<th>Government ministry/department name</th>
<th>UN/multilateral agency name</th>
<th>NGO/community partner/other name</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is their mission?</td>
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<tr>
<td>How does it fit with the improvement of RMNCAH?</td>
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<td>Are there any specific criteria that they use to determine partners?</td>
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<td>Do they have any history of working with any RMNCAH programmes?</td>
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<td>What potential benefits would they see in collaborating with you?</td>
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(Continued)
### Key questions

| At what time of year do they develop their annual workplans? How far ahead do they plan their activities? |
| What is their legal status, e.g. registered NGO, international organization, etc.? |
| How well are they regarded by other agencies? |
| Do they have a system of financial management and auditing in place to ensure that funds are properly spent? |

### B. List the resources offered by potential strategic partners in the following worksheet:

**Worksheet: Resources inventory for strategic partners**

<table>
<thead>
<tr>
<th>Human resources available</th>
<th>Government ministry/department name</th>
<th>UN/multilateral agency name</th>
<th>NGO/community partner/other name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who can help in the planning/monitoring of activities</td>
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</tr>
<tr>
<td>Staff with relevant competencies who can help in the implementation of activities</td>
<td>Government ministry/department name</td>
<td>UN/multilateral agency name</td>
<td>NGO/community partner/other name</td>
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<tr>
<td>Voluntees, free consultancy</td>
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<tr>
<td>Training courses, study visits and scholarships</td>
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</tbody>
</table>

**Material resources available**

| Specialist equipment for short- or long-term use | Government ministry/department name | UN/multilateral agency name | NGO/community partner/other name |
| Supplies of consumables, e.g. medicines, injection equipment and training materials | | | |

| Offices or service equipment | Government ministry/department name | UN/multilateral agency name | NGO/community partner/other name |
| Vehicles/other transportation | | | |

**Financial resources available**

| Funds for project activities | Government ministry/department name | UN/multilateral agency name | NGO/community partner/other name |
| Other | | | |

C. Decide whether or not each of the potential partners is likely to be useful in implementing your intervention package

When you have completed this part of the exercise, discuss your work with a facilitator
Part 2: Develop a presentation for a potential partner

Work in small groups. Each group will prepare for a meeting with one selected partner to ask for their support for an intervention package, and to identify ways in which they can help. Prepare five slides for your presentation. Refer to page 16 in this module to remind you of the principles of developing a presentation, including developing effective slides.

Tell your facilitator when your small group is ready to make a presentation

Part 3: Presentations to potential partners (plenary)

One person from each small group will make the presentation to the large group. Before you begin the presentation, describe to the group the target audience (the potential partner) at whom the presentation is directed. After each presentation, the entire group will then discuss the questions below.

While other participants are making presentations, think about the following questions, and make notes. Then there will be a brief discussion.

A. Was it clear what the partner was being asked to do?

B. Was there a good justification/rationale for the activity presented? Were you convinced?

C. Was it clear how the partner could benefit from the collaboration?

D. Was the presentation appropriate for the target audience?

E. Were the slides interesting? Were they clear?

F. What was done well in the presentation? Consider content, timing, simplicity, overall message, organization and body language, and the style of the presenter.

G. What could have been done to improve the presentation?
2.2 Mobilize donor funds

Fig. 10 shows the sub-steps to mobilize funds for a maternal and reproductive health programme’s activities.

Fig. 10. Mobilize donor funds

2.2.1 Identify potential donors

A donor is any organization or individual who can provide financial resources. Donors have different interests, funding procedures and methods. It is useful to prepare an inventory of possible donors listing their interest in programmes and projects they have funded in the past. Examples of different kinds of donors are presented in Table 2 below.

The Global Financing Facility (GFF) is a World Bank-based financial platform for women, children and adolescents, and is helping governments in low- and lower-middle-income countries transform the way they prioritize and finance the health and nutrition of their people. This will contribute to saving up to 35 million lives by 2030, and it will greatly improve people’s and countries’ abilities to thrive in the global economy.

One must be very careful when involving private companies as donors as there may be a conflict of interest (for example, a tobacco company or a company that produces breast-milk substitutes).

Table 2. Types of potential donors

<table>
<thead>
<tr>
<th>Type of organization</th>
<th>General information on the type of resource provider</th>
<th>Specific examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>National NGOs/ international NGOs (INGOs)</td>
<td>International NGOs operate in more than one country. In some cases, they have funds from fundraising in their own countries, but they also submit proposals to donors. Local NGOs are active in the implementation of programmes.</td>
<td>International NGOs: MSI, PSI, JSI, Jhpiego, Save the Children, World Vision, CARE, Red Cross. National NGOs.</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Type of organization</th>
<th>General information on the type of resource provider</th>
<th>Specific examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civil society organizations</td>
<td>These include women's organizations, professional associations, trade unions, self-help groups, social movements, business associations, coalitions, and advocacy groups</td>
<td>They vary from country to country</td>
</tr>
<tr>
<td>Community-based organizations</td>
<td>Community-based organizations, local NGOs</td>
<td>They vary from country to country and between regions in the same country</td>
</tr>
<tr>
<td>Religious groups/ institutions</td>
<td>Churches and religious institutions, mission societies</td>
<td>They vary from country to country and between regions in the same country</td>
</tr>
<tr>
<td>UN agencies</td>
<td>UN organizations are sources of technical expertise and funds</td>
<td>WHO, UNDP, UNFPA, UNAIDS, UNICEF, UNHCR, UN WOMEN, ILO</td>
</tr>
<tr>
<td>Government donors (bilateral donors/ international development agencies representing governments)</td>
<td>Provide funds and technical support to MoHS, NGOs and other groups</td>
<td>Australia, Canada, Germany, Netherlands, Scandinavian countries, United Kingdom, United States of America, etc.</td>
</tr>
<tr>
<td>Multilateral donors</td>
<td>Donors representing regional groups</td>
<td>Asian Development Bank, World Bank, Bill &amp; Melinda Gates Foundation, European Community, Gavi</td>
</tr>
<tr>
<td>Private companies</td>
<td>They are sometimes interested in sponsoring specific events, activities or developments. The largest often have their own charities</td>
<td>Wellcome Trust</td>
</tr>
</tbody>
</table>

### 2.2.2 Make initial contact with potential donors

Making initial contact (through meetings or telephone calls) is important in order to inform the donor organization about your organization and programme(s), and to find out more about the donor organization, including its funding interests and requirements. After the initial contact, summarize the findings and decide which donors to pursue further.
Key questions to ask the donor about funding include:

- **What technical areas are of most interest to the donor?** Many donors have areas of focus such as AIDS, maternal health, child health, women’s health and nutrition or micronutrients, and these areas of interest can change.

- If your country has a strategic plan or implementation plan, you can **negotiate with the donor** to support your activities based on their mandate.

- **Are there preferred target groups or beneficiaries for the funding?** Sometimes donors are interested in working with particular groups such as women, young people, urban populations, remote populations or refugees.

- **Do matching funds need** to be provided by your organization or from others?

- Are there limits to the **amount of funds** that will be provided?

- **When are funding requests accepted?** Some donors are willing to receive funding requests throughout the year. Others have specific deadlines.

- What is the required format for proposals? What **indicators** should be used for monitoring and evaluating progress?

- **Are local partners needed on the funding application**, in addition to your organization? For example, are funds sometimes specifically allocated to local NGOs?
### Table 3. Example of donor inventory

<table>
<thead>
<tr>
<th>Category of organization</th>
<th>Example of organization</th>
<th>Likelihood of interest in maternal and reproductive health</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGOs/INGOs</td>
<td>CARE</td>
<td>Highly interested in serving rural areas; they have local-level projects in maternal and reproductive health</td>
</tr>
<tr>
<td>Civil society organizations</td>
<td>Women United</td>
<td>Mainly involved with the advancement of women, but might be willing to make a small donation and involve its members, particularly in pregnancy care, respectful care at birth and postpartum family planning</td>
</tr>
<tr>
<td>Community-based organizations</td>
<td>Chikoka District Cooperative Organization</td>
<td>May be prepared to provide funds for a short-term education campaign, but unlikely to provide long-term support</td>
</tr>
<tr>
<td>Religious groups/ institutions</td>
<td>YWCA</td>
<td>Highly likely to provide education and advocacy through the involvement of members, but unlikely to provide financial support</td>
</tr>
<tr>
<td>UN agencies</td>
<td>UNFPA, UNICEF and WHO</td>
<td>Highly likely to provide technical support and may provide some funding for certain types of activity based on their respective mandates</td>
</tr>
<tr>
<td>Bilateral donors</td>
<td>USAID</td>
<td>Is interested in providing maternal and child health funds, particularly if activities are collaborative with local NGOs</td>
</tr>
<tr>
<td>Multilateral donors</td>
<td>European Union</td>
<td>Will be prepared to consider providing funds if it fulfils the terms of reference of its most recent call for funding proposals</td>
</tr>
<tr>
<td>International foundations or philanthropic organizations</td>
<td>Bill &amp; Melinda Gates Foundation</td>
<td>Provides support for several child health-related activities</td>
</tr>
<tr>
<td>Private companies</td>
<td>Novartis Foundation for Sustainable Development</td>
<td>Highly likely to provide funding for the development of m-health applications</td>
</tr>
</tbody>
</table>
2.2.3 Prepare a letter of intent

An early step in the process of obtaining funding is usually submitting a letter of intent. If the donor is interested, they will request a detailed funding proposal.

Donors often ask for a letter of intent. This is a 1–2-page summary of proposed programme activities with a 2–3-page attachment (e.g. timetable and budget). It is used for initial negotiations with the donor. The document needs to be clear and concise. It should provide an external reviewer, who is not necessarily knowledgeable about the subject, with a clear idea of what the project is about. Based on the letter of intent, donors will make a decision on whether they would like to see an expanded project document.

A suggested list of headings for a letter of intent is as follows:

1. Title
2. Summary of the problem and public health need
3. Goal and objectives
4. Estimated population of beneficiaries of programme activities
5. Desired outcomes
6. Summary of main activities and timetable
7. Monitoring and evaluation
8. Budget
9. Annex: list of abbreviations

Fig. 12. Example of letter of intent

(Note: This is just an example of a letter requesting financial assistance from potential donor/s in the country. In reality, the procedures for financial request should be in accordance with the protocol and procedures within the Ministry of Health).

Ministry of Health, Country X

Letter of intent submitted to the European Union

Problem: High maternal deaths

Summary of problem and needs: Maternal deaths in the Metropolis region are persistently higher in number than in any other region in the country. The worst affected districts are MIRA and YAMA. Recent DHS and national EmONC needs assessments (Continued)
suggest that almost 90% of the deaths are due to preventable direct causes, and the majority are due to postpartum haemorrhage and unsafe abortions. According to the Demographic and Health Survey 2015–2016, the contraceptive prevalence rate (CPR) is only 25% in the Metropolis region. The female literacy rate is low in this region; the transportation system is not satisfactory; and the terrain is difficult. Many women opt to deliver at home (without skilled attendance) and the rate of institutional deliveries is as low as 35%. In the neighbouring mountainous region, the level was similar five years ago, but it was reduced to half after an intensive programme of training health workers, conducting outreach, and educating families.

**Goal:** Reduce MMR by 50% over three years in the Metropolis region.

**Objective:** Increase the rate of institutional deliveries from the current 35% to 70% over three years.

**The main beneficiaries:** 125 000 women of reproductive age in the Metropolis region.

**The desired outcomes:**
- Increased knowledge on planned pregnancies, birth spacing and ANC; increased awareness of the importance of skilled attendance at childbirth among couples.
- Improved the availability and quality of antenatal care for pregnant women with timely referrals for complications.
- Improved availability and quality of care during childbirth at health facilities.

**The main activities:**
- Community education.
- Outreach activities.
- Training of health staff ANC, FP and on safe and clean delivery.

**The methods of implementation:**
- Recruitment and training of community health workers (CHWs) on community education and identification of women with complications
- Community IEC (information, education and communication) activities and establishment of mothers' support groups.

**Workplan and budget:** The workplan and budget are attached. The resources include government contributions and other partners’ contributions for sustainability.

**Monitoring and evaluation:** A list of indicators for monitoring the training of health staff and community education and counselling are attached in the annex. Results will be measured using baseline and end-line household surveys, facility assessments and health management information systems (HMIS).
European Union

Review of the letter of intent for project in the Metropolis region

Relevance:
Data provided shows that the programme meets a real need. The target group is well-defined. Maternal mortality is one of the priorities in the national RMNCH strategic plan. Focus on maternal mortality fits well into our organization’s mandate.

Added value:
In the long term, training of the health staff will enhance capacity to respond to other reproductive health problems. The involvement of the women and the community could be built upon for future health education activities. The IEC and counselling materials used will be those already developed for the existing programme, thereby saving development costs. The challenge is the difficulty in transportation and communication.

Likely impact:
The programme is highly committed to tackling the problem. The target is ambitious but in line with the impact achieved by the neighbouring region. It is, therefore, possible that a well-planned programme could achieve its planned impact. Issues that will have to be considered when planning implementation is underway include: supervision of staff to maintain quality; ensuring adequate supplies of medicines and equipment; ensuring access to education and counselling; and access to referral facilities for severely ill women or pregnant mothers.

2.2.4 Prepare a detailed project proposal

A project proposal is an expanded version of the letter of intent. This is submitted to donors for a more detailed review when considering funding. Donors usually ask for a project proposal after they have considered the initial letter of intent and decided that they are interested in providing support. If a project proposal is approved, it will act as part of the contract. Therefore, it needs to clearly specify activities, timelines and roles and responsibilities.

A donor may have very specific requirements for a project proposal, such as:

- language;
- section headings;
- targets and indicators to be used;
• specific project management tools;
• budget layout;
• accompanying documents such as annual reports, audited accounts and legal documents on the status of partners;
• number of copies needed;
• signed statements of commitment from partners.

Be sure that you are aware of these requirements and follow them closely. Studying a previously successful proposal may be helpful. Sometimes, proposal requirements are posted on websites. For example, the European Union has posted guidelines on project cycle management and logical frameworks that they expect to be used for all project proposals to the European Union.

Table 4. Key elements of a project proposal

<table>
<thead>
<tr>
<th>Element</th>
<th>Content</th>
</tr>
</thead>
</table>
| 1. Organizational information and proposal summary | • What is the name and address of your organization?  
• Who is the main contact person and what is his/her contact details?  
• In what state/region(s)/district(s) will the work take place?  
• What are the impact and coverage targets?  
• What is the total budget; what fraction is provided by other donors?  
• What is the time frame for the work, including the start and end dates? |
| 2. Rationale for the proposed work    | • Which problem is the work expected to solve?  
• How does the work relate to this problem?  
• What experience do you have of working on these issues?  
• Have you used past experience/evaluations to inform the proposal? |

(Continued)
<table>
<thead>
<tr>
<th>Element</th>
<th>Content</th>
</tr>
</thead>
</table>
| 3. Project design | • What interventions, packages and delivery approaches have been chosen?  
• Who are the direct and indirect beneficiaries?  
• Are the beneficiaries involved in project design or implementation?  
• What is the coverage of the project (area, number of people, etc.)?  
• How sustainable will project strategies be in the long term? |
| 4. Management and implementation | • How will the work be implemented and managed, and by whom?  
• What human and material resources are required?  
• How will you collaborate with other organizations?  
• What is the timeline for activities |
| 5. Monitoring, evaluation and dissemination of findings | • How will activities be monitored and evaluated?  
• How and when will progress be reported?  
• How will conclusions and lessons be shared? |
| 6. Risks/assumptions considered in the design | • What are the main risks that could affect implementation?  
• What measures have been taken to minimize potential risks? |
| 7. Budgetary information and explanation | • What is the total cost?  
• How are the costs distributed?  
• What other sources of funds and resources are available? |

**Discussing a project proposal within the MoH and with strategic partners** *(steps may vary among partners and ministries)*

Follow local guidelines and procedures to ensure the approval of project documents. This might include an internal review within the Ministry of Health or other government departments, as well as review by strategic partners. If the submission must happen quickly to meet a tight deadline, alert staff who will review the proposal about the deadline. Strategic partners might also require internal clearance from senior officials in their own organizations, and sufficient time should be allocated for this.
Involve key staff as early as possible in the development and review process. This will minimize changes needed near the time of submission.

