The supervision of health personnel at district level

D. FLAHAULT
Senior Medical Officer
Division of Health Manpower Development
World Health Organization
Geneva, Switzerland

M. PIOT
Formerly Senior Medical Officer
World Health Organization
Geneva, Switzerland

A. FRANKLIN
Formerly Director
Health Services Development
World Health Organization
Brazzaville, Congo

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Introduction

This publication attempts to show that supervision is a set of necessary activities for improving both the qualitative and quantitative aspects of health services. Starting from this assumption, it describes the supervision activities that should be undertaken at district level, a level that is often neglected despite its importance. Effective supervision can be achieved by proper planning and the use of suitable instruments, but requires appropriate training by means of short workshops for the various health manpower categories concerned.

In any health system human resources and their management are of paramount importance, although the efficient use of staff is dependent on other resources, such as health establishments, supplies, equipment, know-how and, of course, the necessary funding for the system to function. In the framework of the Global Strategy for Health for All by the Year 2000,[1] it is emphasized that "all types of health personnel as appropriate to the country will have to be motivated and mobilized". Motivation and mobilization, however, depend not only on management, but also on leadership: hence the need to develop leadership skills among personnel with supervisory responsibilities.[2]

Supervision is one of the functions of both management and leadership, and has been defined as *the overall range of measures to ensure that personnel carry out their activities effectively and become more competent at their work.* Supervision thus appears as the interface between management techniques and the qualities of leadership which all primary health workers in positions of responsibility should in theory possess and in practice display at all levels of the health system.

The *district* level, however, must be singled out as vitally important to the continuing development of primary health care. This is the most decentralized level at which there is both a representative of political authority to coordinate socioeconomic development activities so as to permit intersectoral cooperation, and a representative of the health services to manage, and hence to supervise, the health workers directly serving urban and rural communities.

In any given country, a district is an organized unit of local government that comprises first and foremost a well-defined population, ranging from under 50 000 to over 300 000 inhabitants, living within a clearly delineated administrative and geographical area, whether urban or rural. A district health system based on primary health care is a more or less self-contained segment of the national health system. It includes all institutions and individuals providing health care in the district, whether governmental, social security, nongovernmental, private, or traditional. A district health system therefore consists of a large variety of interrelated elements that contribute to health in homes, schools, workplaces, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities, up to and including the hospital at the first referral level and

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[1] *Global strategy for health for all by the year 2000.* Geneva, World Health Organization, 1981 ("Health for All" Series No. 3).

[2] Flahault, D. & Roemer, M. I. *Leadership for primary health care.* Geneva, World Health Organization, 1986 (Public Health Papers No. 82).

the appropriate laboratory, other diagnostic, and logistic support services. Its component elements need to be well coordinated by an officer assigned to this function in order to draw together all these elements and institutions into a fully comprehensive range of promotive, preventive, curative, and rehabilitative health activities.

Supervision presupposes that there is a programme whose objectives and development have already been determined. It is one of the management activities and it has its place alongside monitoring, control and evaluation. *Monitoring* looks at how activities are being implemented and at their results in terms of productivity. *Control* relates to the cost-effective utilization of mainly material resources. *Evaluation* checks to ensure that the objectives set are indeed attained, by measuring the efficacy, results and impact of the activities undertaken. *Supervision* is concerned with the human resources involved in the execution of activities and the pursuit of objectives.

This booklet sets out to remind supervisors and trainers, whether men or women, of the principles, methods and instruments required for effective supervision of health workers by addressing the following questions:

1. Why supervision?
2. What activities does supervision at the district level involve?
3. What supervision instruments can be used?
4. How is supervision to be carried out?
5. What is the profile of the supervisor?
6. How can a workshop on training for supervision be organized?

1. Why supervision?

The purpose of supervision is to *promote continuing improvement in the performance* of health workers. It will address the four major factors on which performance essentially depends:

- the adoption of appropriate objectives,
- surmounting the difficulties encountered,
- the development of staff motivation,
- the stimulation of staff improvement.

1.1 Making sure that the objectives are appropriate

If a programme is to function satisfactorily, there must be agreement, as regards the objectives, among the management, the staff involved in its implementation and the users or consumers.

A lack of agreement on the objectives of the programme will result in poor performance and ineffective service, whereas unanimous agreement between the various parties will make for high levels of performance and efficacy.

Supervision is one of the appropriate ways:

- to make sure that the objectives correspond to the needs;
- to restate, discuss, explain, justify and obtain endorsement for the objectives of the programme;
- to make sure there are no divergences between the objectives of the management (e.g. standards of performance), the objectives of the staff involved and the objectives of the users;
- to seek solutions to any conflicts that may exist between the various parties regarding the programme objectives.

These aims are achieved by direct discussion between management, personnel and users. Other opportunities for this kind of exchange of views on objectives occur during recruitment, basic training, annual assessments and specialized surveys.

1.2 Making sure that the staff adjust to the difficulties encountered

Through close agreement on objectives, through the information derived from the monitoring of activities, through control of resources and through evaluation, it is possible to form an idea of the way the programme is performing in each field of activity (e.g. the maternal and child health programme), geographical area, institution or unit. Analysis of this kind makes it possible to identify performance problems but does not necessarily provide any very clear explanation for them. Supervision is then the appropriate way:

- to observe how the tasks entrusted to different categories of workers are carried out, and under what conditions;

- to analyse the positive factors and the obstacles to performance (knowledge and attitudes of workers, environment, resources needed, etc.);
- to identify jointly the causes of these difficulties.

While supervision is a necessary part of this process, it is not in itself sufficient. There are certain essential prerequisities: job descriptions, the distribution of tasks, and a schedule or timetable of work.

1.3 Helping to develop staff motivation

Programme objectives, however good they may be, do not generate good results of their own accord. These objectives need to be perceived, accepted and understood by workers eager to achieve them. Supervision is an appropriate way:

- to get a clear picture of the motivation of health workers in respect of their fundamental needs (especially the need to belong, the need for respect, and the need for a sense of achievement);
- to help them to develop the necessary maturity to assume responsibility, in particular by identifying and discussing the work-related factors that enhance or discourage motivation;
- to identify shortcomings in their skills in communication, problem-solving and the resolution of conflicts;
- to adapt the style of leadership given by supervisors to the expectations of the staff, taking into account the nature of their work, their maturity and their sociocultural environment.