**Submitting the project proposal**

Submission may be to an in-country office or the international headquarters. This will determine how to submit the proposal, for example, by personal delivery, courier or email attachment.

Late receipt of a funding proposal can lead to rejection or postponement of consideration until the next round of funding. If unforeseen circumstances delay submission of the proposal, notify the donor and ask whether they would still accept it.

Once the proposal is submitted, there may still be a need for follow-up. Donors may fail to respond to your proposal for a number of reasons:

- They may be too busy.
- They may have forgotten about the proposal.
- The proposal may have been submitted to the wrong person and got lost in the system.
- The deadline had lapsed, and it will be considered in the next funding round.
- The contact details were incorrect.
- The resource provider may need additional information.
- The donor’s decision committee has not met yet.
- The donor may be checking the information provided, e.g. references of partners.
- The application may have been unsuccessful.

If a significant amount of time has passed and nothing has been heard from the donor, the proposal should be followed up by:

- Telephoning, writing or e-mailing the contact person;
- Seeking a meeting with the contact person;
- Asking anyone with contacts in the organization to enquire about it.

If the proposal is rejected, arrange a meeting with the contact person to identify how to improve it for the next funding cycle.
EXERCISE C: Mobilize funds from a donor

In this exercise, you will analyse the possible donors on a worksheet, analyse your past experience with donors, and write a letter of intent to a potential donor to request funds.

1. Prepare an inventory of possible RMNCAH donors who may be able to provide financial support for RMNCAH activities.

Worksheet: Donor inventory

<table>
<thead>
<tr>
<th>Category of organization</th>
<th>Organizations</th>
<th>Likelihood of interest in RMNCAH activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>NGOs/international NGOs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Civil society organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based organizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious groups/institutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>UN agencies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bilateral donors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multilateral donors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>International foundations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private companies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Describe your experience with donors in the past (in the space below). Have you had problems working with donors? If so, what problems have you had? What could you do to prevent these problems?
3. Write a letter of intent for a period of 1–3 years, focusing on scaling up or introducing your selected intervention package (on a separate sheet of paper or on your computer). At the top of the sheet, indicate the organization that is writing the letter and to whom (the individual or agency) it will be submitted.

Follow the format of the sample letter of intent. Make it no longer than one page (you do not need to prepare the attachments).

4. Exchange your letter of intent with another participant. Assume the role of a donor and consider:
   - How well does the writer fulfil the requirements for a letter of intent?
   - What are the strengths and weaknesses of the letter of intent?

Give feedback to the other participant and receive feedback on your letter of intent.

When you have completed this exercise, discuss your work with a facilitator.
Manage human, material and financial resources

**Fig. 14. Manage human, material and financial resources**

1. Advocate for RMNCAH
2. Mobilize resources
3. Manage human, material and financial resources
4. Manage supervision
5. Monitor progress and use results

**3.1 Manage human resources**

Health workers are the single-most important resource required for the delivery of RMNCAH interventions. Without well-trained, competent, organized and motivated health staff, effective programmes will not be possible. This is why management of human resources is such an important skill.

WHO and its Member States have committed to work towards the global health-related goals, including universal health coverage (UHC) and the Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all, at all ages. Addressing health workforce shortages, maldistribution and performance challenges is essential for progress towards most health-related goals, including UHC. The WHO Global Strategy on Human Resources for Health: Workforce 2030 encourages countries to adopt a diverse, sustainable skill
mix, harnessing the potential of community-based and mid-level health workers in interprofessional primary care teams. Globally, it is proposed to have a norm of 44.5 health workers per 10,000 population as a benchmark. However, in most countries the required health workers are not available in adequate numbers.

It is important that processes and procedures are in place for training health workers and for planning, supervising, supporting and monitoring their work, and to ensure that they provide quality health services.³

Important elements of managing human resources include:

- Estimating human resource needs (described in Module 2: Planning implementation);
- Estimating the cost of human resources (described in Module 2: Planning implementation);
- Organizing work in facilities and communities (described below);
- Training;
- Managing supervision including preparing supervisors (described in Skill 4 in this module).

Health workers are the single-most important resource required for the delivery of maternal and reproductive health interventions.

3.1.1 Organize work at health facilities

When work is divided among different categories of technically skilled people, and the work is well-directed and coordinated, the group becomes a team, with each member applying their own skills towards achieving the common objective. This is the principle of division of labour. This along with the skill mix of the health staff can have a major impact on the effectiveness and efficiency of services. When labour is divided appropriately, work can be done easily and more effectively, and the level of satisfaction among both health staff and clients is improved. Information on how work is currently organized in a health facility can be obtained by:

1) observing daily practices at the health facility;
2) interviewing the health workers and facility manager;
3) speaking to supervisors who visit the facility regularly;
4) speaking to clients (women, pregnant mothers and caregivers) who may have opinions on what worked or did not work, and what can be improved;

5) assessing and analysing how time is allocated and used, and how the staff and clients move through the facility;

Key questions include:

• **What services do clients need?** On an average, how many pregnant mothers, children, adolescents and women of reproductive age are consulted/examined each day? The reason for the mother’s/child’s visit to the health facility will determine the **skills required** of the health worker and **how much time** the interaction will take. The trained staff will need to attend to pregnant mothers/sick children. Other staff may be assigned to do basic screening and immunizations or conduct postnatal check-ups.

• **What categories of staff** are currently available? What pre- and in-service training have they received? Health workers’ skills will help determine their role in the facility. Ensuring that health workers are adequately trained and supported will allow them to assume roles with additional responsibilities.

• **Can we organize the service delivery for better efficiency?** For example, at one facility, one midwife managed all the antenatal visits while the other two midwives only weighed and measured children and administered immunizations. The queue of pregnant women was usually long, and the two midwives who handled the weighing and immunizations were not busy most of the time. The work was thus reallocated; once the weighing was over and the immunization queue had reduced, one of the midwives was assigned to sharing the task of managing antenatal visits. As a result, the queue of pregnant women moved much more quickly.

• **Can scheduling for non-urgent cases** be changed so that staff can be used more efficiently?

  ⊗ For example, follow-up visits could be scheduled on certain days and at certain times of the day.

• **As this is subnational-level planning, this document does not describe task-shifting and task-sharing, which are central-level functions.**
A district implemented a new programme that effectively trained all midwives who care for children and pregnant women to apply IMNCI, antenatal care (ANC) and postnatal care. Most first-level health facilities have two midwives and two health assistants.

A supervisor who visited six of the first-level facilities soon realized that the midwives were not happy. They were having trouble making time for the new services that they were required to provide. They spent a lot of their time with sick children; women had to wait for a very long time for ANC; and most clients would complain that they had to wait for long periods of time.

The district manager visited two facilities to interview the midwives and met several supervisors to get their inputs on why the midwives were dissatisfied. He asked the following questions:

- How long does it take you to provide services to your clients now? Is this longer than it used to take? Why do you think it takes longer?
- Which part of the new services (IMNCI, ANC and postnatal care) is the most difficult for you to do? Why is it difficult?
- How do mothers react when you provide care to their children according to the IMNCI guidelines?
- What is the case-load and what services do clients need?

Based on the interviews, he identified some possible causes of the problem and the possible solutions as shown below.

<table>
<thead>
<tr>
<th>Possible causes</th>
<th>Possible solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training was brief. There has been no follow-up after training. Staff are not sure how to perform the new tasks and are slow to do so</td>
<td>Ensure additional practice with feedback to help staff develop skills, speed and confidence</td>
</tr>
<tr>
<td>Some staff do not want to do ANC and postnatal care – they say they do not know how to do it or do not feel comfortable doing it</td>
<td>Divide assignments so that one midwife does ANC and postnatal care while the other staff can concentrate on treating sick children</td>
</tr>
<tr>
<td>Mothers do not like it when they are not given the medicines that they think they need (for instance, antibiotics for colds or diarrhoea), and are hostile to health staff, which makes them unhappy</td>
<td>Teach health staff the relevant information and skills to better discuss with and communicate to mothers why they do not need antibiotics for colds or diarrhoea</td>
</tr>
<tr>
<td>Health assistants are not being utilized to do some tasks that they used to do. The midwives do it all now</td>
<td>Reassign some tasks to health assistants (if task-shifting has already been done at the central level) to save the midwives some time</td>
</tr>
</tbody>
</table>

The supervisor did not provide additional clinical practice, but implemented the other solutions. After a few weeks, the supervisor found that the midwives were coping better and their motivation had improved. He asked the trainer to do follow-up visits to refresh the midwives’ skills in IMNCI, and these visits were scheduled for the next month.
3.1.2 Establish regular clinic hours and schedule health staff

The regular clinic hours of the health facility should be posted in a visible place and health workers should always be available during this time. Limited clinic hours can be a barrier to the effective use of health services. If the health facility is not open 24 hours, set the working hours in such a way that they are convenient for the public. For example, it may be possible to increase use by opening early in the morning, and/or by extending clinic hours into the early evening on some days. Also ensure that some kind of “on-call” system for emergencies is in place.

Key considerations when scheduling health workers include:

- Presence of enough staff during peak hours.
- Presence of staff with the appropriate skills.
- Labour regulations (overtime, night shifts, seniority, etc.).
- Night-time coverage.

For more information on the organization of work, see the WHO publications: “On Being in Charge: A guide to management in primary health care” and “Determining Skill Mix in the Health Workforce: Guidelines for managers and health professionals” and other related literature.4

3.2 Manage logistic supplies

In addition to human resources, the uninterrupted availability of drugs, equipment and other supplies is an important prerequisite for the delivery of RMNCAH interventions. It is important to procure quality goods that are worth their price. Logistic management includes creating a distribution system for RMNCAH commodities that maintains them in good condition by rationalizing storage points, using an efficient transport modality, reducing incidences of theft and fraud and, most importantly, providing information to forecast needs, thereby reducing stock-outs. This requires good system management along with a well-designed information system, which is called the logistic management information system (LMIS).5

Estimating material needs and costs is discussed in Module 2: Planning Implementation.

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5 A logistic management information system (LMIS) is a system of records and reports – whether paper-based or electronic – used to aggregate, analyse, validate and display data (from all levels of the logistic system) that can be used to make logistic decisions and manage the supply chain.
If the manager has the authority to purchase goods independently, the following processes need to be followed:

- Get estimates from at least three suppliers to ensure that you have the best price. This is particularly relevant for expensive items such as capital goods (i.e. goods that are purchased less often and last for more than one year).
- Review quality and reliability, in addition to the price of an item. Cheaper items that are of lower quality or have a shorter life expectancy may not be cost-effective in the long term.
- Ensure that the date of expected supply is specified, so that the supplier takes on the risk in case of price rise.
- Ensure that supplies are insured in case of loss or damage during transport.

It is important for the managers purchasing goods to be well-versed with their specifications, prices and quality. Currently, there are well-developed RMNCAH supplies systems such as “UNFPA Supplies”, which provide medicines, supplies and equipment related to reproductive, maternal and newborn care services.

If the manager does not have the authority to purchase goods independently, then goods must be ordered from a central agency or supplier. Prices are fixed and there is often limited choice. In this case, managers need to ensure that requests to the central store are made on schedule to allow for enough time for the goods to be released. Regular follow-ups with store managers may be required.

Monitoring and ordering

Clear policies and procedures are needed for monitoring and ordering stock. If the programme or facility is large, full-time staff are allocated to this task. Reordering must be done on schedule so that materials can be delivered in time and stock-outs can be avoided. Sometimes, the stock manager is responsible for reordering, while at other times it is done by a programme manager.

The stock card is an important tool for the management of medicines and other supplies at a health facility, hospital or storage facility. Accurate records allow managers to track what has been used, when and for what purpose. This information allows managers to know the amount of each item available at any time, how much to order and when to reorder. It is also important for ensuring accountability. An example of a stock card is shown below.

---

Principles of maintaining stock records are:

- Make a stock card for each item in the store.
- Keep the stock card with the item on the shelf.
- Keep the record up-to-date. Make an entry every time an item is received or issued. Do not wait until the end of the clinic session, day, week or month; otherwise, there is a risk of details being forgotten. Keep an accurate running balance of the number of items available.
- Count the stock at regular intervals (for example, once a month) and record the actual physical count on the stock card. Compare this with the balance on the stock card. If there are significant discrepancies, investigate what may have happened.
- It is essential to monitor the expiry dates of the stocks and note the expired/close-to-expiry items.

Where computers are available, managers may use them to keep track of stocks. In such situations, it is still recommended to keep a physical stock card so that the staff who do not use the computer can record the use of stock. The stock card is also a backup record in case of loss of computer data.

Keep a record of equipment and other assets as well; sometimes this is referred to as an “assets register”. The records should contain a description of the asset, the manufacturer, serial number, date of purchase, supplier, purchase reference and cost.
Stock outside of the health facility should also be monitored. For example, health workers in a community outreach programme, community health workers or community volunteers may be allocated materials and will need to have a system for reordering their stock.

**Reordering medicines and supplies**

Medicines and other supplies are reordered based on their rate of consumption to ensure that stock-outs are avoided. The *reorder factor* can be used for calculating the reorder level and the quantity to reorder each time. The reorder factor, shown in Fig. 17 below, takes into account some additional safety stock to allow for unexpected demands, delays in transport and in receiving the order, or other unexpected events (the reorder factor is equivalent to the number of months in the order period multiplied by 2, plus 1).

The *reorder level* is the threshold below which an order should be placed, and also denotes the quantity to be reordered at that time. Determine the reorder level by multiplying the average monthly consumption of the medicine by the appropriate reorder factor.

The steps below are commonly used to order stock based on past consumption:\(^7\)

**Fig. 17. Reorder factors and reorder levels**

The reorder factor is calculated by doubling the number of months in the order period and adding an extra month. It is used to determine the reorder level and the quantity to be reordered each time.

If supplies are delivered once a month, the reorder factor is 3

- If every 2 months = 5
- If every 3 months = 7
- If every 4 months = 9

The reorder level is the stock threshold below which an order should be placed and is also the quantity to reorder at that time.

The reorder level is calculated as follows:

\[
\text{average monthly consumption (AMC) \times reorder factor} = \text{reorder level}
\]

\(^7\) Different countries, facilities or programmes may use different systems. The method used does not matter, provided it is systematic, easy to follow and used consistently.
1. Using stock cards, calculate the average monthly consumption (AMC) of each item in the store.

2. Determine how often the facility receives deliveries.

3. Determine the reorder factor of each item in your store based on the information in Fig. 17.

4. Calculate the reorder level by multiplying the average monthly consumption by the reorder factor.

5. Determine when and how much to order by comparing the reorder level with the balance in stock. If the balance in stock is more than or equal to the reorder level, it is not time to reorder. If the balance is less than the reorder level, it is time to reorder. Order the reorder level of the item.

6. Place the order in writing to the medical supplier and consider the expiry date when ordering.

Example: Reordering medicines for XX district

Item: Paracetamol tablets (100 mg)

AMC = 10 bottles
Delivery frequency = every 3 months
Reorder factor = 7
Reorder level = 10 x 7 = 70 bottles

On 1 March, balance in stock is 83
Do not reorder paracetamol

On 1 April, balance in stock is 68.
Order 70 bottles of paracetamol

Procedures are different when ordering medicines and supplies to manage seasonal diseases, epidemics or other emergencies. Instead, consider the following:

- Based on local experience of the onset of seasonal diseases in your area, order enough supplies well in advance. Do not order the reorder level; instead base estimates on the quantity ordered last season, adjusting for last season’s experience and any possible population changes.

- For an epidemic or emergency, estimate the number of cases expected from past experience or the experience in other settings. This may require estimating the total population or number of persons in a certain age group, and the proportion of those who are expected to get sick, based on the expected rate for a disease or public health problem. Ordering in this situation usually takes place as an emergency order, outside of normal channels.
Receiving and storing materials

Procedures to receive supplies properly include:

- Receiving the supplies in person.
- Checking the outside of the box for damage or theft.
- Keeping a record of deliveries (date, amount, recipient).
- Checking the supplies received against the items on the requisition form (item and quantity), and asking the delivery person to sign the form to verify the delivery (and to note and sign in case of any discrepancies).
- Checking the expiry dates of all items.
- Checking the basic quality of the delivered items.
- Documenting all problems.
- Sending a note to the supplier that the materials have arrived, and describing any problems.

After the goods have been checked and received, they need to be stored. Supplies should be organized so that the storekeeper (or other people with access to the store) can easily find what they are looking for.

During storage, remember to:

- Choose a secure room that can be locked.
- Double-lock the store and keep it locked at all times when not in use.
- Inspect the physical structure regularly.
- Control the temperature, light and humidity.
- Prevent water damage.
- Keep free from pests (e.g. rats, roaches, ants and wasps).
- Store similar items together.
- Arrange and label the supplies on the shelves, with a stock card for each item.
- Arrange medicines by the expiry date and ensure that items that will expire first are issued first. Remove any expired and poor-quality medicines.

File notes on the delivery and the invoice for payment.
When arranging medicines with an expiry date, apply the principle: “first expiry, first out”. This means that medicines due to expire first should be placed in front of medicines that will expire later. Apply the principle “first in, first out” for items without an expiry date; newly received items should be placed behind items that are already on shelves.

Ensure that there is enough storage space for materials and supplies. If space is not available, it is necessary to:

1) negotiate more frequent (smaller) deliveries; or
2) build more storage space.

**Distributing materials**

Different countries follow different distribution systems depending on the organization of their health systems.

**National/regional RMNCAH managers** may have to work with the supply agency, suppliers, receivers and logistic people in districts depending on the systems in different countries to ensure the smooth distribution of the materials needed. If they are not directly responsible for ordering and distribution, then they need to liaise with the department that is responsible to ensure that adequate supply levels are maintained.

**District RMNCAH managers** need to work with facility-based staff to ensure that supplies get to where they are needed. Often, this means using all the available opportunities for delivery, including supervisory visits, trips to the district office by facility staff or coordinating visits with staff in other programmes.

**For community outreach**, materials need to be taken from facilities to community service delivery points or to community health workers. Distribution systems will often be different, depending on the distances involved, the available transportation and the possibilities for collaborating with local partners for distribution. The quantity of materials sent should not exceed that which the receiving facility or staff can safely receive and store.

Health staff who receive material resources are **accountable** for them, just as they are held accountable for financial resources. Regular physical count of materials and supplies allow a review of the actual stock. If discrepancies are discovered between what should be in stock and the actual stock, the cause needs to be identified and appropriate action taken.
Example of identification of causes and solutions for stock-outs

A newly assigned district RMNCAH manager learned that most health facilities in the district report stock-outs of essential medicines almost every month. Medicine supplies from the district level are usually reliable. The district RMNCAH manager analysed the problem as shown below.

<table>
<thead>
<tr>
<th>Possible causes for stock-outs</th>
<th>Possible solutions for stock-outs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health facilities as well as the district store do not calculate needs correctly or place orders too late.</td>
<td>Train responsible people how to calculate needs and when to reorder.</td>
</tr>
<tr>
<td>Transportation to health facilities has been unreliable, so deliveries of medicines are often late or are completely missed (because of lack of fuel, impassable roads and security issues such as theft of medicines from trucks).</td>
<td>Try to solve the problem of fuel shortage.</td>
</tr>
<tr>
<td></td>
<td>Increase the size of stocks in health facilities, so that they have sufficient stocks despite delayed or missed deliveries.</td>
</tr>
<tr>
<td>The needs in this district have been unexpectedly high, perhaps because more patients are availing health facilities (e.g. influx of migrant workers) or because there is more sickness than usual (e.g. seasonal variations or outbreaks after flooding).</td>
<td>Find out whether needs were unusually high and, if so, why.</td>
</tr>
<tr>
<td></td>
<td>Teach responsible people how to adjust estimates of medicines needed for seasonal changes, and how to order additional supplies in an emergency.</td>
</tr>
<tr>
<td>Medicines are not well accounted for. Stock cards are not kept up to date. Theft or wastage of medicines from stocks is not detected.</td>
<td>Train responsible people to keep stock cards up to date and supervise them; keep the stockroom locked except when medicines are taken out or in; record any wastage; do a physical count of stock every month; and justify discrepancies on stock cards.</td>
</tr>
</tbody>
</table>

After doing this analysis, the manager decided that they must investigate further to determine which of the possible causes were indeed true, before applying a solution.
EXERCISE D: Manage medicines and supplies

In this exercise, you will answer questions related to managing medicines and supplies.

Part 1: Reordering medicines

You are responsible for ordering medicines and supplies at a first-level health facility. Answer the questions relating to Scenarios A and B. The item to be ordered is iron-folate tablets (bottles).

Scenario A

AMC: 3 bottles
Frequency of delivery: once per month
Stock card balance: 12 bottles

What reorder factor should be used? ___________________________ _______________

What is the reorder level? ___________________________ _______________

Is it time to order? _________________________________________________ ________

If yes, how many items should be ordered? ______________________________________

Scenario B

AMC: 8 bottles
Frequency of delivery: every 2 months
Stock card balance: 32 bottles

What reorder factor should be used? ___________________________ _______________

What is the reorder level? ___________________________ _______________

Is it time to order? _________________________________________________________

If yes, how many items should be ordered? ______________________________________
Part 2: Discrepancies between issued and actual materials

You are the manager of a health facility and are responsible for issuing materials to a mobile community outreach programme. Two months ago, you issued five weighing scales to the mobile clinic, but during stock monitoring this month, you learn that only two remain.

1. What are the possible causes of this discrepancy?

2. How can you address this problem?

3. What can you do to prevent this situation from happening again?

When you have completed this exercise, discuss your work with a facilitator.
### 3.3 Manage financial resources

Managing financial resources is an important function of an RMNCAH manager. Financial management includes developing accurate budgets, establishing safe systems for handling funds, monitoring spending, minimizing waste, and reporting on the use of the funds. While good financial management is essential in any setting, it is particularly important when resources are limited. There are a few publications by WHO and other organizations related to this. Budgeting, including estimating human and material resource costs, was summarized in Section 6.3 of Module 2: Planning implementation.

Fig. 18. Manage financial resources

<table>
<thead>
<tr>
<th>3. Manage human, material and financial resources</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1. Manage human resources</td>
</tr>
<tr>
<td>3.2. Manage material resources</td>
</tr>
<tr>
<td>3.3. Manage financial resources</td>
</tr>
</tbody>
</table>

#### 3.3.1. Estimate available funds

A proportion of the total estimated budget will come from the government. Determine the proportion to be funded by the government by maintaining regular communication with the Ministry of Finance or other key staff. In some cases, the annual funding is fixed and will not change, regardless of requirements. In other cases, the amount allocated to RMNCAH may change every year depending on shifting priorities.

Once the funding available for RMNCAH for the budget period is known, managers can compare the total budget with this amount. If the funding is sufficient, all activities can be implemented as planned. If there is insufficient funding, then alternative sources of funds must be mobilized or plans for activities must be modified.

Mobilizing resources for RMNCAH is described in Section 2 in this module.

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3.3.2 Identify opportunities for cost savings

Given that financial resources are limited, managers should try to save on costs whenever possible, without compromising on the quality of material resources. Cost savings can be made in a number of ways, including:

- Implementing strategies such as IMNCI that have been proven to be cost-effective (IMNCI has been demonstrated to reduce unnecessary medicine use, and, therefore, to reduce medicine costs).

- Removing activities that are not essential, for example, by prioritizing some activities and delaying others until the next phase.

- Better packaging of interventions with existing activities. Examples include combining new training with another planned training course or training existing staff to perform new duties (immunization staff may distribute vitamin A or outreach workers can have ANC counselling added to their current tasks).

- Improving access to equipment, supplies and staff from other sections of the Ministry of Health, for example:
  - health education/communication staff, equipment and materials;
  - technicians for operating and maintaining equipment;
  - vehicles and fuel;
  - medicines and supply logistics;
  - a focal person who can help work with the media.

- Monitoring medicines in the pharmacy or storage room to ensure that they are stored correctly and managed to avoid unnecessary waste. Monitor to ensure that medicines are used before their expiry dates (follow the rule “first expiry, first out” or “FEFO”) so that they do not have to be discarded. This requires good stock management procedures such as the use of stock cards.

- Using new technology to improve communications. Use mobile phones/tablets for better, more effective communication. For example, mobile phones may be used to rapidly report adverse events, report immunization coverage or to assist with the referral of cases of severe illness or obstetric complications. The mobile phone number of a skilled birth attendant may be given to pregnant women to facilitate rapid contact. Similarly, mobile phone messages could be used to remind the clients of their next appointment dates and to disseminate health education messages.

- Linking activities, which is often possible in the area of transportation. For example, the regular delivery of medicines, contraceptives and vaccines by the government or by NGOs can be linked with the delivery of other supplies and materials or with transportation for supervisory visits. This is applicable even to transporting items to
clinic centres. For example, vaccines and family planning (FP) items should not be distributed separately as two programmes.

- Monitoring the ordering system to ensure that adequate but not excessive materials are ordered.
- Ensuring that staff are accountable for the funds and materials they handle to minimize wastage and the inappropriate use of resources.

Even when a manager does not have control over a certain area, such as procurement of medicines, it is often possible to influence the decisions and plans made by others. Provide recommendations to them that are supported by accurate and persuasive information.

### 3.3.3 Ensure accountability

Managers and health personnel of the government are accountable for how financial resources are used. The government is, in turn, accountable to the general public. To ensure accountability at all levels of a programme, managers should:

- Ensure that there are sound procedures for requesting, handling and distributing funds.
- Know how money has been spent at any given moment in the implementation cycle.
- Ensure that money is spent as intended.

These steps are part of what is referred to as “internal control”.

### Requesting funds

Transfer of funds from the government or donors may be scheduled automatically. However, sometimes funds for RMNCAH activities need to be requested directly. Requests should be made in a timely manner, and managers should have a system in place that will alert them (or whoever the responsibility has been delegated to) when funds will be needed.

This requires monitoring bank accounts and cash reserves continuously. It is time to request more funds when the balance reaches an amount that is insufficient to cover possible contingencies. Different sources of funding (MoH and donors, for example) may need different time periods to process requests and transfer funds; it is important to know the time required to process the different transfers.
Handling funds

Keep records of all payments received from the MoH and donors, as well as from patients (as user fees, for example). Government money is often allocated for specific needs such as medicines or other materials. These funds are transferred and do not involve cash transactions, but this movement of funds still needs to be tracked and recorded.

Keeping accounts

Managers and health personnel at all levels need to be skilled at maintaining accounts and accounts books. Simple systems for collecting, compiling and analysing financial data are needed. In many countries, these are now done via computer-based programmes. It is important to enter transaction data regularly. This helps to identify potential problems (such as overspending) early and allows for timely action to correct the problem. An accounting system also assists with the preparation of financial reports (see Section 3.3.4).

Monitoring expenditures

The most important tool for monitoring expenditures is the budget. The budget shows how much should be spent on different activities and tasks over a given time, usually one year.

Allocate one day each month (or more frequently, especially at the end of the financial year) for reviewing expenditures. All health staff who have a role in spending should be present. Review expenditures line by line to ensure that they are within the budget. If the budget is being used up too quickly or too slowly, identify the reasons for the same. Expenditures should be reviewed in the following areas:

- **By item**: Expenditures on some items may be higher than budgeted and some may be lower. For example, salary expenditures are often higher than budgeted, due to unexpected increases. Similarly, it is common to spend more on fuel than planned. Sometimes money has not been spent as planned. Identify areas where spending can be improved since unspent money may need to be returned at the end of the fiscal year. In most cases, funds should be spent as soon as possible; this is particularly important for materials and supplies that can be ordered in advance.

- **By function**: Particular activities may be delayed while others may have happened sooner than expected. For example, the implementation of training activities may be slower than expected, leading to underspending.

- **By level**: Different levels can have different rates of expenditure and different costs. For example, you may find that you are overspending at the facility level but that you are underspending on community outreach activities.
Once the sources of discrepancies between the budget and actual expenditures have been identified, address the problem by increasing or decreasing the rate of spending. For example:

- Spending can be reduced by looking for alternative ways to meet costs. For instance, fuel costs can be decreased by using vehicles only when absolutely necessary.
- Spending can be increased in key areas by improving the availability of certain resources. For example, if training has not occurred because trained facilitators were not available, funds could be used to train additional facilitators, and then the planned training courses can be conducted.

If it is not possible to influence the expenditure pattern, which is sometimes the case, then it may be necessary to move money between budget lines. This approach reallocates funds, while maintaining the same overall spending levels. Sometimes, clearance from the funding organization is required to legally permit the transfer of funds from one activity to another.

3.3.4 Report on the use of financial resources

Providing end-of-period reports on the use of financial resources is an important part of financial management. Financial reports need to be tailored to their target audience, which is why different organizations require different formats. In addition, reports from different levels of the health system will have varied content. Different levels of financial reporting include:

- **Community**: Local managers of community activities will usually report to district-level managers. The financial details will relate to the human and material costs of community activities.
- **Districts**: District managers can report to the national level or sometimes to the higher subnational level in decentralized programmes. These financial reports will cover the entire district budget that will include all recurrent and non-recurrent human and material expenses.
- **National**: National managers often have to report to the government and to international donors. When some elements of the programme are funded by the government and others by donors, reports must be tailored accordingly and these must indicate how specific funds contributed to the entire programme.
EXERCISE E: Manage financial resources

In this exercise, you will analyse some ways to improve financial management in an RMNCAH programme. Write down the answers to Parts 1 and 2 below. Then, there will be a group discussion.

Part 1: Monitoring expenditures in a district

a) Complete the subtotals, totals, and the last column in the table (round off decimals, e.g. 0.625 = 0.63).

<table>
<thead>
<tr>
<th>Cost</th>
<th>Budget</th>
<th>Expenditure at mid-year</th>
<th>Expenditure as % of budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capital costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure</td>
<td>14 000</td>
<td>6 000</td>
<td></td>
</tr>
<tr>
<td>Vehicles</td>
<td>16 500</td>
<td>11 250</td>
<td></td>
</tr>
<tr>
<td>Equipment</td>
<td>10 000</td>
<td>5 500</td>
<td></td>
</tr>
<tr>
<td>Training (non-recurrent)</td>
<td>1 000</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Communication/IEC (non-recurrent)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal capital</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recurrent costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>68 000</td>
<td>31 750</td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td>20 000</td>
<td>12 500</td>
<td></td>
</tr>
<tr>
<td>Other supplies</td>
<td>3 000</td>
<td>1 400</td>
<td></td>
</tr>
<tr>
<td>Maintenance and operations – infrastructure</td>
<td>2 000</td>
<td>900</td>
<td></td>
</tr>
<tr>
<td>Maintenance and operations – vehicles</td>
<td>8 000</td>
<td>4 750</td>
<td></td>
</tr>
<tr>
<td>Maintenance and operations – equipment</td>
<td>1 700</td>
<td>625</td>
<td></td>
</tr>
<tr>
<td>Training (recurrent)</td>
<td>1 250</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Communication/IEC (recurrent)</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Administrative expenses</td>
<td>1 000 000</td>
<td>425 000</td>
<td></td>
</tr>
<tr>
<td>Utilities (electricity, water, etc.)</td>
<td>7 800 000</td>
<td>4 675 000</td>
<td></td>
</tr>
<tr>
<td><strong>Subtotal recurrent</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
b) Then answer the following questions

1) Did the district’s total expenditure by mid-year stay within the budget? If yes, what percentage of the budget was underspent? If no, what percentage of the budget was overspent?