If leadership is to inspire motivation, it must be able to address problems of human relations as may be necessary (information, understanding, involvement, etc.) as well as the specific tasks to be performed, and supervisors should be continually concerned with both of these aspects.

It must also be remembered that, in the primary health care (PHC) context, all health workers are required to exercise leadership, not only in respect of their subordinates, but also in relation to the communities to which they are responsible (e.g. in taking a leading role in development committees).

1.4 Helping staff to improve their performance and competence

Supervision differs from conventional inspection in that the supervisor gives support to the workers being supervised. Support should be given wherever the need is felt, whether it be in the understanding of objectives, in the performance of tasks or in human relations. Supervision is an appropriate way:

- to identify the need for information on:
  the community being served,
  the health problems,
  the goals, methods and structures of the programme,
  the standards to be attained;
- to identify the skills needed for:
  patient care,
  management,
  information, communication, education,
  training,
  problem-solving;
- to decide jointly on the learning methods by which the health workers can remedy these deficiencies: reading, private study, case studies, discussion groups, etc.;
- to set up a continuing education programme which will meet the workers' needs for improvement of their skills;
- to identify the workers' basic needs (see section 4):
  need for security
  social needs
  need for respect
  need for achievement;
- to select and plan the methods of management or training that are appropriate: consultation, incentives, changes in the style of leadership, etc,;
- to identify any particular needs for logistic or financial support;
- to discuss and pass on suggestions for remedial action to the management.

Supervision is not the only way in which support to health workers can be contemplated and provided, but it is the only level at which support can be adapted to workers' *individual* needs.

Supervision, therefore, concentrates on people and sets out to improve performance. It is mainly justified by the fact that it gives the supervisor an opportunity not only to provide guidance and to advise, help, teach and motivate workers in the field with a view to enhancing performance and thereby improving the delivery of services, but also to learn.

2. What activities does supervision at district level involve?

A process of supervision which sets out, at district level, to adjust the procedures optimally to local working conditions, to develop inspiring leadership and to guide the members of the PHC team, will clearly be a continuous process carried out at a number of different levels. Notwithstanding this overall concept, supervision will nevertheless consist in time-limited activities which are carried out repeatedly at regular intervals, or occasionally on an *ad hoc* basis.

In presenting a set of practical guidelines, it is first of all necessary to examine the specific activities that must be carried out by any supervisor at the district level. It is from the district level that field supervision must be organized and that "peripheral" health services and health workers must be managed.

In this chapter the activities of which supervision is comprised are divided into three stages and described in sequence. At the preparatory stage, the necessary instruments for the task must be assembled, the priorities set and the schedule of supervision announced. At the implementation stage, the supervisor studies performance in the workplace and identifies the workers' support needs. The follow-up stage involves working out and introducing supervisory and supportive measures to help improve performance.

2.1 Stage one: activities involved in preparation for supervision

Supervision must address issues that are specific if it is to be successful: do the problems to be remedied relate to the relevance of a programme, the efficacy of the services provided, the productivity of certain categories of workers, the performance of certain individuals, or the economic management of resources?

2.1.1 Study of documents

Good supervision will therefore require careful preparation, involving study of the documents relating to the objectives, targets and operational standards, and the level of performance noted in the course of continuous monitoring of programmes and services. Evaluation reports will also be a valuable source of information. Although supervision is possible without these documents, it may lack relevance and not be very effective.

Supervision, like research, is founded on working hypotheses that have their basis in established facts and which will be confirmed or invalidated in the course of implementation. These working hypotheses will enable the supervisor to single out the most important, most difficult or least well understood aspects of the work for special attention, as and when this may be needed.

The following documentation is useful for the proper preparation of supervision at this stage:

- objectives, targets and standard norms (the "Plan", post descriptions, organizational charts, etc.),

- progress reports (continuous monitoring),
- recent evaluation reports,
- previous supervision reports.

(*See* Supervision instruments 1 and 2, pp. 20–21)

2.1.2 Identification of priorities for supervision

Supervision will not be effective unless there is a clear perception of the priorities among the numerous aspects of the services that might need to be supervised: which programmes or activities, in which areas, institutions or units, and which categories of workers must receive priority attention?

The supervisor will first review the "Plan" and single out and summarize in writing:

- the operational objectives and targets,
- standards relating to the quantity and quality of work,
- the full range of resources available,

in respect of each programme, district, institution or unit, and the workers to be supervised, and for a given period of time (e.g. one month or three months).

Secondly, it is important to review regular progress reports and *ad hoc* evaluation reports in order to extract:

- statistics on the services provided,
- the rates of coverage/participation achieved,
- the rates of morbidity/mortality observed,
- the resources utilized,

during a given period or periods, e.g. per quarter, in respect of each programme, district, institution or unit and the workers to be supervised.

Thirdly, the supervisor will identify discrepancies between planned targets and norms and the levels of performance reported or assessed in respect of each programme, district, institution or unit and the workers to be supervised. These discrepancies may then be compared with those observed during previous supervisory surveys in order to indicate recent trends.

Fourthly, the supervisor will identify the most important discrepancies in terms of the efficacy, productivity and cost of services and will formulate a number of hypotheses as to the possible causes of these discrepancies, particularly as regards the conditions that may affect performance, such as:

- the techniques used,

- the organization of work in the institution or unit,
- the skills of the workers involved,
- the attitude of the users/public in the district concerned,
- the resources available for the programme in question.

Fifthly, the supervisor will use these hypotheses to draw up a list of specific points to examine in the course of supervision in order to confirm or refute these hypotheses. This *checklist* will spell out the activities and tasks to which priority attention should be given in respect of each programme, district, institution or unit, and type of health worker (e.g., nutritional counselling of mothers at antenatal clinics; maintenance of a patients' register). This checklist may be used to notify the workers of the object of the forthcoming supervision, as well as in establishing a detailed schedule of supervisory visits. (*See* Supervision instrument 2, p. 21.)