2) Which budget lines were overspent at mid-year and which were underspent?

3) What percentage of the total expenditure so far was spent on vehicles?

4) What percentage of the recurrent expenditure at mid-year was spent on medicines?

5) What percentage of the total expenditure at mid-year was spent on personnel?

6) What is your conclusion regarding this programme’s spending compared with its budget?
Part 2: What are the most common problems with budgeting for your programme?

To prepare for a group discussion, make notes below on the most common problems with budgeting for your programme.

Consider:

• How are budgets developed by the staff?

• How are budgets allocated at the national, provincial or district level?

• How are budgets routinely spent?

• How are expenditures monitored?

When you have completed this exercise, tell your facilitator that you are ready for the group discussion.
Supervision is a staff development strategy that leads to higher quality of service; improves staff performance, including adherence to standards and protocols; promotes integrated and collaborative teamwork; and ensures continuous professional development.

The aim of supervision is to provide safe, quality services by health staff who are supported, and engaged, and participate in continuous professional development.

There are four important functions of supervision:

1. **Management**: Review competency of staff, adherence to protocols; provide opportunity to discuss work; acknowledge good practices; and challenge and manage poor performance of staff.
2. **Support:** Provide support to staff to ensure health and well-being at work, and to promote a positive environment for evidence-based practice and performance.

3. **Learning and development of each individual:** Identify the strengths and learning needs and areas for development, and plan and set targets for professional development.

4. **Engagement/mediation:** Ensure healthy engagement with and communication between staff and the management.

Supervision is an important working relationship rather than a punitive interaction.

**Supervision** is a support system aimed at improving the knowledge, attitudes and skills of health staff and, thus, the quality of health programmes. Supervisors provide feedback and support, give training and help solve problems.

### 4.1 Review and improve the organization of supervision

Supervision is important for maintaining a high level of performance and motivation among health staff, thereby maintaining the quality of health services. The organization of supervision in the programme includes **what and who is supervised, how, when and by whom.**

#### 4.1.1 What is examined during supervisory visits?

- Clinical care, including case management practices and counselling.
- Programme activities, including routine reporting, medicine/vaccine ordering, health education, supply management and training.
- Work by facility staff in the community, such as doing outreach sessions, supervising community health workers, supporting mothers’ groups.

When deciding what will be supervised, a manager should consider what needs to be supervised beyond health staff at health centres and clinics. Other types of staff and their work require supervision as well, such as trainers, supply officers and health educators. Plan for a supervisor to visit all the different types of workers who perform activities for the programme. Also plan in such a way that each of the types of activities listed above are supervised.

It would be ideal for supervisors to check whether each type of worker performs all their assigned activities, and whether they adhere to standard operating procedures (SOPs). However, it is nearly impossible to review all activities in one visit. Supervisors are always limited by the availability of resources – people, time and funding. Therefore, it is necessary
to prioritize those activities and tasks that are most important for a programme’s success, and to focus on supervising them. The tasks or items that need to be supervised may change over time. When deciding what to supervise, consider the questions in Fig. 20.

Fig. 20. What to supervise?

**Questions to consider**

- What are the key tasks of clinical practice or case management performed by health staff that should be checked against technical standards?
- Which activities are showing inadequate performance? What specific failures would seriously interfere with the success of the programme?
- Which tasks and activities are the most difficult or challenging for health workers?
- Which tasks and activities are new/complex to health workers?

When deciding what will be supervised, try to combine intervention packages or programmes. **Joint supervision** has a number of benefits, including:

- saving resources such as vehicles and travel time;
- avoiding duplication of work among supervisors;
- reducing disruption of routine facility services;
- promoting stronger and closer collaboration between programmes.

A supervisor should check that health workers have the system-level support they need to work effectively. When visiting a health facility, a supervisor should look for the following:

- Adequate supplies of medicines and vaccines, with proper storage conditions and good record-keeping.
- Adequate supplies and functionality of essential equipment and materials.
- Availability of current guidelines, protocols, circulars, etc.
- Potable water, handwashing facilities and latrines.
- Infection control procedure, including proper waste disposal system.
- Sufficient stocks of registers and records.
- Functional management information system.
The supervisor should also assess whether the health system, at the higher levels, is providing these basic requirements:

**Adequate staff to administer the facilities and training to do so**
- Adequate staff to administer the facilities and training to do so.
- Adequate working conditions, including accommodation, regular payment and career advancement.
- A functional system for distributing medicines, vaccines, materials and supplies.
- Adequate budget for routine activities.
- Clear guidelines on routine reporting requirements.
- Resources for regular supervision.

If these are not present, the supervisor should inform the higher-level management, and provide details of the problem and its impact, so that they may facilitate the process. All supervisory visits should give the staff an opportunity to express the problems they have encountered in their work.

**4.1.2 What are the methods used during supervisory visits?**

There is no single best method of supervising. Several methods exist, all of which have advantages and disadvantages.

- **Observation of health worker practice:** This method is the only way supervisors can see what a health worker is actually doing, and at the same time appreciate the environment in which they work. Observation is also key to assessing supply management and the organization of the health facility.

- **Speaking to health workers:** This may help assess their knowledge on different topics. It also allows supervisors to understand what health workers see as problems, and what they see as possible solutions.

- **Review of records:** This is a quick way to review some of the activities of the health workers since the last supervisory visit. Keep in mind that record review is only useful for activities for which records are complete and well-kept.

- **Exit interviews with the caregiver or client/patient:** After the consultation, supervisors can assess the caregiver or client's/patient's knowledge of the relevant medical information and specifically review how much they remember of the advice given during the consultation, and can also assess the perceptions about the care that was received.
• **Community interviews**: Interviews with caregivers and other community members, either one-on-one or in small focus groups, can address how they perceive the quality of services provided by the health facility.

On any supervisory visit, it is recommended to use a combination of these methods.

### 4.1.3 When are supervisory visits conducted?

When developing a schedule for supervisory visits, decide how frequently and when visits will be conducted. Supervisory visits should occur regularly (i.e. recur at fixed intervals), such as monthly or quarterly. Health staff should be able to count on the supervisor coming in on a regular schedule.

Visits should be scheduled when supervisors are available, and are able to devote sufficient time, such as in the middle of the month rather than at the end of the month, when there may be many tasks to be completed, such as reporting and ordering. If a supervisor is rushed, he or she will have limited time to assess all areas, give feedback and solve problems (“drive-by” supervision, as shown in the figure below, provides little help, and may damage trust in the supervisor).

Visits should be scheduled when health workers are likely to be available as well. For example, outreach days, salary days, holidays, festivals or national immunization days are poor times for visiting facilities. Supervisors may use tools to plan their supervisory visits (Annex 3).
Supervisory visits should occur frequently enough to provide the required support and identify and solve problems before they turn significant. Monthly visits to health facilities are recommended, if feasible. Staff or facilities identified as having problems should be visited often. Staff who have recently been trained often need more frequent visits until they have gained experience in applying their new skills.

4.1.4 Who will conduct supervision?

Select staff to conduct supervisory visits keeping in mind:

- **Geographical proximity:** Proximity to the facility to be visited (to minimize distances and expenses for travel as much as possible).

- **Activities or tasks to be supervised:** For example, clinical practice versus administrative tasks.

- **Previous training/experience:** For example, antenatal care (ANC) or family planning (FP) supervisors should have had ANC or FP training and experience, respectively, with follow-ups after training.

- **Who will be supervised:** Can nurses be supervised by medical assistants? Can health workers be supervised by non-medically trained staff? Ideally, supervisors will have equal or higher qualification or rank as the staff they supervise, and are usually country-specific.

- **Availability for regular supervisory visits:** The number of days per month that supervisors will need to devote to making visits.

Fig. 21. Summary of options for the supervisor

<table>
<thead>
<tr>
<th>National/regional staff visit districts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Supportive supervision helps district managers and supervisors.</td>
</tr>
<tr>
<td>2. Technical supervision at referral facilities is usually done by national staff.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>District staff visit health facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Visit by a trained clinical supervisor:</strong> Supervisory visits by a trained clinical supervisor allow for observation and validation of case management, assessment of facility supports, immediate feedback and problem-solving.</td>
</tr>
</tbody>
</table>
2. **Visits by a non-clinical supervisor:** In many districts, visits are already being carried out for many reasons, often by staff who are not trained to assess the clinical practice of health workers. Non-clinical staff can, however, assess administrative tasks and essential supports.

**Supervision within a facility**

1. **By a trained senior health worker:** A senior worker can be trained to provide skill reinforcement, solve problems and record monitoring information. In some countries, certain categories of staff by default have a supervisory role to play (the matrons and nurse managers/supervisors are expected to supervise staff nurses).

2. **Within facility peer review:** Two or more trained staff in the same facility or from nearby facilities could assess and give feedback on one another’s performance during clinical rounds, case conferences or morbidity/mortality audits.

**Health workers visit district office or hospital for supervision**

Visits to collect pay or supplies can be used as opportunities to discuss problems, get information on the availability of essential medicines and supplies, observe the labour rooms, and/or observe case management. However, it is always better to have organized supervisory visits.

**Other contacts between health workers and district managers**

Telephone, email, SMS and other forms of communication may be used to report the availability of equipment and supplies, and discuss problems.

**Self-assessment and reporting**

It may be possible to teach health workers to review and document their own performance and the problems they encounter with RMNCAH programme activities.

To summarize, the organization of supervision in the programme includes what and who is supervised, how, when and by whom. The following table provides a sample worksheet that specifies these aspects in a district.
### Sample worksheet: Organization of supervision

#### Interventions/packages: Postnatal care

<table>
<thead>
<tr>
<th>Where</th>
<th>What and whom to supervise</th>
<th>Supervisory methods</th>
<th>When: Frequency</th>
<th>Who will conduct supervisory visits</th>
<th>Interventions that could be supervised at the same time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community level</td>
<td>CHWs performing postnatal visits to check on the mother and the baby; help with cord care, breastfeeding, look for danger signs in both, and refer if necessary</td>
<td>Observation using a checklist, Interview postpartum mother/family, Discussions with CHW</td>
<td>Quarterly</td>
<td>Sub-district-level managers/health facility staff</td>
<td>Breastfeeding Promotion of postpartum FP</td>
</tr>
<tr>
<td>First-level health facilities</td>
<td>Health staff providing postnatal care</td>
<td>Observation of the health staff providing postnatal care, Discussions with the staff on health education/counselling, Review the record-keeping</td>
<td>As required</td>
<td>District/sub-district supervising staff</td>
<td>Immunization, breastfeeding</td>
</tr>
<tr>
<td>Training courses</td>
<td>Trainers providing training</td>
<td>Observation of training sessions</td>
<td>When trainer is new, semi-annually; thereafter annually</td>
<td>District trainer</td>
<td></td>
</tr>
</tbody>
</table>
Note: Areas for supervision could include the following:

- Medicines, equipment and supplies, printed forms, health education materials.
- Case management practices and procedures such as postpartum IUD insertion.
- Administrative tasks such as reporting and medicine ordering.
- Maintenance of the health management information system (HMIS).
- Knowledge and practices of caregivers.
EXERCISE F: Improve the organization of supervision

In this exercise, you will answer questions about supervision and plan improvements for the organization of supervision in your programme.

1. What are the problems commonly associated with getting supervisors for your programme? How could you manage these problems?

<table>
<thead>
<tr>
<th>Problems</th>
<th>Management solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. In the following worksheet, outline an improved supervision plan for the intervention package you have designed.

Write down your answers in the appropriate box in the worksheet.

- In the left column, specify where the supervised work is occurring in the health system. In the additional rows below, you may specify additional locations, such as referral facilities and training courses.
- In the second column, list what and whom to supervise. Be specific.
- In the remaining columns, specify:
  - the supervision method(s) for the person/activity/task;
  - how frequently supervision is necessary, based on local feasibility;
  - staff who will conduct the supervisory visits;
  - other interventions or packages that could be supervised simultaneously (for instance, how could you integrate supervision to make it more efficient?).
### Worksheet: Organization of supervision

#### Interventions/packages

<table>
<thead>
<tr>
<th>Where</th>
<th>What and whom to supervise</th>
<th>Supervisory methods</th>
<th>When: Frequency</th>
<th>Who will conduct supervisory visits</th>
<th>Interventions that could be supervised at the same time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-level health facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral health facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When you have completed this exercise, discuss your work with a facilitator.
4.2 Ensure that supervisors are well prepared

4.2.1 Provide comprehensive supervisory checklists and recording forms, and train supervisors to use them

A supervisory checklist is a good tool that clearly outlines what to cover during a supervisory visit. They also remind the supervisor of what to check and record.

Periodically, review supervisory checklists to find ways to improve them, and in turn improve supervisory visits. For example, there may be a section that supervisors rarely or never fill out; this may either indicate that supervisors do not know how to complete it or that they do not perceive the information as important.

Supervisory checklists should:

- follow clear technical standards,
- be as concise as possible as time is limited,
- remind the supervisor of items to cover:
  a) Review the health worker’s performance, including
     - observation of clinical practice; for example, the examination of pregnant women,
     - review of records and other administrative tasks.
  b) Review health system support, such as the availability of medicines, vaccines, equipment and supplies and infrastructure.
  c) Interview caregivers and communities to determine their satisfaction with services and local perceptions of the quality of care.

See Annexes 4 and 5 for examples of supervisory checklists.

Annex 4 is a supervision checklist for maternal and reproductive health from Myanmar and Annex 5 is a supervision checklist for a polyclinic providing a range of reproductive, maternal and child health services from Sri Lanka.

Supervisory recording forms are used to note down the findings and recommendations from each supervisory visit. The recording form may be the same as the supervisory checklist or it may be a separate form based on the supervisory checklist, which is used as a reference but is not written on. One copy of the recording form is usually left at the health facility or with the health worker, and the supervisor submits another copy to the district-level office or a higher office.
Supervisory recording forms should:

- Be easy to use.
- Document the date and site of the visit; items checked; strengths observed; problems identified; actions taken at the facility; actions planned; and people responsible in the future.
- Be integrated, i.e. include multiple technical areas so that different areas do not require different forms. For example, the supervisory record form for a community clinic could include ANC, FP and immunization.
- Produce data that can be abstracted at the district level or higher and be used to monitor progress at facilities (if supervisory visits include the collection of monitoring data). This data is needed for planning implementation (Step 2).

Train supervisors to use the checklists

A simple but effective training session should include a description of each item on the checklist. Teach supervisors how to make entries for each item, demonstrate the filling-in process or show a sample completed checklist, and have them practise filling out a checklist in the field during the training. If possible, have supervisors-in-training accompany an experienced supervisor on a visit, complete a checklist and request feedback.

If the checklist is designed to be the report as well (entries and comments are entered on the checklist itself), detail when the checklist should be completed and copied, and to whom copies should be given.

4.2.2 Train supervisors in the technical skills that they will oversee

Supervision of case management practices requires that the supervisor re-examine each mother/child to see whether the health workers treated them correctly. Supervising FP, ANC, delivery and postnatal care requires clinical skills. Supervisors who visit health facilities to assess clinical practices must have all the relevant clinical training.

Similarly, supply management supervisors must understand the associated procedures and be able to identify problems when reviewing supply records.

Never train health workers without training their supervisors!
4.2.3 Train supervisors in supervisory skills and techniques

Find out what the supervisors in your programme currently accomplish during supervisory visits and the tactics they use. Supervisors who believe that their role includes exerting power, finding mistakes or reprimanding staff must be retrained and re-educated on effective supervision methods. Just as supervisors assess health workers by observing them at work, managers should evaluate how supervisors conduct supervisory visits by observing them during some of those visits. If their techniques are inadequate, feedback and training or a refresher training course may be necessary.

It is recommended that all supervisors be trained or attend a refresher training course to help improve their supervisory procedures and techniques. This may be accomplished through training courses, tutorials or briefings. A training session should include role play, so that supervisors can practise giving feedback and can work on their communication skills. The following topics are applicable to all levels of supervisors:

a) Providing supportive supervision;

b) Preparing for a supervisory visit;

c) Conducting a supervisory visit;

d) Giving feedback during a supervisory visit;

e) Leading a problem-solving discussion;

a) Providing supportive supervision.

An important aspect of supervision is the manner of interacting with health workers. Supportive and punitive supervisory visits have varied results. Better compliance with performance standards, long-term behavioural changes and improved quality of care can be achieved within a supervisory system that health workers welcome rather than fear.

Fig. 22. Principles of supportive supervision

**Supportive supervision should:**

- Use technically sound guidelines and standards
- Be accessible, not mysterious
- Reward positive behaviour, and help amend negative behaviour
- Include concrete and immediate feedback
- Motivate health workers to perform better
- Be flexible
- Involve realistic examples
Table 5. A comparison of supportive and punitive supervisory approaches

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Supportive</th>
<th>Punitive</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>To identify problems and help health workers solve them</td>
<td>To identify issues/mistakes and reprimand those responsible</td>
</tr>
<tr>
<td></td>
<td>To recognize good performance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To show health workers that their performance matters</td>
<td></td>
</tr>
<tr>
<td><strong>Technical basis</strong></td>
<td>Behavioural science, communication and programme planning are important technical skills</td>
<td>No technical basis for interpersonal contact except for expertise in solving problems</td>
</tr>
<tr>
<td><strong>Tools and methods</strong></td>
<td>Diverse strategies to assess and understand the situation</td>
<td>Use checklists inflexibly</td>
</tr>
<tr>
<td></td>
<td>Observe practices and environments</td>
<td>Make judgements based on assumptions, impressions or hearsay</td>
</tr>
<tr>
<td></td>
<td>Listen to concerns and offer help</td>
<td>Intimidate health workers</td>
</tr>
<tr>
<td></td>
<td>Share information</td>
<td>Withhold information</td>
</tr>
<tr>
<td></td>
<td>Communicate effectively</td>
<td>Communicate poorly</td>
</tr>
<tr>
<td><strong>Feedback</strong></td>
<td>Recognize achievements, focus on solvable problems, and offer training and support</td>
<td>Offer little positive feedback, which is usually unstructured and critical</td>
</tr>
</tbody>
</table>
b) Preparing for a supervisory visit

Before a supervisory visit to a facility, a supervisor should prepare to be thorough and helpful.

- **Review past performance at the facility.** Read reports from previous supervisory visits, including problems identified and actions planned, the workplan (if available), and health statistics, to determine trends in the number of births and maternal deaths.

- **Find out about follow-up actions** that have been taken in response to previous visits or actions that still need to be taken, so that you can update the staff at the facility.

- **Take appropriate checklists, recording forms** and the report from the previous visit to use during the current visit.

- **Prepare to inform staff at the facility of any updates, plans** (such as for upcoming immunization days), and changes in procedures or feedback.

- **Collect supplies, equipment** and/or materials that can be delivered.

- **Collect materials** (such as training materials, current SOPs and circulars, etc.) to prepare for problem-solving.

- **Confirm logistic arrangements,** such as transportation to the facility, any accompanying staff, funds for fuel and other expenses. Contact the facility to confirm the date of the visit; if the date has been changed, call to announce the new date so that the staff know when to expect the visit.

c) Conducting a supervisory visit

Important steps for conducting a supervisory visit to a health facility are outlined below. At each point, the supervisor should note strengths and weaknesses. The purpose is not to spot the staff making mistakes but to find ways to help them improve. The order of the steps may vary, and some steps are not always required.

1. **Schedule a private interview with the person in charge** to discuss progress, actions taken and problems encountered since the last visit. Refer to the report from the last visit.

2. **Review and assess** current practices, procedures, logistics and general appearance of the facility (walkabout).
3. **Conduct a technical assessment** of the performance of health workers and health services using a checklist and observations of their clinical practices, how they communicate with the patients, respect them and maintain their dignity. When observing health workers' practices, reassure the health worker that you are not there to criticize. It is important, during the observation, to avoid comments, signals or postures that might convey disapproval. Showing disapproval of health workers in the presence of a patient may damage the trust that patients or caregivers have in the health worker.

4. **Discuss the perceptions of services and activities** with caregivers or community leaders/groups (if they are a part of the supervision strategy).

5. Provide **feedback or results** directly to health workers and other facility staff and lead a discussion on the findings. Some discussions may be in groups, and some may be one-on-one interactions with health workers to address specific problems in their work (see Section d below).

6. Offer **health workers the opportunity to ask questions** and discuss their concerns openly, in a supportive setting. Invite health workers to ask questions and express problems and concerns.

7. **Carry out problem-solving.** Some issues can be resolved at the facility itself. Focus on such problems and lead a discussion with the staff to identify likely causes. When causes are agreed upon, jointly brainstorm for appropriate solutions, including the need to improve competencies. Support the staff in facilitating solutions and offer on-the-job training, if necessary. For example, the supervisor may help correct the poor infection prevention procedures, if found. Some problems must be taken up to the district level or higher if solutions cannot be provided at the facility.

8. **Plan for next steps.** Allocate tasks to facility staff and the supervisor (yourself). Plans can be made verbally and immediately, but should be documented on a reporting form. Schedule the next supervisory visit at this point.

9. **Complete post-visit actions.** Prepare a supervisory report and send a copy to the district/region and the facility staff. Communicate the needs to the higher levels (facility to district; district to region). Take action to address problems locally, if possible. Share findings with colleagues in the local health team.

Note: The actions that supervisors propose to solve problems should be taken as quickly as possible. If, for some reason, supervisors cannot uphold their promises, they should inform the health staff, and look for alternative solutions during the next visit.
d) Giving feedback during a supervisory visit

Giving feedback involves communicating to the staff your impressions of their work-related performance. The specific topics covered during a feedback session depend on the positive and negative findings from the visit. Feedback is more effective when expressed in a supportive manner. Comments should be:

- **Task-related**: Talk about observations made during the visit. Comment on the tasks observed or problems noted.

- **Prompt**: Give feedback during the visit, after observing how the health worker performs tasks or after reviewing administrative practices or medicines and supplies. The longer you wait to give feedback, the less effective it will be.

- **Motivating**: Always start with positive findings, and then talk about areas for improvement. Show interest in the facility, the staff and their work, and confidence in the staff’s abilities. Listen to their comments and concerns.

- **Action-oriented**: Focus on improvements that the staff can make independently.

- **Constructive**: For each area that needs improvement, discuss with the staff how improvements could be made and offer support, such as training. Ask the staff to summarize the plans as a way to ensure that they understand what has been decided.

These techniques are demonstrated in two scenarios on the next page.
Punitive versus supportive feedback

Example: Punitive (ineffective) feedback

‘I had watched how you handled that pregnant lady Lena, and frankly, I did not like what I saw. You hardly did anything right. You were so mechanical and talked to her sparingly. You forgot to ask how she was feeling, where she was planning to go for childbirth. Also, you did not bother to ask whether she was taking iron tablets daily, especially as she had recorded a low haemoglobin level. And you just checked the fetal heart rate only for a few seconds; why don't you have a wrist watch? I wonder how you spent your time during training? Do you know how much time and money were spent putting you through training? You seem to have forgotten that you've got the ANC guidelines with you here. Go back and read them! It is quite simple when you use the guidelines, so I hope to not see mistakes like this again.’

Example: Supportive (effective) feedback

“When you managed Lena, you followed the assessment process systematically, and I came to the same diagnosis as you did: uncomplicated pregnancy of period of gestation of 34 weeks. I really appreciate the way you were asking questions to gauge complications and the way you took her blood pressure reading. It is good that you asked her to attend the clinic at 36 weeks.

“There are a few things you should do differently when you see pregnant women at the clinic. You should check the fetal heart sound for a full one minute. And you should not only tick the checklist, but also ask about well-being and planning for the birth. It is also important to verify whether they are taking iron tablets, especially since many of them are anaemic. Before leaving, we will review the guidelines again to refresh your memory.”
e) Leading a problem-solving discussion

When problems are identified during the supervisory visit, discuss them with the staff. If a problem involves only one person’s performance, discuss the issue with that person first. If a problem is widespread or involves several people, discuss it with the group. Your goal is to agree on a plan for solving the problem and to clearly allocate responsibilities.

Feedback should be task-related – describe the problem with reference to the activity or task you observed. Be clear about the difference between what should be done and what is actually being done.

When a problem is clearly stated, try to identify the likely cause(s). Analyse which of the following categories of causes resulted in the performance problem:

- Has responsibility for the task been clearly assigned or is there a role conflict as to who should do what?
- Does the health worker lack the necessary skills or knowledge to do the work?
- Does the health worker lack motivation to complete the work? Do they know how to do it, but not want to for reasons such as pressure from clients, the unpleasantness of the task, or cultural or social attitudes towards the illness or some clients?
- Are there obstacles preventing them from doing the task correctly, such as a lack of time, authority, money, medicines or supplies, or an issue with the geographical location?

Think about what you have observed and ask the staff why they think the problem is occurring. Ask questions to test your theories about the cause, and to uncover other possible views on the cause of the problem. Health workers often know the cause of a problem, but may reveal it only when they trust that the supervisor is genuinely interested and will not assign blame.

When the causes of a problem have been generally agreed upon, continue the discussion with the health staff to jointly propose feasible solutions. Fig. 23 shows the types of solutions that are appropriate for different categories of causes. Note that training can only solve the problem when the cause is a lack of skills and knowledge. When health workers know how to perform a task but are prevented or discouraged from doing it for some reason, a different type of solution is necessary.

Health workers can often suggest effective solutions and solve problems when they have the support of a supervisor.
### Fig. 23. The cause determines the solution

<table>
<thead>
<tr>
<th>If the CAUSE is:</th>
<th>Then an appropriate SOLUTION would be:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Responsibility for the work is not clearly assigned</strong></td>
<td>Review and assign responsibilities</td>
</tr>
<tr>
<td>For example:</td>
<td></td>
</tr>
<tr>
<td>• Unclear assignment of responsibilities</td>
<td></td>
</tr>
<tr>
<td>• Conflicts among staff about roles and responsibilities</td>
<td></td>
</tr>
<tr>
<td><strong>Health worker lacks the necessary skills and knowledge to do the work</strong></td>
<td>Provide the necessary skills and knowledge (such as a training course, on-the-job training, a refresher training course or tutoring, or provide a job aid/reference)</td>
</tr>
<tr>
<td>For example:</td>
<td></td>
</tr>
<tr>
<td>• Health worker is under-qualified</td>
<td></td>
</tr>
<tr>
<td>• New tasks were introduced/assigned without adequate training</td>
<td></td>
</tr>
<tr>
<td>• Poor availability of training</td>
<td></td>
</tr>
<tr>
<td>• Ineffective training/skills not improved</td>
<td></td>
</tr>
<tr>
<td>• Tasks are done infrequently, and the health worker has forgotten how to do them</td>
<td></td>
</tr>
<tr>
<td><strong>Health worker lacks the motivation to work</strong></td>
<td>Motivate staff to do the work (for instance, by offering supervision, minimizing the punishing aspects of the work and providing recognition and other positive rewards and incentives for good work)</td>
</tr>
<tr>
<td>For example:</td>
<td></td>
</tr>
<tr>
<td>• Lack of or irregular supervision (the health worker thinks that performance does not matter)</td>
<td></td>
</tr>
<tr>
<td>• Health workers are overworked; time pressure leads to rushed jobs or shortcuts</td>
<td></td>
</tr>
<tr>
<td>• Inadequate salary</td>
<td></td>
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<tr>
<td>• Lack of recognition</td>
<td></td>
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<tr>
<td>• No career advancement</td>
<td></td>
</tr>
<tr>
<td>• Health worker is over-qualified</td>
<td></td>
</tr>
<tr>
<td>• Pressure from patients’ mothers to prescribe antibiotics/injections</td>
<td></td>
</tr>
<tr>
<td>• Belief that patients’ family practices will not change</td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
If the CAUSE is: | Then an appropriate SOLUTION would be:
---|---
Obstacles preventing effective performance | Address the bottleneck or reduce its effects.
For example:
- Stock-outs.
- Limited medicines or vaccines (due to poor practices, poor ordering/distribution practices, an ineffective distribution system or an inadequate budget).
- Lack of authority (for example, to prescribe antibiotics).
- Limited amount of equipment and supplies (due to poor ordering practices, inadequate budget or careless use/wastage).
- Inadequate potable water or a lack of functional latrines.
- High case-load, resulting in difficulty with managing each case systematically.
- Poor organization of work, making it difficult to review each case systematically.
- Inadequate staffing.

### 4.3 Ensure sufficient management of transportation and funding for supervision

A lack of resources for supervision is a pressing issue. Poor frequency and reliability of visits will eventually affect the quality of care that health workers provide. Use limited resources carefully, with strategies such as:

- conducting joint supervisory visits by evaluating several programme areas simultaneously, using the same vehicle.
- using every opportunity to make supervisory visits (for instance, if visits for other purposes are arranged).
- meeting health staff when they come to the district for other reasons and discussing problems with them.
Finding funds for supervision is always challenging. Sometimes, the local budget includes a line item for this purpose and, occasionally, other programmes have budgets for supervision that can be shared. In some cases, international agencies or NGOs may offer additional resources for supervision.

Ensure that functional procedures are in place so that supervisors may:

- schedule vehicles (or arrange to use public transport);
- request payment or reimbursement for fuel;
- request funds or reimbursement for the use of public transport;
- receive a per diem, when applicable.

Supervisors need to know the procedures and be confident that the required transport and funds will be available to fulfil the supervisory schedule.

### 4.4 Supervise the supervisors

**Bring supervisors together for meetings** to share experiences, updates (such as those on technical issues, checklists, scheduling or reimbursement procedures) and feedback on programme achievements.

**Provide feedback** to supervisors on how they are completing supervisory checklists or recording forms. If they are leaving items blank, find out why. Describe examples of how supervisory reports are informative, and allow supervisors to identify and solve problems.

**Observe supervisors' performance** occasionally. The only way to know what supervisors do during visits to health facilities and assess their work is to observe them periodically.

**Demonstrate that supervision matters** to you and to the programme. By training supervisors and supporting their work, you demonstrate that supervision is important. Listen to their concerns and read their reports. Help them solve the problems that occur when making (or trying to make) supervisory visits. Also, share stories about instances where supervisors were able to improve on or sustain the performance of health workers.

**Develop a supervisory plan** and monitor it quarterly. Agree on a minimum number of supervisions for a supervisor for a month/quarter (for example, district maternal health officer should do a minimum of eight supervisory visits/month). These may include first-level hospitals that provide intranatal care, ANC clinics and CHWs who provide postnatal care.

It is important to plan joint supervisory visits thus reducing the time and the cost.
EXERCISE G: Analyse common problems

In this exercise, work with your group to practise solving common problems in an RMNCAH programme. This includes thinking of possible causes of a problem and suggesting solutions.