2.1.3 Preparation of a supervision schedule

In addition to the checklist just described, the programme will include an itinerary and a schedule of visits. The structure of the checklist will depend on the district

and the institutions or units to be supervised, while the availability of the workers involved in each programme will dictate the most suitable time to visit any particular institution or unit. In so far as certain activities must be observed in the context in which they are performed, the supervisor should set aside the necessary time, including the time needed to accompany the staff to the place where they will carry out their work. Moreover, as supervision frequently means the need for discussions and concerted involvement of the entire health team, the supervisor should also take into account the dates and times of staff meetings. And if the questions at issue in the process of supervision involve the community, the dates of village committee meetings should also be fitted in.

The frequency of the visits, and hence the duration of a supervision cycle will, of course, depend on the urgency of the problems to be resolved and the supervisor's other duties. Generally speaking, when a new programme or new activities have recently been introduced in a district, visits should initially take place at least once a month and subsequently every three months. Two supervision visits a year should be regarded as the minimum.

The schedule of visits will be determined by the content of supervision as set out in the checklist, and the itinerary will depend on the schedule thus established.

2.2 Stage two: activities involved in supervision as such

Having determined the purpose of a round of supervision, i.e. drawn up a checklist of activities for priority attention, a schedule of visits and an itinerary, the supervisor is ready to begin work.

2.2.1 Establishment of contacts

Contacts will be of three types: individual contacts in the workplace with the workers involved in the implementation of the PHC programmes; contacts with village committees (or other local community representatives); contacts with the full health team at each institution or unit visited.

In the course of these contacts, dialogue, observation and analysis will first of all provide an opportunity to go more deeply into the causes of shortcomings in performance (confirming, or refuting, as the case may be, the hypotheses made at the previous stage). The supervisor will ensure that objectives and targets are understood and that established norms are complied with, and will investigate sources of motivation or discouragement, gaps in knowledge and skills in the various areas of activity, and shortcomings in logistic support, focusing throughout on the activities singled out for "priority supervision".

This will be followed by discussion, suggestions and conclusions, and concerted efforts to decide upon remedies for the shortcomings which have been identified. These supervision activities then culminate in a *plan of action* for each health team/institution or unit visited; the implementation of this plan, with the support of the supervisor, will be discussed in the following chapter.

The supervision instruments that will be used at this stage are:

- job descriptions,
- task descriptions,
- weekly timetables,
- checklist or rating scale for each function.

(*See* Supervision instruments 2–10, pp. 21–54.)

2.2.2 The supervisor reviews the objectives, targets and established norms with the worker

The supervisor will first ensure that the worker is acquainted with the objectives and operational targets of the programme under consideration and/or of the institution concerned, and that the individual understands and accepts them. The supervisor and the worker will discuss in particular the targets relating to the activities and tasks singled out for "priority supervision" (according to the checklist).

Secondly, the supervisor will review the worker's job description, concentrating especially on the description of the duties, activities and tasks, and on the duty roster and weekly timetable, to ensure that the worker knows, understands and accepts them. Special attention will be devoted to activities earmarked for "priority supervision" (according to the checklist).

Thirdly, the supervisor and the worker will examine how much time is at present spent on each of the duties mentioned in the job description, the duty roster and the weekly plan of work (i.e. not just the tasks for "priority supervision"). They will estimate the proportion of time actually spent on each function and compare these estimates with the established norms. The supervisor and the worker will discuss any discrepancies they observe, especially with regard to the impact this timetable may be having on the performance of activities under "priority supervision".

Fourthly, the supervisor will observe the worker's implicit or explicit motivations about the actual use of work-time, and especially its effects on performance of activities for "priority supervision".

The supervisor will make a note of any actual or potential conflicts between primary health care objectives and the underlying motivation of the worker, his/her colleagues and immediate superiors.

2.2.3 The supervisor observes the worker carrying out his or her tasks

The supervisor will arrange to observe – without intervening – the performance of all tasks involved in activities under "priority supervision", with particular regard to:

- the skills (technical, managerial, etc.),
- the attitude (towards users, colleagues, etc.),
- the organization of resources (at the workplace, of equipment, etc.),
- the utilization of resources (time, supplies, etc.),

displayed or evidenced by the worker.

The supervisor and the worker will then discuss the points that have been noted by the supervisor. They will refer to task descriptions, technical manuals and other documentary reference sources, and will identify the "good" and "less good" aspects of performance which may have a bearing on the efficacy, productivity or economic aspects of the provision of services.

2.2.4 The supervisor identifies gaps and needs for follow-up

The supervisor will first of all ask the worker to suggest what changes can be made to help improve performance of the tasks that have been observed. Together they will identify particular needs to improve the worker's knowledge, attitudes and practical dexterity as regards activities under "priority supervision".

The supervisor will then ask the worker to suggest specific ways in which the necessary learning can be accomplished, and will make a note of any suggestions.

Lastly, the supervisor will take note of any needs for logistic support, supplies, or other factors relevant to the proper performance of the tasks that have been observed.

2.2.5 The supervisor consults community representatives

The supervisor will ensure that the village committee is familiar with the objectives and targets of PHC, and that they are understood by the committee and supported by the community. In connection with activities under "priority supervision", the supervisor will find out whether the committee is aware of the norms which should in theory apply to the services provided by the institution or unit serving the community. This is an opportunity for the supervisor to help to clarify any points that have not been properly understood by committee members.

The supervisor will endeavour to assess the level of "consumer" satisfaction by discussing with the members of the committee (and possibly with other members of the

community, at the district level) the users' perceptions of the relevance, quantity and quality of services provided. The supervisor should try to find out what they think of the behaviour of the health workers involved, including village health workers, traditional birth attendants and volunteers. He or she will also identify needs for skills and leadership within the committee and, indirectly, among the health personnel.

The supervisor will invite, discuss and take note of the specific suggestions of the members of the village committee concerning ways of improving the community's understanding of the objectives and targets of PHC, of the norms and methods of the institution or unit serving the community, and ways of improving the services provided, especially with regard to the organization of the work, the behaviour of the personnel and the quality of the services.

A special situation arises when the community has not yet set up a village committee to coordinate health activities. Contact will then be made with leading local figures with a view to setting up such a committee.

2.2.6 The supervisor reports to the health team

After talking individually with the team members affected the supervisor will, at a general meeting of all the staff of the institution or unit:

(a) Firstly, go over the checklist of priority concerns, summarize any differences in interpretation with respect to the objectives, targets and established norms, and

lead the discussion towards resolution by consensus of any conflicts between objectives. The supervisor will explain the points of view of the management and of the community, reconcile issues as far as possible and emphasize the need to harmonize these objectives in order to promote better performance.

(b) Secondly, summarize the comments that have been made on the use of time, and discuss their implications with respect to PHC objectives and targets and to the performance of the team as a whole. The supervisor will pass on any suggestions received for alterations to the timetable to improve performance, particularly with regard to activities under "priority supervision".

(c) Thirdly, carefully and tactfully explain the hypotheses developed and present observations on the way tasks were performed during supervision in the workplace. In summing up, the supervisor will underline the positive aspects and will conclude by indicating the particular points where knowledge, attitude and skills need to be improved.

(d) Lastly, outline the salient points of the contacts with the village committee and/or representatives of the community, particularly with regard to their awareness, understanding and approval of PHC objectives, and to the users' perceptions of the services and reactions to the health workers' behaviour. The supervisor will lay emphasis on the needs for information, communication and education of the public, and on the training needs of the village health workers and members of the development committee. In addition it is important to stress the need to coordinate health activities with the activities of other sectors (education, agriculture, etc.); this is a good way of promoting intersectoral collaboration and socioeconomic development at district level.

The supervisor will be providing the health team with very valuable information through this kind of feed-back, and, in doing so, will boost their motivation and help to improve their performance.

2.3 Stage three: activities involved in follow-up of supervision

Hypotheses have given place to diagnosis, ideas that were hitherto unrelated have been brought together and the remedial action needed is now fairly evident. There is now an opening for leadership, based on the perception that the supervisor who has carried out the evaluation is there to help. Collective rather than individual motivation now tends to be critical. The time is right to embark on a most important supervision activity: follow-up.

As with the analytical stages that have gone before, follow-up must be systematic. As with earlier observations and discussions, follow-up will focus on workers individually and corrective action will be addressed to the needs of each in turn. This action will therefore be "à la carte", i.e. tailored to the individual needs that have been identified in each case.

It will, however, be the group, i.e. the entire "health team", that will discuss, determine and carry out the follow-up activities; leadership will pass from the supervisor to one or more members of the staff selected to assume this responsibility.

Supervision instruments at this stage are:

- the supervisor's report
- the programme of work of the health team.

(*See* Supervision Instruments 11 and 12, pp. 55–57.)

2.3.1 The supervisor and the health team clarify the objectives and targets of the programme

The points of departure for this aspect of follow-up are, on the one hand, the information gathered by the supervisor in the course of contacts with community representatives, and on the other hand, the objectives and targets of the programme. The supervisor will now:

(a) Lead the group in discussion to identify all objectives and targets with respect to which there is a broad measure of agreement among the various partners involved. These objectives and their corresponding targets will be reviewed and classified as known, understood, accepted, and formally approved at all levels of the community (users *and* district and/or village committees), of the institution or unit (workers *and* team leader) and of the programme (district level *and* central management).

(b) Invite suggestions from the health team with respect to the objectives that are not known, not well understood or not well accepted. After discussion, the supervisor will take up the best suggestions and the members of the team who will be responsible for their implementation will be designated. In principle, endorsement of objectives by all parties concerned should result in the long run in improved performance.

2.3.2 The supervisor and the health team jointly attempt to organize a programme of training activities

Firstly, the supervisor and the health team will review each worker's needs for training (already identified in connection with tasks under "priority supervision"). These needs will be noted and the components (intellectual, affective, practical) will be spelt out as far as possible. Where necessary, the team will have recourse to qualified teachers for assistance.

Secondly, the supervisor and the team will review and attempt to identify the method of learning best suited to each subject. This may be reading, demonstrations, workshops, seminars, discussion groups, films, etc.

Thirdly, a training programme, to which the supervisor will contribute personally, will be drawn up for a given period. It must be remembered that this training programme will affect the timetable of the workers in question; time should not be taken out of the periods devoted to the activities of care and promotion to which the public is accustomed, and "slack" time should therefore be used to the extent possible.

Fourthly, training support needs will be noted and passed on to the senior staff qualified to deal with them. Such needs may include the supply of books, the preparation of teaching materials, the provision of teachers, the loan of video equipment, or funds or allowances for the travel of teachers and staff.

These activities and needs will be discussed with the heads of manpower training establishments, particularly those responsible for continuous training, in order to find the best practical solutions to the problems.

2.3.3. The supervisor and the health team jointly reorganize the timetable as needed

The comments made by the supervisor when reviewing the use of work-time of each member of the team will serve as the basis for the reorganization of the team's timetable and weekly plan of work and, if necessary, of the official duty roster of the institution.

The supervisor will lead the discussion on the changes suggested until consensus on their adoption is achieved.

The discussion will be directed first of all to the most time-consuming activities of the staff, starting with health care and promotional activities and continuing with a discussion of "unproductive time", in order to reduce it as much as possible.

The supervisor will then direct the discussion to management and support activities, which will have to be adjusted in the light of the changes already made to health care and promotion. The need to redistribute tasks within the team may emerge in the course of discussion, either because someone is overworked, or because one member does not (yet) have the necessary skills.

In conclusion, alterations to timetables and plans of work will be set down in writing and it will be for the team leader to see that they are carried out, in so far as he/she has the authority to do so.

It is when the timetable is reorganized in this way that conflicts between different members of staff, or between workers and their team leader, are most likely to emerge. These conflicts reflect the disparity of motivation noted in the course of individual supervision and the different interpretations of the programme objectives.

Conflict over the timetable or the distribution of tasks may in fact be merely symptomatic of deeper conflicts which will have to be brought to light, if not at a working meeting, at least in private discussions, particularly between the team leader and the workers concerned ("arbitration").