Your facilitator will lead the discussion. Complete the following worksheet. For each common problem listed, each participant should suggest a possible cause. When the list of causes is complete, take turns to suggest appropriate solutions.

In the bottom row, list one more problem that you or another participant has noticed in your area of work within the RMNCAH programme. Analyse the problem’s possible causes and solutions.

Worksheet: Common problems identified during supervisory visits

<table>
<thead>
<tr>
<th>Clinical problem</th>
<th>Possible causes</th>
<th>Possible solutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health workers claim that their case-load is too heavy. They do not take enough time to examine every sick child using standard case management procedures</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caregivers say that they have to wait for very long at facilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health workers report finding it difficult to implement the newly introduced ANC guidelines, as it takes very long to note down a patient’s history, conduct tests and fill out forms at antenatal clinics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant women complain about the long waiting time at the ANC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A problem that you have identified in your own programme</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remember to consider different possible categories of causes: a lack of clear work assignments, skills and knowledge and motivation, and obstacles that prevent effective performance.
EXERCISE H: Give feedback and solve problems

In this exercise, you will observe and perhaps take part in a role play of a supervisor's visit to a health worker's facility.

Part 1: Observe a problem-solving interview

In this exercise, you will watch two people enact a meeting between a supervisor and a health worker. The supervisor will offer feedback on the health worker's performance. The supervisor should:

- Begin by commenting on what they observed today, including some good things that the health worker did;
- Describe a problem with the health worker's performance today;
- Ask the health worker whether they have ideas on the cause of the problem and a possible solution. Come to an agreement about the cause(s);
- Offer support to the health worker in solving it;
- Agree together on how to proceed;
- Ask the health worker if they want to discuss other questions or concerns.

As you listen to each interview, think about whether the supervisor is being supportive or punitive, and whether all important aspects of a supervisory interaction are included.

Script 1: A supervisor's interview with a health worker after walking around the clinic/facility

Supervisor: I have looked around your clinic and I am shocked. First, patients have been complaining about how long they have to wait. Many have travelled more than 10 miles, with small children, from villages on the other side of the lake. Some had to wait for more than three hours.

Health worker: Yes, there are many...

Supervisor: As if that isn't bad enough, there is no toilet or running water. Why isn't there a toilet? This is a fundamental human right. Every household in this country is supposed to have a pit latrine at the least, but this health centre cannot manage to provide one. If we cannot provide a toilet at a health centre, then we are no better off than animals.

Health worker: On the issue of a toilet, we have been asking the village committee to dig a ventilated pit latrine for over two years, but they have ignored our
requests. They have, however, funded the building of a new HIV-testing laboratory. I attend the committee meeting every month to ask for their support, but to no avail. Perhaps you could talk to the committee chairman.

**Supervisor:** That is hardly my responsibility. You are from this area, and you know the people on the committee. You need to be more assertive; perhaps visit the committee chairman at home. Or, better still, bring him down to the clinic and let him see things for himself.

**Health worker:** On the issue of long waiting hours – this has been a consistent problem since we had the ANC training. It has slowed us down. There are two of us here, and we try to follow the guidelines, as we were taught. We have found that this takes a lot of time – half an hour or more per case. In the past, we could get through a case in about three minutes. I know this sounds ridiculous, but the guidelines have made our jobs much harder. So, although I am happier with the quality of care we provide now, the lines are far longer.

**Supervisor:** The quality of care does not matter if people stop coming because they have to wait for so long. Have you considered changing how you organize the work? The nurse at the front desk does not seem to be doing much – perhaps she could help with the clinical work. I don’t know the answers; you have to decide what is best for you. But frankly, if you don’t make some changes quickly, your clinic will soon be defunct. This is a scandal in the making because the last government spent a small fortune on these new clinics.

**Health worker:** In my opinion, we have a problem with staffing. There are not enough staff members to run the clinics. We have patients coming here from villages all around the lake. So, we need three or four more staff. At the moment, we work very hard and every day, except on Sundays.

**Supervisor:** Complaining is useless. There is nothing you or I can do about staffing – it is over our heads. Reorganize your work to improve the distribution of manpower. Make use of that nurse who is doing nothing at the front desk. I believe you have a pharmacist here, so make better use of him. He could offer drug counselling. The answer is clear – achieve better results through division (or reallocation) of work. Divide and conquer. Now, it is getting late and I have another clinic to visit today, so I must be on my way. Next time I visit, I hope to see some changes.
Script 2: A supervisor's interview with a health worker after observing a clinical practice

Supervisor: I watched you managing Luke, the two-year-old, and I must say that you did several things well. You checked for danger signs and all the main symptoms and found that his only problem was diarrhoea. I saw you looking for sunken eyes and doing a skin pinch. It was also good that you offered Luke some water – he drank it eagerly, so he must have been thirsty. I agree with your classification: diarrhoea and some dehydration. Well done.

Health provider: Thank you.

Supervisor: You recommended oral rehydration solution (ORS) at home, which is the correct treatment. However, you also prescribed an antibiotic, which is inappropriate for watery diarrhoea. Also, you did not ask the mother whether she knew how to give ORS at home or demonstrate how to do so, nor did you explain how she should feed Luke at home or when.

Health provider: The problem here is that mothers always expect an antibiotic. If they don’t get one, they speak badly of us and complain to local politicians and the district office. These same mothers will go and get an antibiotic anyway, often from a village quack. And these quacks often give them very strong antibiotics. So that’s why we prescribe antibiotics here. As for giving ORS, all mothers in this area know how to go about it.

Supervisor: I understand; sometimes mothers can be demanding. However, antibiotics are not good for watery diarrhoea. Also, using antibiotics when they are unnecessary can contribute to the development of antibiotic resistance. In the long term, this means that none of these antibiotics will be effective. So, we really cannot prescribe antibiotics in such cases – this is our responsibility as health professionals.

Health provider: It is difficult when mothers put pressure on us every day; it is hard to imagine doing things differently.

Supervisor: Let me make a suggestion. I think this problem involves providing information and problem-solving. It could be helped by counselling mothers and helping them find solutions.
We should explain to them why we are not prescribing antibiotics, and that antibiotics can be harmful; I suggest taking two or three minutes longer with these mothers to counsel them. I don’t think you should assume that all mothers know how to administer ORS – many of them, particularly new mothers, do not.

Health provider: Okay. I suppose I should be using the counselling information card that I received at the training session. But I have lost it.

Supervisor: That is not a problem. I will get you a new counselling card. Also, in a moment, I will show you what I mean with a real case. I will assess and classify the child and counsel the mother – you can watch what I do.

Health provider: Thank you.

Supervisor: You did several things well today. The main problems were that you prescribed antibiotics for watery diarrhoea, and did not provide enough counselling about home management. Do you agree?

Health provider: I agree; I need to offer more counselling. Also, I will meet the village leaders and give them some information about diarrhoea and discuss with them how to solve the larger problem. They need to understand that antibiotics are not always appropriate or necessary.

Supervisor: That is a great idea. I will return in about three months, and I will send your counselling card in two weeks with the next vaccine delivery. Do you have any other questions or problems?

Health provider: Not at the moment.

Supervisor: Make sure to write down any problems you have, so that we can discuss them the next time.

Part 2: Practise giving feedback and problem-solving

For this part of the exercise, your facilitator will organize some role plays for you to practise giving feedback and solving a problem during a supervisory visit. One person will play the supervisor and another will play the health worker at a first-level health facility.
Other members of the group will observe the role play and note:

- verbal and non-verbal communication;
- nature of the feedback – punitive or supportive;
- if the problem was clearly described;
- if the causes were analysed and the health worker’s ideas were considered;
- if the solutions to the problem were mutually agreed upon; and
- if the health worker had the chance to raise other concerns or questions.

After the role play, the group will discuss the nature of the feedback, and whether appropriate steps were taken during the role play. Other participants will act in additional role plays if time permits.
Monitor progress and use results

Fig. 24. Monitor progress and use results

Fig. 25. Key points about monitoring

- **Definition of monitoring**: Monitoring is the collection and analysis of information about a project or programme, undertaken while the project/programme is ongoing. Supervision deals with the performance of health workers, including offering them support and assessing conditions in the health facility.

- Monitoring activities help managers track progress and identify and solve problems before they cause delays in implementation.

- Monitoring facilitates finding effective solutions to problems after identifying the likely causes.

- It is important to give feedback to staff on the findings of monitoring.
5.1 Analyse monitoring data

Summarizing monitoring data and calculating indicators are processes that computers have simplified and sped up. Computers do not make mathematical errors; however, there is always the possibility of errors resulting from incorrect data entry or programming.

Calculating indicators involves identifying the correct numerator and denominator, determining a current value for each from the data, and doing the mathematical calculation. After indicators are calculated, check that they are reasonable given the raw data and levels expected. A district manager might calculate indicators for:

- a facility
- certain groups of facilities
- the district (sum of all facilities in the district)

When indicators are calculated, the manager could analyse the progress by making comparisons, such as:

- for all indicators with set targets, compare the level of achievement with the target
- compare achievement levels with a past level, such as the previous month, quarter or year
- determine trends over time
- compare the achievement level with that in other facilities or districts.

5.2 Use monitoring data to improve the programme

Programme managers should follow a systematic process to regularly review monitoring data, identify problems, describe the possible causes and work on solutions. To identify the most likely reasons for problems, managers must speak to staff at all levels, including at the district, facility and community. In addition, local staff should be involved in the process of formulating and implementing solutions.

5.2.1 Review the status of monitoring indicators regularly

Reviewing indicator data regularly allows a manager to identify problem areas. The manager may identify indicators that are higher or lower than expected, and discrepancies in indicators across facilities or time periods. When indicators seem to highlight a problem, investigate them further to determine if there has been a change that is a concern. A change in an indicator may reflect good progress in implementing activities, a significant problem
or merely a change in the data collection. For example, if a denominator is only 2, a change from 100% to 50% in an indicator may not be as significant as it first seems.

5.2.2 Identify problem areas and describe the specific issues

When an indicator shows that there is a problem in the implementation of activities, it usually reveals the presence of a broader problem area. For example, 70%–90% of facilities in the district had stock-outs of the contraceptive item depoprovera (depot medroxyprogesterone acetate) in the first and second quarters, respectively.

It is important that health facilities do not run out of contraceptive commodities. However, planning a solution to the problem is impossible without zeroing in on the broader problem area. The question of who is not doing what will help to identify the specific (performance) problem. Possible specific problems are:

- District staff are not calculating and sending the necessary amounts of contraceptive items to health facilities.
- Staff at the regional/national supply store do not send sufficient stocks of contraceptive items that the district requests.
- Management at the regional/national level has reduced the budget for contraceptives.

By narrowing down the problem in this way, it becomes easier to identify which aspects to investigate. You need to determine who (the type of health staff) is not performing adequately, and then analyse causes and propose a solution. Determine whether the problem is with the district staff, the regional supply store, health workers or the regional budget. If you decided to offer more training to health workers, but the problem is actually a lack of supply chain management skills at the district level, the problem would persist. The most appropriate solution would depend on the specific nature of the problem, its cause(s) and the people involved.

Some investigation is required to determine which of the specific problems is actually occurring; there may also be other monitoring information that verifies one or more of these problems (e.g. supply records at the national or district levels may show inadequate ordering or distribution practices; supervisory reports may document incorrect prescription practices).

Note: Generally during supervisory visits, when a problem is identified, it is clear whose work is lacking. However, when analysing monitoring data, programme managers must identify underlying causes and systems issues, and must conduct further analyses to pinpoint specific issues.
5.2.3 Identify possible causes

Once a specific problem is defined, including who is not performing the work as required, causes can be investigated. Consider the possible categories of causes (described in the previous chapter on managing supervision):

- Has the responsibility for tasks been clearly assigned?
- Do the staff have the necessary skills or knowledge to carry out the work?
- Do the staff know how to carry out the work but lack motivation?
- Are there obstacles preventing staff from carrying out the work effectively, such as a lack of time, authority, money or materials, or a constraining geographical location?
- Have the staff been allocated other type of work?

Investigate possible causes using reports from previous supervisions, and those on training, supplies or community activities. Discuss possible causes with supervisors who visit facilities and other staff at the district or other levels to determine the causes involved.

5.2.4 Identify and implement feasible solutions

Solutions will depend on the causes identified, as described in Table 6. Solutions should:

- eliminate the cause of the problem (or reduce it as much as possible) so that planned activities can continue;
- be affordable;
- do not negatively impact the delivery of another service;
- be realistic.

It is helpful to get input from staff to plan a solution and its implementation. Be certain that responsibilities in implementing solutions are clearly assigned and agreed upon. Only when planned solutions are effectively implemented does the programme improve as needed.
5.2.5 Give feedback to staff at all levels based on findings from monitoring, solutions planned and actions taken

Feedback is an important part of any systematic monitoring process. Feedback can be given in the form of:

- written communication, such as summaries or reports sent via postal mail or email;
- meetings or workshops held in central and peripheral locations;
- one-on-one discussions during supervisory and other field visits.

Table 6. Example of problem areas, specific problems, possible causes and solutions

<table>
<thead>
<tr>
<th>Problem areas</th>
<th>Specific problems</th>
<th>Possible causes</th>
<th>Possible solutions</th>
<th>People responsible for implementing the solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent stock-outs of essential medicines</td>
<td>• Health workers use antibiotics and injections indiscriminately (they do not adhere to standard protocol)</td>
<td>• New health workers are not trained in standard protocol/case management</td>
<td>• Train new health workers in standard protocol/case management as soon as possible</td>
<td>Supervisors/programme managers</td>
</tr>
<tr>
<td></td>
<td>• Stock management at health facilities (inventory or ordering) is done ineffectively</td>
<td>• Workers comply with demands from mothers for prescribing injections/medicines</td>
<td>• Reinforce standard protocol/case management and appropriate prescription practices during supervisory visits</td>
<td>Programme managers/facility staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Responsibility for stock management is not assigned; staff take turns doing it</td>
<td>• Assign responsibility for stock management in the facilities</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Health workers are not trained in stock management</td>
<td>• Offer on-the-job stock management training to those responsible</td>
<td></td>
</tr>
<tr>
<td>Problem areas</td>
<td>Specific problems</td>
<td>Possible causes</td>
<td>Possible solutions</td>
<td>People responsible for implementing the solution</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------</td>
<td>----------------</td>
<td>-------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Vehicles and/or fuel are inadequate for delivering medicines</td>
<td>• Investigate better options for supplying facilities, such as giving medicines or supplies to staff who visit the district for other reasons, getting supervisors to carry medicines or supplies, or having EPI staff carry essential medicines and supplies for maternal and child health</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Investigate better options for supplying facilities, such as giving medicines or supplies to staff who visit the district for other reasons, getting supervisors to carry medicines or supplies, or having EPI staff carry essential medicines and supplies for maternal and child health</td>
<td>• Review the status of the adaptation of materials and ensure that staff are allocated to complete it</td>
<td>Programme managers</td>
</tr>
<tr>
<td>Planned training courses have not taken place</td>
<td>• The national-level office has not printed training material</td>
<td>• Adaptation of materials has not been completed</td>
<td>• Review the availability of facilitators and give them firm dates for the training; if they are unavailable, select other facilitators</td>
<td>Supervisors</td>
</tr>
<tr>
<td></td>
<td>• Facilitators do not commit to conducting the training programmes</td>
<td>• Dates for the training are not finalized, so facilitators cannot plan accordingly</td>
<td></td>
<td>Programme managers</td>
</tr>
</tbody>
</table>

(Continued)
<table>
<thead>
<tr>
<th>Problem areas</th>
<th>Specific problems</th>
<th>Possible causes</th>
<th>Possible solutions</th>
<th>People responsible for implementing the solution</th>
</tr>
</thead>
</table>
| Outreach visits do not take place regularly | • Health workers do not make outreach visits to villages  
• There are no extra medicines and other supplies available for outreach visits | • Staff do not have the time to make outreach visits; no one is assigned that responsibility  
• There is no room in the budget for additional medicines and other supplies | • Discuss allocations of staff time at facilities and assign staff to outreach  
• Discuss the importance of outreach visits with the health workers | Supervisors  
Programme managers  
Programme managers/supervisors |

(Continued)
<table>
<thead>
<tr>
<th>Problem areas</th>
<th>Specific problems</th>
<th>Possible causes</th>
<th>Possible solutions</th>
<th>People responsible for implementing the solution</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Health workers use financial resources allocated for outreach visits (per diem and fuel) for other things</td>
<td>• The staff in charge of the stock do not know how to order additional medicines and supplies for outreach or how to calculate such needs</td>
<td>• Assign responsibilities and schedule dates for outreach visits; set aside per diem and fuel as necessary</td>
<td>• Work with the staff in charge of stocks on a method for estimating the requirements for outreach</td>
</tr>
<tr>
<td></td>
<td>• Transportation is unavailable</td>
<td>• The car is old or, often, has broken down</td>
<td>• Ensure that budget allocation for outreach is available; some of the funds are for medicines and supplies</td>
<td>• Review the availability of vehicles; consider sharing vehicles between several sites on outreach days</td>
</tr>
</tbody>
</table>
EXERCISE I: Monitor progress and use results

In this exercise, you will analyse some monitoring results from a district to identify successes and problem areas in the implementation of activities.