2.3.4. The supervisor and the health team make changes in logistic support if needed

Comments on the inadequacy or inappropriate nature of logistic support (equipment, supplies, transport) will provide the supervisor with the information on the basis of which to:

- draw up a list of requests, regardless of their feasibility at this stage,
- identify the items that might have the greatest impact on the team's performance with respect to activities "for priority supervision",
- consider the logistic and financial implications of these suggestions before formulating a programme of recommendations for submission to the competent authorities.

2.3.5 The supervisor makes a report

Before concluding the section on follow-up, it should be noted that whatever has been decided in the way of measures to improve performance will automatically become subject to "priority supervision" in the course of the *next* round of supervision. It will therefore be useful to keep supervisors at various levels informed of the schedule of these activities (of training, follow-up and support) so that they can take account of them in preparing their next rounds of supervision in the district.

At the same time, whatever has been decided in the course of a supervisory visit that involves further the responsibility of the supervisor—such as support for the training programme, alterations to the logistic arrangements, administrative decisions to be taken at higher levels—must be communicated to the various levels concerned.

Thus it is clear that the follow-up activities described above involve a two-way flow of information, from workers to supervisors and from supervisors to workers. It is this flow of information that will ensure that supervision is not just a series of one-off activities repeated at intervals, but is really a continuous process.

The first concrete step in this follow-up is for the supervisor to draw up and circulate a supervision report. This will be a report of the "management by objectives" type, i.e. containing information with a bearing on decision-making. The supervision report will include:

(a) the purpose of the visit, the working hypotheses and activities for priority supervision,

(b) the observations made and the contacts established,

(c) the needs identified and the measures to be taken,

(d) a programme for the introduction of these measures, including a schedule of implementation and the designation of persons responsible,

(e) the necessary support measures, and

(f) the scheduled date of the next supervisory visit.

To sum up, this chapter has outlined supervision activities in three stages:

Stages	Objectives	Activities
Stage one	Preparation for supervision	1. study of the available documents 2. identification of priorities 3. preparation of a supervision schedule
Stage two	Supervision as such	1. establishment of contacts 2. review of objectives, targets and norms 3. observation of the workers as they carry out their tasks 4. identification of gaps and any follow-up and support needs 5. consultation with community representatives 6. reporting to the health team
Stage three	Follow-up of supervision	1. clarification of objectives and targets 2. joint organization of a training programme if needed 3. reorganization of the timetable as needed 4. making changes in logistic support if needed 5. preparation and circulation of a supervision report

3. Examples of supervision instruments

As supervision is necessary to promote continuous improvement in health workers' performance, it is important to facilitate the activities that make it possible. A three-stage process has been suggested in the previous chapter:

- a stage of preparation,
- a stage of implementation,
- a stage of follow-up.

As an aid to supervision, it is always useful to prepare tables, questionnaires or lists to be filled in or completed, to serve as instruments or tools to facilitate the supervisor's task.

Some examples of instruments of supervision will now be given for each stage. Supervisors will be able to prepare a variety of instruments, which may be simpler or more suitable than those given here, to meet their specific needs and to cater for the particular purposes of each supervisory visit.

Readers are invited to refer:

- for the preparatory stage, to instruments 1 and 2, pp. 20–22;
- for the implementation stage, to instruments 2–10, pp. 21–54;
- for the follow-up stage, to instruments 11 and 12, pp. 55–57.

Supervision instrument 1

Selected points from the objectives, targets and norms and from continuous assessment reports and performance evaluation

Programme..... MCH/FP[1]
Region ..... South-east
Institution/Unit..... Health centre No. 34
Staff member..... Midwife or TBA

Activities	Indicators	Targets (rates desired) (%)	Performance[1] (rates reported) (%) Period II/85	II/86
1 Concerning women				
Antenatal consultations	% with 2 or more visits	60	48	50
Deliveries	% supervised by midwife	80	72	75
Postnatal consultations	% with 3 or more vistis	75	**31**	**36**
Family planning	% women (15-44) using contraception	15	12	12
Antenatal	% pregnancy complications	<7	9	8
Deliveries	% complications	<2	5	4
Postnatal	% complications	<3	5	4
MCH	Maternal mortality (per thousand)	<1‰	0.9	0.9
2 Concerning newborn infants				
Births	% registered	100	**80**	—
	% with birth weight ≥ 2500 g	85	75	72
	Perinatal mortality per thousand	<10	12	12
	Infant mortality per thousand	<100	**122**	**126**
3 Concerning families				
Family planning	Average size (number of persons)	4	5.1	—
	% of families of > 6 persons	25	40	39
4 Concerning the community				
Support to village development committees	% of villages with committees	80	80	80
	% of villages with a registered TBA trained in modern methods	80	72	80
5 Concerning resources				
Costs	Currency units per birth	25	**30**	**32**
	Currency units per couple using contraception	15	**20**	**20**

[1] The replies given here are for the sake of illustration. The figures in bold characters are the ones that show an important difference from the target figures.

Supervision instrument 2

Working hypotheses and checklist of activities for priority supervision

Programe..... MCH/FP[1]
Region ..... North-west
Institution/unit ..... Health centres 11 and 12
Staff members..... Midwife and TBA

Centre No. 11		Centre No. 12	
Hypotheses	**Priority activities for supervision**	**Hypotheses**	**Priority activities for supervision**
Why is postnatal coverage so low?		*Why is the number of supervised deliveries so low?*	
– Ineffective education of mothers? – Poor utilization of working time? – Inadequate paediatric skills?	1 Education of mothers	– Village committees not informed of this objective? – Refusal of mothers? – Bad reputation of the unit?	1 Supervision of deliveries attended by TBAs
– Inconvenient times of postnatal consultations?	2 Organization of postnatal consultations	– Inadequate means of communication? – Resistance on the part of TBAs?	
– Village committees not involved?	3 Promotion of MCH/FP in the community	– Midwife's schedule of work?	
Why are births not recorded?		*Why is there a lack of information on families?*	
– Village committees not informed of this objective? – TBAs not competent? – Midwife not interested? – Records poorly maintained?	4 Recording of data	– Village committees not competent? – Information not reported to the health centre? – Lack of responsibility on the part of the midwife?	2 Maintenance of records at the health centre
Why is infant mortality so high?		*Why is there a delay in the establishment of committees?*	
– Insufficient postnatal coverage?		– Who is responsible for promotion?	3 Promotion and support of village committees.