Background information

Yama district in Country X has:

- Twelve (12) health facilities.
- Thirty seven (37) health workers in facilities who manage pregnant mothers.
- Four (4) supervisors who share visiting responsibilities to the 12 facilities (among other duties).
- Seventy two (72) communities/villages.

A training course on new antenatal care (ANC) package for pregnant women was planned for the current year – one session in the first quarter, two sessions in the second quarter and one in the fourth. Trainers should follow up with all recently trained health workers.

Efforts are on to recruit more community health workers (CHWs) to increase their numbers. These newly recruited CHWs are being trained in ANC, and related danger signs by the district RMNCAH manager and their training team. An NGO is training them in counselling skills. Staff from health facilities will supervise the CHWs.

Below is the quarterly report of monitoring indicators for the first three quarters, which was prepared at the end of the third quarter. To help in the analysis, the data assistant listed the relevant activity-related targets for the current year, which were set by the district, in the last plan.

First, review the monitoring data summary on the next two pages. Then answer the questions that follow. When everyone is ready, the facilitator will lead a discussion.

Yama district: Monitoring data summary (Part 1)

Third quarter of the current year

Target for the current year: All (100%) health facilities will have at least 60% of health workers, who care for pregnant women, trained in ANC.

<table>
<thead>
<tr>
<th>Year:</th>
<th>District:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Training</td>
</tr>
<tr>
<td>Indicator</td>
<td>First quarter</td>
</tr>
<tr>
<td>Proportion of the training budget spent</td>
<td>0.35</td>
</tr>
<tr>
<td>Proportion of the planned ANC package courses completed</td>
<td>1/1 = 1.0</td>
</tr>
</tbody>
</table>

(Continued)
### Training

<table>
<thead>
<tr>
<th>Indicator</th>
<th>First quarter</th>
<th>Second quarter</th>
<th>Third quarter</th>
<th>Fourth quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of health workers in facilities who need training in new ANC package trained (Target – 37)</td>
<td>8/37 = 0.21</td>
<td>17/37 = 0.46</td>
<td>25/37 = 0.67</td>
<td></td>
</tr>
<tr>
<td>(from 1st &amp; 2nd quarters)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of health facilities that have at least 60% of health workers, who care for pregnant women, trained in new ANC package (Target – 100%)</td>
<td>2/12 = 0.17</td>
<td>5/12 = 0.42</td>
<td>7/12 = 0.58</td>
<td></td>
</tr>
<tr>
<td>(from 1st &amp; 2nd quarters)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of (recently) ANC-trained health workers who had at least one follow-up visit (Target is to have all [100%] trained health staff to have at least one follow-up visit)</td>
<td>0/8 = 0</td>
<td>4/25 = 0.16</td>
<td>4/25 = 0.16</td>
<td>8/25 = 0.32</td>
</tr>
<tr>
<td>(from 2nd &amp; 3rd quarters)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of CHWs trained in ANC (Target is to train 50 CHWs in ANC)</td>
<td>10/50 = 0.2</td>
<td>12/50 = 0.24</td>
<td>22/50 = 0.44</td>
<td></td>
</tr>
<tr>
<td>(from 1st &amp; 2nd quarters)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Medicines and supplies

<table>
<thead>
<tr>
<th>Indicator</th>
<th>First quarter</th>
<th>Second quarter</th>
<th>Third quarter</th>
<th>Fourth quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of medicine deliveries to the district that were on time in the last three months</td>
<td>1/1 = 1.0</td>
<td>1/2 = 0.5</td>
<td>0/1 = 0</td>
<td></td>
</tr>
<tr>
<td>Proportion of facilities with all essential medicines and vaccines available (no stock-outs) during the quarter</td>
<td>4/12 = 0.33</td>
<td>5/12 = 0.42</td>
<td>4/12 = 0.33</td>
<td></td>
</tr>
<tr>
<td>Proportion of facilities with all essential vaccines available</td>
<td>9/12 = 0.75</td>
<td>10/12 = 0.83</td>
<td>9/12 = 0.75</td>
<td></td>
</tr>
<tr>
<td>Proportion of facilities with appropriate records of medicines and supplies</td>
<td>2/12 = 0.17</td>
<td>4/12 = 0.33</td>
<td>5/12 = 0.42</td>
<td></td>
</tr>
</tbody>
</table>
**Yama district: Monitoring data summary (Part 3)**

**Target for the current year:** 90% of health facilities will have had at least one supervisory visit in the previous three months.

<table>
<thead>
<tr>
<th>Supervision</th>
<th>First quarter</th>
<th>Second quarter</th>
<th>Third quarter</th>
<th>Fourth quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of supervisors trained to use the checklist for observation</td>
<td>0/4 = 0</td>
<td>3/4 = 0.75</td>
<td></td>
<td>0/4 = 0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3/4 = 0.75 (from 2nd quarter)</td>
</tr>
<tr>
<td>Proportion of health facilities that had at least one supervisory visit in the last three months</td>
<td>3/12 = 0.25</td>
<td>4/12 = 0.33</td>
<td>8/12 = 0.66</td>
<td></td>
</tr>
<tr>
<td>Proportion of planned supervisory visits to health facilities completed</td>
<td>3/12 = 0.25</td>
<td>10/30 = 0.33</td>
<td>22/30 = 0.73</td>
<td></td>
</tr>
<tr>
<td>Proportion of CHWs that had a supervisory visit that included the observation of a home visit</td>
<td>0/50 = 0</td>
<td>0/50 = 0</td>
<td>0/50 = 0</td>
<td></td>
</tr>
</tbody>
</table>

**Yama district: Monitoring data summary (Part 4)**

**Target for the current year:** 40% of villages will have a community health worker trained to provide pregnant women with counselling and referrals.

<table>
<thead>
<tr>
<th>Household and community</th>
<th>First quarter</th>
<th>Second quarter</th>
<th>Third quarter</th>
<th>Fourth quarter</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion of villages with community health workers</td>
<td>50/72 = 0.69</td>
<td>50/72 = 0.69</td>
<td>50/72 = 0.69</td>
<td></td>
</tr>
<tr>
<td>Proportion of villages with community health workers trained in basic ANC</td>
<td>0</td>
<td>6/72 = 0.08</td>
<td>12/72 = 0.17</td>
<td>18/72 = 0.25 (from 2nd &amp; 3rd quarters)</td>
</tr>
<tr>
<td>Proportion of villages with community health workers trained in counselling skills</td>
<td>13/72 = 0.18</td>
<td>12/72 = 0.17</td>
<td>5/72 = 0.07</td>
<td>30/72 = 0.42 (from all 3 quarters)</td>
</tr>
</tbody>
</table>
Questions to discuss:

1. What are the main successes according to the monitoring data?

2. What are the main problems according to the monitoring data?

3. Is Yama district likely to achieve these activity-related targets by the end of the current year? Write a comment on your analysis of each.

   **Target:** All (100%) health facilities will have at least 60% of health workers, who care for pregnant women, trained in in new ANC package.

   **Target:** 75% of reproductive health clinics will have no stock-outs of essential medicines and vaccines in the last quarter of the year.

   **Target:** 90% of health facilities will have had at least one supervisory visit in the previous three months.

   **Target:** 40% of villages will have a CHW trained to provide pregnant women with counselling and referrals.

4. a) There is no indicator related to the quality of antenatal care provision at health facilities, but what do you think the quality might be like?

   b) How can the manager find out about the quality of antenatal care?
5. Specify a few problems (i.e. who is not doing what) that are occurring or that may be occurring, in the left column. Then, for each problem, list in the right column whom the manager should contact to discuss possible causes and plans of action.

<table>
<thead>
<tr>
<th>Specific problem: Whose work is lacking?</th>
<th>Whom to contact to discuss possible causes and solutions?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. To whom should the manager give feedback based on the findings from the monitoring? Remember to consider staff at all levels.

When you have completed this exercise, tell your facilitator that you are ready for the discussion.
Managing programmes on reproductive, maternal, newborn, child and adolescent health
Annexure for Module 3
Use of digital technology in programme management

The Seventy-first World Health Assembly resolution on Digital Health unanimously approved by Member States in May 2018 demonstrated a collective recognition of the value of digital technologies to contribute to advancing universal health coverage (UHC) and other health aims of the Sustainable Development Goals (SDGs).

While recognizing the innovative role that digital technologies can play in strengthening the health system, there is an equally important need to evaluate their contributing effects, and ensure that such investments do not inappropriately divert resources from alternative, non-digital approaches.

Digital technology could be used for:

- birth notification via mobile devices;
- death notification via mobile devices;
- stock notification and commodity management via mobile devices;
- client-to-provider telemedicine across all health conditions;
- provider-to-provider telemedicine across all health conditions;
- targeted client communication (TCC) via mobile devices (spread across five population groups for sexual, reproductive, maternal, newborn, child and adolescent health [SRMNCAH]);
- health worker decision support via mobile devices across all health conditions;
- digital tracking of patients'/clients' health status and services via mobile devices across all health conditions;

• provision of training provided to health workers via mobile devices (mLearning) across all health conditions;

• routine indicator data collection and management;

• data storage and aggregation; and

• data synthesis and visualizations.
An example of press information

WHO Myanmar
Ending preventable maternal mortality: Maternal Death Review and Surveillance System launched in Myanmar
23 September 2016

Nay Pyi Taw, 23 September 2016 – Despite the progress made during the Millennium Development Goals era, maternal mortality in Myanmar still remains unacceptably high – with the latest population census estimating the maternal mortality ratio (MMR) in the country to be 282 deaths per 100,000 live births. In 2015, almost 3000 women died in Myanmar before, during or soon after giving birth.

Maternal deaths have extensive repercussions not only at the individual and family levels, but also on the more general socioeconomic parameters. In order to continue on the current path of positive development and achieve the objectives of the 2030 Sustainable Development Goals (SDGs), maternal mortality in Myanmar will need to be targeted in a comprehensive and concerted manner, with the collaboration of all health workers and health authorities at each level of the country’s health system.

For this reason, the launch of the new Maternal Death Surveillance and Response (MDSR) system in Myanmar represents a pivotal step towards the reduction of maternal mortality and the achievement of the SDGs.

The MDSR system is a form of continuous surveillance linking the local with the national level, with the aim to understand the causes and circumstances related to each and every maternal death, and trigger an appropriate response at all levels of the health system.
Since September 2016, maternal deaths have been declared a notifiable event in Myanmar within 24 hours of the death.

Only through effective surveillance and investigation will health authorities be able to reduce these deaths, by implementing appropriate and evidence-based corrective actions. The MDSR system was developed by the Maternal and Reproductive Health Division of the Ministry of Health and Sports with technical support from the United Nations Population Fund (UNFPA) and the WHO Country Office for Myanmar. Funding was provided by the Three Millennium Development Goal (3MDG) Fund.

After the high-level launch ceremony in Nay Pyi Taw on 23 September, including an address by H.E. Dr Myint Htwe, Minister for Health and Sports, subsequent advocacy and training sessions will take place at the state and provincial levels across Myanmar.

WHO wishes to congratulate the Ministry of Health and Sports for the commitment and efforts towards this important public health objective, and remains ready to support health authorities in the subsequent phases of MDSR implementation.

For more information, please contact:
Office of the WHO Representative for Myanmar
No. 403 (A1), Shwe Taung Kyar Street, Bahan District
Yangon 11201, Myanmar
Example of the supervisory plan of a district*

| District: ______________________________ | Year: ______________________________ |

<table>
<thead>
<tr>
<th>Facility to be supervised</th>
<th>Jan.</th>
<th>Feb.</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>First-level hospital 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-level hospital 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-level hospital 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-level hospital 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First-level hospital 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyclinic 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyclinic 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyclinic 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polyclinic 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional drug stores</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral hospital</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Adopted from the guidelines and tools for supervision; Family Health Bureau, Ministry of Health, Sri Lanka
## Codes for supervisors:

<table>
<thead>
<tr>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>District RMNCAH Manager</td>
</tr>
<tr>
<td>Child Health Officer</td>
</tr>
<tr>
<td>Immunization Officer</td>
</tr>
<tr>
<td>Maternal Health Officer 1</td>
</tr>
<tr>
<td>Maternal Health Officer 2</td>
</tr>
<tr>
<td>Maternal Health Officer 3</td>
</tr>
<tr>
<td>Regional Medical Stores Manager</td>
</tr>
</tbody>
</table>
Supervision checklist for maternal and reproductive health

(Sample checklist from Myanmar)

Supervision checklist for maternal and reproductive health

(to be administered to the head of the health facility)

**Basic information**

Name of health facility _____________________________________________

Type: ___________________ Tertiary ______ Secondary ______ Primary _________________

District: _________________________________________________________________

State/Region: ____________________________________________________________

I. Record

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Available/Not available</th>
<th>Up-to-date/Not up-to-date</th>
<th>Complete/Not complete</th>
<th>Correct/Not correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AN register</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>RH indicator sheet</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>MCH handbook</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### II. Report

<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Available/Not available</th>
<th>Up-to-date/Not up-to-date</th>
<th>Complete/Not complete</th>
<th>Correct/Not correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Family planning (1-D)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>MDSR forms</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Form 1/Form 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Form A/Form B1 or B2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### III. Logistics

#### III.A. Equipment and medicines

(A.1) Equipment and medicines required for quality antenatal care

<table>
<thead>
<tr>
<th>No.</th>
<th>Equipment</th>
<th>Received</th>
<th>Use</th>
<th>Condition (good/bad)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>BP cuff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Stethoscope</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3*</td>
<td>Hb colour scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4*</td>
<td>Urine albumin test strip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>HIV and syphilis test kits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other equipment (if needed): ________________________________

<table>
<thead>
<tr>
<th>No.</th>
<th>Medicines</th>
<th>Received</th>
<th>Used</th>
<th>Balance</th>
<th>Expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Iron tablets</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mebendazole</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other medicines (if needed): ________________________________
(A.2) Equipment and medicines required for delivery

<table>
<thead>
<tr>
<th>No.</th>
<th>Equipment</th>
<th>Received</th>
<th>Use</th>
<th>Condition (Good/bad)</th>
<th>Enough/</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clean delivery kit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>MW kit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3*</td>
<td>Partograph</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*To be filled by districts with RH project*