[1] The replies given here are for the sake of illustration.

Centre No. 11		Centre No. 12	
Hypotheses	**Priority activities for supervision**	**Hypotheses**	**Priority activities for supervision**
– Inadequate recording? – Inadequate nutritional education of mothers? – Rate of immunization coverage? – Domestic accidents? *Why are unit costs so high?* – Excessive supplies? – Transport costs?		– Lack of skills in promotion? – Lack of organization? – Political resistance?	

Supervision instrument 3

Job description and description of duties, activities and tasks

Programme..... MCH/FP[1]
Region ..... South-east
Institution/unit ..... Health centre No. 34
Staff member..... Midwife

Job description

The midwife posted to Centre No. 34 will be responsible for maternal and child health among the population of the south-eastern region served by this Centre.

She will carry out all the functions, activities and tasks described below.

She will work under the authority of the chief medical officer of the health centre with respect to day-to-day administration, and of the chief midwife of the region with respect to the technical aspects of her duties.

She will be assisted in the performance of her duties by 10 traditional birth attendants, who are registered with the chief medical officer of the region, and for whom she will have direct responsibility for technical supervision.

She will collaborate with the nursing and hygiene staff attached to the health centre in setting up and maintaining primary health care services in the framework of the strategy of HFA/2000.

She will be able to draw upon the support of subordinate staff and the logistic support available at the health centre to an extent proportionate with MCH/FP services.

She will cooperate with village development committees with respect to the development of the MCH/FP programme in the framework of PHC.

Description of functions, activities and tasks

Functions	Activities	Tasks
1 Care	1.1 Antenatal	– Identification of high-risk pregnancies – Routine surveillance of normal pregnancies – Referral of cases at risk – Hospitalization of emergencies – Treatment of minor complications – Vaccination of pregnant women

[1] The replies given here are for the sake of illustration.

Functions	Activities	Tasks
	1.2 Delivery	– Care of the mother during delivery – Care of the newborn – Identification of complications
	1.3 Postnatal	– Growth/weight monitoring of infant – Referral of social problem cases to the appropriate authorities – Immunization as per EPI schedule[1]
2 Promotion	2.1 Communication	– Information of health committees and public: – About the MCH/FP services available – About the nature and scope of MCH/FP problems – About results expected and obtained
	2.2 Motivation	Draw the attention of health committees and the public to: – The benefits of MCH/FP – The need to prepare for delivery – The importance of breast-feeding
	2.3 Education	– The risks to mothers and children – Hygiene during pregnancy – Nutritional balance – Birth spacing
	2.4 Development	– Women's participation in development committees – Dangers of infibulation (suture of the vulva) – Female literacy
3 Management	3.1 Planning	– Maintain a schedule of work – Maintain a calendar of expected dates of delivery
	3.2 Organization	– Ambulance service for mothers at delivery
	3.3 Control and supervision	– Control of stocks and equipment – Control of maintenance of the premises – Control of the timetable – Supervision of traditional birth attendants (TBAs)

[1] EPI=Expanded Programme on Immunization

Functions	Activities	Tasks
	3.4 Information	– Registration of births and deaths – Maintenance and analysis of clinical records – Preparation of progress reports
4 Training	4.1 Learning	– Reading of obstetrical journals – Study of MCH/FP reports – Updating of risk evaluation scale
	4.2 Sharing of experience	– Participation in meetings of district midwives – Participation in health centre staff meetings
	4.3 Teaching	– Continuing education of registered TBAs – Training of nurses and senior TBAs in emergency and obstetrical care
5 Research	5.1 Operational	– Investigation of the reasons for non-attendance by mothers
	5.2 Clinical	– Investigation of the efficacy of new drugs
	5.3 Epidemiological	– Study of maternal mortality in relation to risk factors
6. Support	6.1 Logistic	– Arrange monthly supplies to TBAs – Organize emergency transport
	6.2 Other	– Give secretarial and editorial support to village committees

Supervision instrument 4

Checklists[1]
Weekly timetable of work
Annual schedule/programme
Duty roster

Programme .....——
Region .....——
Institution .....——
Staff member.....Midwife

---

1 Is the worker being supervised in possession of a **weekly timetable** of work?
yes ☒ no ☐

- Distribution of time: how many working hours are allotted to each of the following duties:

		No. of hours	% of total
Care	Antenatal clinics Postnatal clinics	*12 h*	*30 %*
Promotion	Visits and deliveries	*12 h*	*30 %*
Manage-ment		*6 h*	*15 %*
Training	Staff meetings	*3 h*	*7.5%*
Research	Participation of women	*2 h*	*5 %*
Support		*5 h*	*12.5%*

- How long has this timetable been in use? *± 2 years.*
- When was the last time it was altered? *At the last supervisory visit.*
- What does the staff member being supervised think of it? *Realistic, except when there are a lot of deliveries.*

---

2 Is the worker being supervised in possession of an annual **schedule/programme** of:

site visits?	yes ☒	no ☐
emergency standby?	yes ☒	no ☐
other activities? (if "yes" please specify)	yes ☐	no ☒

- Does the programme specify:

date and time?	yes ☒	no ☐
place?	yes ☒	no ☐
the exact purpose?	yes ☐	no ☒
the person or unit to contact?	yes ☐	no ☒

- Is the programme for the last 12 weeks detailed clearly and in full in the schedule?
yes ☒ no ☐

---

[1] The replies given here in italics are for the sake of illustration.

- Is it possible to see whether visits and emergency standby duty have been carried out as planned?

  yes ☒ no ☐

- If so, to what extent are they reported to have been carried out?

	0	25	50	75	100%
visits:		*x*			
standby:			*x*		

- Is the programme for the next 12 weeks detailed clearly and in full in the schedule?

  site visits yes ☐ no ☒
  standby duty yes ☒ no ☐

- What are the views of the worker being supervised?
  (a) *"The programme should be planned three months in advance and people should be notified a fortnight in advance."*
  (b) *"The visits and standby duties carried out could be noted on the schedule in order to facilitate evaluation and the preparation of reports."*

---

3 Is the worker being supervised included in the **duty rosters** which provide for the rotation of activities (standby, outpatient consultations, etc.) at the Health Centre?

yes ☒ no ☐

- In the last 12 weeks, how many times has this worker been assigned to:
  – night duty *3*
  – weekend duty *1*
  – holiday duty *1*
  – other ( ) —

  according to the duty roster?
- Does the duty roster show whether these activities have been carried out as planned?

  yes ☐ no ☒
- Has the duty roster been made up for the next 12 weeks?

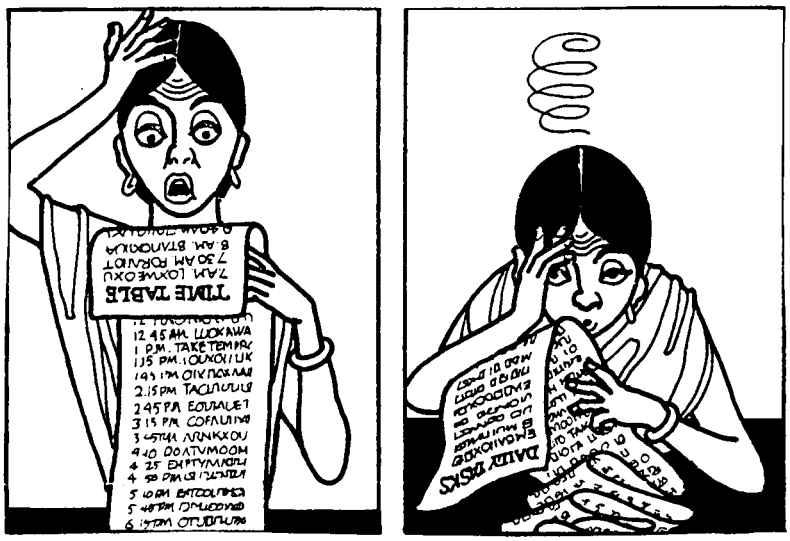
  yes ☒ no ☐
- When was it first drawn up? *2 years ago*
- When was the last time it was altered? *± 1 year ago*
- By whom and in consultation with whom was it drawn up? *The doctor in charge and the chief nurse*
- What are the views of the staff being supervised? *Would like to participate in the preparation of the duty roster*

---

4 **Discussion, comments and suggestions**

- Is the weekly timetable satisfactory?
- Are the programme and schedule of visits planned sufficiently far in advance?
- Have the people to be contacted and the reasons for these contacts been specified?
- Mark X when visits have been carried out and 0 when they have not.

- The percentage of visits carried out should be calculated in relation to the number of visits planned and this figure should be available at the next supervisory visit.
- Care should be taken to ensure that standby duties are fairly distributed among the staff qualified for these duties. A staff meeting to discuss duty rosters should be planned.



Supervision instrument 5

Timetable

Programme ..... MCH/FP[1]
Region ..... South-east
Institution ..... Health centre No. 25
Staff member ..... Midwife

1 — *Analysis of information*

- Statutory number of working hours per week: 45 hours plus standby duties.
- Number of authorized/approved days' absence per month: none.
- Number of hours' work carried out in the last four weeks: first: 48 hours; second: 45 hours; third: 44 hours; fourth: 45 hours (average 45½ hours).
  Remarks: standby duties: one day per week.
- Number of hours per day devoted to the following activities:

	Mon	Tues	Wed	Thur	Fri	Sat	Sun	Total
Health care Preventive Curative Rehabilitative	3	4	2	4	3	–	–	16
Promotion Information Communication Development	2	2	2½	1	3	–	–	10½
Management Planning Organization Control	1½	1½	½	1½	1½	2	–	8½
Training Self-learning Sharing of experience Teaching	–	–	2	–	–	–	–	2
Research	–	–	–	–	–	2	–	2
Non-productive activities (spare time)	1½	½	1	1½	½	1		6
Total	8	8	8	8	8	5	–	45

[1] The replies given here are for the sake of illustration.

Remarks and comments (examples) on hypotheses concerning timetable:

- in relation to the weekly schedule and timetable: week well filled, appears to be little slack time;
- in relation to specified norms:
  - care and promotion do not correspond to the weekly timetable;
  - management is taking up more time than planned, should be examined in detail;
- in relation to instructions given during previous supervisory visits:
  - details of care and promotion still lacking.

2 — *Detailed analysis of the work carried out* (during the last four weeks)

Services	No.	Type of activity	Time (average)	Total time
No. of deliveries:	12	Care	3 hours	36 h
requiring:		Education	½ hour	6 h
No. of antenatal visits:	30	Promotion	18 min	9 h
requiring:		Prevention	10 min	5 h
No. of postnatal visits:	20	Promotion	10 min	3 h 20
requiring:		Prevention	5 min	1 h 40
No. of family planning visits:	20			
requiring:		Promotion	5 min	1 h 40

3 — *Proportion of time spent on care and promotion*

	Care	**Promotion**
Deliveries	—	—
Antenatal	—	—
Postnatal	—	—
Family planning	—	—
Total	—	—

Remarks and comments on the work carried out (examples):

- efficacy of services: "Postpartum care takes up time needed for postnatal care: imbalance reflected in the figures for postnatal complications and infant mortality";
- coverage of the population in respect of various services: "Women stay with their mothers for the first two months after delivery";

- distribution of time between different activities: "Spend more time on the promotion of postnatal care";
- proportion of slack time: "Appears to be little, well done".

Supervision sheet completed (date) .....
by (signature of supervisor) .....
and (signature of worker) .....

Discussed with hierarchical superior (signature) .....

Supervision instrument 6

Checklists of health care activities

Programme ..... PHC
Region ..... —
Institution/unit ..... Health centre No. 7
Staff/member ..... Midwife

1 — *Checklist for evaluation of history-taking at an antenatal health visit*[1]

Name of patient .....
Name of midwife .....
Name of supervisor .....
Programme .....
Site .....
Date .....