<table>
<thead>
<tr>
<th>No.</th>
<th>Medicines</th>
<th>Received</th>
<th>Used</th>
<th>Balance</th>
<th>Expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Misoprostol</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Injection oxytocin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Injection magnesium sulfate</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other medicines (if needed): __________________________________________________________

(A.3) Equipment and medicines required for family planning

<table>
<thead>
<tr>
<th>No.</th>
<th>Equipment and Medicines</th>
<th>Received</th>
<th>Used</th>
<th>Balance</th>
<th>Expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IUD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Implant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3-month DMPA (SC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>OC pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>3-month DMPA (IM)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Emergency OC pills</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(A.4) Equipment and medicines required for family planning

<table>
<thead>
<tr>
<th>No.</th>
<th>Equipment</th>
<th>Received</th>
<th>Used</th>
<th>Balance</th>
<th>Expiry date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>IUD</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Implant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3-month DMPA (SC)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Condom</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

(A.5) Storage and distribution of equipment and medicines

(a) Good    (b) Fair    (c) Poor

III.B. IEC materials

<table>
<thead>
<tr>
<th></th>
<th>Received/ Not received</th>
<th>Used/Not used</th>
<th>Displayed/Not displayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poster</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pamphlet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flip chart</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vinyl</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IV. Service provision

IV. A. Condition of facility

(1) Notification board for opening hours    (a) present    (b) absent
(2) Room for antenatal care                (a) present    (b) absent
(3) Labour room                            (a) present    (b) absent
(4) Equipment in the labour room           (a) present    (b) absent
(5) Running water                          (a) available   (b) not available
(6) Toilet facilities                      (a) good       (b) fair       (c) poor
(7) Waste disposal                         (a) good       (b) fair       (c) poor
IV. B. Achievement

(1) Number of antenatal care visits during previous three months (old and new)  

____________________________________________________________________

(2) Number of births attended by skilled birth attendant (midwife) during previous three months  

____________________________________________________________________

(3) Number of total deliveries during previous three months  

____________________________________________________________________

(4) Number of post-abortion care cases during previous three months  

____________________________________________________________________

(5) Number of RH counselling provided  

____________________________________________________________________

V. Staff

<table>
<thead>
<tr>
<th></th>
<th>Number of staff in facility</th>
<th>Number of staff who attend to pregnant mothers</th>
</tr>
</thead>
<tbody>
<tr>
<td>OGs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other doctors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health assistant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lady health visitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midwife</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others (please describe)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
VI. Training

<table>
<thead>
<tr>
<th>Name of training/CME</th>
<th>Date</th>
<th>Duration of training</th>
<th>Trainer</th>
<th>Received manual or not</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

VII. Supervision

(1) Supervision during last year  (a) Yes  (b) No
(2) Number of supervisory visits  ( )
(3) If yes, level of supervisor  (a) District  (b) State/Regional  (c) Central
(4) Any feedback received after supervision  (a) Yes  (b) No
   If yes, please describe ____________________________________________________________
   ______________________________________________________________________________
(6) Room for antenatal care  (a) present  (b) absent
(7) Labour room equipment  (a) present  (b) absent

VIII. Problems, solutions and recommendations

<table>
<thead>
<tr>
<th>No.</th>
<th>Problems encountered</th>
<th>Solutions proffered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Comments ____________________________________________________________

________________________________________________________________________

________________________________________________________________________

Recommendations ________________________________________________________

________________________________________________________________________

________________________________________________________________________

Signature of supervisor ____________________________________________________

Name of supervisor ________________________________________________________

Designation ______________________________________________________________

Names and designation of health worker/s supervised: _________________________
Checklist for supervision of a polyclinic

Supervision of a polyclinic*

Name of the supervising officer : .................................................................

Designation : .........................................................................................

Date of supervision : ................................................................................

Time when supervision started : ................. Time ended ........ : ..............

Objective of the supervision : .................................................................

Was the PHM** informed regarding the supervision: Yes / No

MOH*** area : .........................................................................................

Name of the clinic : ..................................................................................

Frequency of the clinic : ...........................................................................

No. of PHM areas covered by the clinic : .....................................................

Population covered by the clinic : ..............................................................

No. of PHM participated in the clinic : .........................................................

*Adopted from the tools for Supervision – Family Health Bureau, Ministry of Health, Sri Lanka

** Public Health Midwife

*** Medical Officer of Health
No. of clients for the clinic from each PHM area

<table>
<thead>
<tr>
<th>Target group</th>
<th>PHM Area 1</th>
<th>PHM Area 2</th>
<th>PHM Area 3</th>
<th>PHM Area 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of antenatal mothers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of H512 B cards brought to the clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of infants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of preschoolers</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. CHDR B portions brought to the clinic</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No. of family planning clients</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Officer conducting the clinic: MOH/AMOH/ MO/RMO/AMO*
Other staff category available in the clinic on the supervision day: RSPHNO/PHNS/SPHM**

1. Clinic environment

a. Cleanliness of the clinic : Satisfactory ☐ Not satisfactory ☐

b. Ventilation : Adequate ☐ Not adequate ☐

c. Electricity : Available ☐ Not available ☐

d. Seating facilities : Adequate ☐ Not adequate ☐

e. Toilet facilities : Available ☐ Not available ☐

f. Accessibility : Satisfactory ☐ Not satisfactory ☐

g. Adequate water : Yes ☐ No ☐

2. Clinic organization

<table>
<thead>
<tr>
<th>No.</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clinic duty roster is available</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Clinic preparation done on previous day</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Health education materials displayed on the wall</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Clinic is organized according to 5’S concept</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Place is organized for different clinic activities</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Medical Officer of Health/ Additional Medical Officer of Health/Medical Officer/Registered Medical Officer/Assistant Medical Officer
**Regional Supervising Public Health Nursing Officer/Public Health Nursing Officer/ Supervising Public Health Midwife
<table>
<thead>
<tr>
<th>No.</th>
<th>Description</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Numbers given to all clients at registration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Clinic sessions are organized for different target groups (e.g. ANC 8.30 am–11.00 am, immunization 11.00 am–12.30 pm, FPC 1.00 pm–3.30 pm)</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8</td>
<td>Clean linen and a clean examination bed are available</td>
<td></td>
<td></td>
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<tr>
<td>9</td>
<td>Health education is provided according to a plan</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>10</td>
<td>Reading materials available for the use of clients</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Waste management is satisfactory</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Use of AD syringes

a. Use AD syringes for all immunizations  
   Yes ☐ No ☐

b. Use safety boxes to collect used syringes  
   Yes ☐ No ☐

c. Safe technique is used for disposal of used syringes  
   Yes ☐ No ☐

4. Sterilization procedure (if any)

a. Sterilization chart is displayed in the clinic  
   Yes ☐ No ☐

b. It is supervised and signed by a senior officer  
   Yes ☐ No ☐

c. PHMM is capable of sterilizing the equipment on time  
   Yes ☐ No ☐

d. Handle sterilized equipment with Cheatle forcep  
   Yes ☐ No ☐

5. Assist MOH in examining the mother

a. Inform the mother that she is going to be examined  
   Yes ☐ No ☐

b. Provide a brief history to the MOH  
   Yes ☐ No ☐

c. Assist the mother in positioning on the bed  
   Yes ☐ No ☐
d. Check the mother's understanding of information provided by MOH  

   Yes ☐  No ☐

e. Inform the mother about the next visit  

   Yes ☐  No ☐

f. Help the mother to get up from the examination bed  

   Yes ☐  No ☐

g. Explain to the mother about referral to specialist care  

   Yes ☐  No ☐

6. Providing micronutrients and antihelminthic drugs

   a. Drugs are packed and ready for distribution among mothers  

      Yes ☐  No ☐

   b. Explain to the mother how to use drugs  

      Yes ☐  No ☐

   c. Explain to the mother how to store them  

      Yes ☐  No ☐

   d. Cross-check with the mother whether she takes them correctly  

      Yes ☐  No ☐

7. Procedure of urine testing

<table>
<thead>
<tr>
<th>No.</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

   - Separate place is allocated for this activity  

   - Availability of equipment and reagents or strips  

       - Urine test strips  
         - Test-tubes  
         - Test-tube holder  
         - Test-tube rack  
         - Spirit lamp  
         - Container to empty test tubes  
         - Benedict’s solution  
         - Acetic acid  
         - Methyl spirit
### 3. Technique of testing

**For protein:**
- Fill two thirds of the test-tube with urine
- Heat upper one third of the test-tube
- Observe after a while

**For sugar:**
- Add 8 drops of urine to 5 ml of reagent
- Heat the test-tube, holding the test-tube away from self and client
- Heat well until the contents boiled
- Keep the test-tube for 2 mins for a colour change

- Enter the results in both mother’s cards
- Give the feedback to the mother on the test findings
- Discard urine appropriately

#### 8. Conduct of health education session

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Planned health education schedule is available for each clinic session</td>
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<tr>
<td>2</td>
<td>PHM is pre-prepared for the health talk</td>
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<td></td>
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<tr>
<td>3</td>
<td>Use appropriate HE material</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Content is relevant to the topic</td>
<td></td>
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<tr>
<td>5</td>
<td>Correct messages given</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>6</td>
<td>Presentation skills of PHM are satisfactory</td>
<td></td>
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<tr>
<td>7</td>
<td>PHM assesses whether the client has increased the knowledge at the end of the session (by a feedback)</td>
<td></td>
<td></td>
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<tr>
<td>8</td>
<td>Summarizes the important messages</td>
<td></td>
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</tbody>
</table>

#### 9. Weighing of infants

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Appropriate scale is available (i.e. beam balance infant scale)</td>
<td></td>
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<tr>
<td>2</td>
<td>Scale is kept on a flat surface</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>It works properly (ascertain by measuring a known weight)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Who measures weight? PHM/volunteers/other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Activity</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>5</td>
<td>Scale is kept in a well-lighted place, on a stable surface</td>
<td></td>
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<tr>
<td>6</td>
<td>Infant’s clothes are removed prior to being placed on the scale</td>
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<td></td>
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<tr>
<td>7</td>
<td>Weight is measured following correct balancing</td>
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<tr>
<td>8</td>
<td>Reading is taken standing in front of the scale</td>
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<tr>
<td>9</td>
<td>Weight is written on the B portion immediately after weighing</td>
<td></td>
<td></td>
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<tr>
<td>10</td>
<td>Nutritional states of infant are explained to the mother</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 10. Measuring of length of infants

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Infantometer is kept on the table correctly</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td>Infant is placed on the infantometer correctly (the head, shoulders,</td>
<td></td>
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<tr>
<td></td>
<td>buttocks and knees should touch the scale)</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>The base is touching the infant’s feet</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>The measurement is read correctly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>It is written on the B portion correctly</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 11. Measuring height and weight of pregnant mothers

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Check if the equipment are in order</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Use correct technique in measuring height</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Use correct technique in measuring weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Record readings in relevant documents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Provide feedback to the mother</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Inform the MOH if there are any unusual findings in the weight</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Accuracy of the weighing scale is checked (if so, when)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 12. Immunization activities

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A separate area is prepared</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Emergency tray is available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>A list of drugs is available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2</td>
<td>Expiry dates of drugs are clearly mentioned</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Activity</td>
<td>Yes</td>
<td>No</td>
<td>Remarks</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
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<td>----</td>
<td>---------</td>
</tr>
<tr>
<td>2.3</td>
<td>Instruction for use is available</td>
<td></td>
<td></td>
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<tr>
<td>3</td>
<td>Check CHDR (Child Health and Development Record) before immunization to ensure appropriateness of the vaccination</td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>Discuss with the mother to identify any contraindications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Ask for adverse effects following immunization for the previous immunization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Maintain cold chain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Check vaccine vials before vaccination for quality assurance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Follow correct technique to draw vaccine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Maintain sterility during the process of immunization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Educate mothers before immunization on reporting of AEFI</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Retain clients for 10–20 minutes to observe adverse reactions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>Proper record-keeping (date, batch number, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Inform clients about the next visit</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14</td>
<td>Maintain vaccine movement register correctly</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Maintain open vial policy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**13. Family planning (FP) activities**

<table>
<thead>
<tr>
<th>No.</th>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Methods available in the clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pills</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Condoms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DMPA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IUD</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Entries made when issuing FP items</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Physical balance of FP items tallies with book balance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Adequate stocks are available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Equipment needed for insertion of at least 5 IUDs are available</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Equipment are in working condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Activity</td>
<td>Yes</td>
<td>No</td>
<td>Remarks</td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------------------------------</td>
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<td>----</td>
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</tr>
<tr>
<td>7.</td>
<td>Special bed used for IUD insertion is available in good condition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Privacy is maintained for each and every mother</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9.</td>
<td>Mother allowed to ask questions with regard to the FP methods</td>
<td></td>
<td></td>
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<tr>
<td>10.</td>
<td>FP items are shown to the mother before enrolling into a method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Mothers counselled before being introduced to a method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Use flash cards for health education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Issue a client record</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Clinic record is correctly maintained</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Attitude of staff towards clients    Positive □    Negative □

Comments.................................................................................................................................

### 14. Disposal of waste and cleaning

a. Adequate number of safety boxes are available                      Yes □  No □

b. Waste disposal is hygienic                                         Yes □  No □

c. At the end of the clinic, the equipment and the clinic are cleaned  Yes □  No □

### 15. Record-keeping

a. The clinic attendance register (H 517) is correctly maintained      Yes □  No □

b. H 518 is correctly filled                                          Yes □  No □

c. Activities are done according to the duty roster                   Yes □  No □

d. Clinic returns are correctly filled and sent to relevant institutes  Yes □  No □

e. FP clinic records are correctly maintained                         Yes □  No □
16. Comments on record-keeping

17. Review clinic performance based on clinic summary and H 527 for the last quarter

No. of clinic sessions held during the last quarter: ........................................................ ........................................

<table>
<thead>
<tr>
<th>No. of clinic sessions conducted by</th>
<th>MOH/AMOH</th>
<th>PHNS</th>
<th>PHM</th>
<th>Other</th>
</tr>
</thead>
</table>

Average attendance of clinic per session

<table>
<thead>
<tr>
<th></th>
<th>Pregnant mothers</th>
<th>Infants</th>
<th>1–5 years old</th>
<th>FP clients</th>
</tr>
</thead>
</table>

No. of FP new acceptors recruited: ......................................
No. of DMPA new acceptors: .............................................
No. of intra-uterine contraceptive devices inserted: ..................
No. of infants weighed in the clinic: ...................................

Blood taken for:
VDRL testing: Performed/Not performed
Hb testing: Performed/Not performed
Blood grouping and DT: Performed/Not performed

18. Problems identified by the staff during clinic activities
.................................................................................................................................
.................................................................................................................................

19. Suggestions of the staff to provide better clinic service
.................................................................................................................................
.................................................................................................................................

20. Details of the last clinic supervision
Date of supervision: ..........................................................
Designation of the supervising officer: ..................................
Recommendations are carried out: Yes/No

Details of recommendations not materialized: ..........................................................
..........................................................................................................................

21. Recommendations on current supervision

Strong points 5 weak points

1. ....................................................... 1. ....................................................
2. ....................................................... 2. ....................................................
3. ....................................................... 3. ....................................................
4. ....................................................... 4. ....................................................
5. ....................................................

Next date of clinic supervision (if necessary): ...............  

22. Action plan to improve the clinic services based on weak points identified

<table>
<thead>
<tr>
<th>Problems identified</th>
<th>Underlying reasons</th>
<th>Proposed solutions</th>
<th>Proposed activity</th>
<th>Responsibility</th>
<th>Time frame</th>
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</thead>
<tbody>
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</tbody>
</table>

Date .................................  Signature of supervising officer ...........................................
Designation .................................................................
Bibliography


Managing programmes on reproductive, maternal, newborn, child and adolescent health

Annexure-3
Managing programmes on reproductive, maternal, newborn, child and adolescent health

I

Annexure-3