Rating scale
0 = question omitted
1 = basic technique needs review; question poorly phrased
2 = understands basic technique but needs more practice
3 = speed, style and manner good
4 = speed, style and manner excellent

	Rating (circle the appropriate number)				
Past obstetrical history					
Menarche	0	1	2	3	4
Menstrual cycle ..... days	0	1	2	3	4
(Varies from ..... to ..... days)					
Gravida	0	1	2	3	4
Abortion/miscarriage	0	1	2	3	4
Live children, number	0	1	2	3	4
Stillbirths, number	0	1	2	3	4
Previous pregnancies (fill out separate form for each)	0	1	2	3	4
Current pregnancy					
Contraception	0	1	2	3	4
Type					
Date discontinued					
Last menstrual period (LMP)	0	1	2	3	4
Previous menstrual period (PMP)	0	1	2	3	4
Quickening	0	1	2	3	4

[1] See Katz, F. M. & Snow, R. *Assessing health workers' performance. A manual for training and supervision.* Geneva, World Health Organization, 1980 (Public Health Papers No. 72).

	Rating (circle the appropriate number)				
Symptoms since LMP					
Nausea and vomiting, indigestion	0	1	2	3	4
Constipation	0	1	2	3	4
Vaginal bleeding or discharge	0	1	2	3	4
Abdominal pain	0	1	2	3	4
Infection	0	1	2	3	4
Radiological examination	0	1	2	3	4
Medications, current and since LMP	0	1	2	3	4
Other	0	1	2	3	4
Past medical history					
Vascular	0	1	2	3	4
Viral infections	0	1	2	3	4
Heart, rheumatic fever	0	1	2	3	4
Hypertension	0	1	2	3	4
Diabetes	0	1	2	3	4
Kidney, bladder	0	1	2	3	4
Jaundice, transfusion	0	1	2	3	4
Thyroid disease	0	1	2	3	4
Venereal infection	0	1	2	3	4
Accidents, surgery	0	1	2	3	4
Other	0	1	2	3	4
Family history	0	1	2	3	4
Diabetes	0	1	2	3	4
Hypertension	0	1	2	3	4
Cancer	0	1	2	3	4
Health of infant's father	0	1	2	3	4
Inherited illness	0	1	2	3	4
Anomalies, twins	0	1	2	3	4
Sickle cell	0	1	2	3	4
Other	0	1	2	3	4
Personal habits					
Smoking	0	1	2	3	4
Alcohol	0	1	2	3	4
Drugs (marijuana, opiates)	0	1	2	3	4
Caffeine (e.g., cola drinks, coffee)	0	1	2	3	4
Other	0	1	2	3	4

N.B. This list will need to be simplified or expanded in the light of local priorities and conditions.

2 — Checklist for supervision of a home birth [1]

Name of TBA..... Observed by.....
Location of TBA..... Date of observation.....

	Performance[2]			Comment
	Plus	Minus	N.O.	
Recognition of onset of labour				
1 Inquires about the presence and duration of:				
– backache or abdominal cramps				
– pink discharge or "show"				
– uterine contractions				
– breaking of "bag of waters".				
2 Examines the abdomen to determine:				
– position of baby				
– duration of contractions				
– severity of contractions.				
Preparation for delivery				
1 Selects site for the delivery that is:				
– quiet, clean, ventilated				
– uncluttered, with adequate space for arranging equipment.				
2 Prepares equipment for the delivery:				
– scrubs hands				
– removes contents of delivery kit				
– boils scissors for 10 minutes				
– arranges items for easy reachability				
– covers equipment with clean cover until ready for use during delivery				
– obtains container for waste				
– covers delivery site with clean material.				
3 Prepares herself for delivery:				
– covers hair				
– scrubs hands thoroughly prior to preparation of mother				
– performs additional hand-scrubbing as necessary during delivery				
– puts on clean apron when delivery is near.				

[1] See: *Traditional birth attendants*, Geneva, World Health Organization, 1979 (WHO Offset Publication No. 44), pp. 70–73.

[2] "Plus" can mean either "yes" or "satisfactory". "Minus" can mean either "no" or "unsatisfactory". "N.O." means "not observed".

	Performance			Comment
	Plus	Minus	N.O.	
4 Prepares mother for delivery:				
– checks if mother bathed early in labour				
– helps mother to bathe if needed				
– cleanses vulva with soap and water				
– uses downward strokes in cleansing				
– discards each swab after use				
– gives fluids throughout labour.				
Care to mother during labour				
– Provides appropriate care during labour:				
– provides backrub for comfort				
– helps mother to change position as necessary				
– provides emotional support to mother				
– relates to family members in culturally prescribed manner				
– avoids unnecessary interference with birth process such as:				
– strong massage of abdomen				
– insertion of hands into vagina				
– administration of medications.				
Recognition of normal progress during birth				
1 Palpates abdomen to determine:				
– baby's position				
– quality and duration of contractions.				
2 Observes perineum for abnormal bleeding				
3 Recognizes danger signs during labour:				
– prolonged labour				
– convulsions during labour				
– breech or shoulder presentation of baby				
– prolapsed cord.				
4 Responds appropriately to complications of delivery:				
– summons midwife or physician if possible				
– initiates appropriate care until help arrives.				
Performance of safe, hygienic delivery				
1 Prepares for delivery:				
– puts on clean apron				
– thoroughly scrubs hands				
– watches perineum for appearance of baby's head.				
2 Prevents perineal laceration:				
– applies gentle pressure to baby's head to slow the delivery				
– instructs mother to pant so as to reduce speed of delivery of head				
– applies gentle manual support to perineal area.				

	Performance			Comment
	Plus	Minus	N.O.	
3 Delivers the baby:				
– supports the head as it emerges				
– feels around baby's neck for cord				
– gently slips cord over head if it was found around neck				
– removes sac from head if it is present				
– wipes baby's eyes, nose, and mouth with clean swab as soon as head emerges				
– supports baby as its body emerges				
– inverts baby to drain mucus				
– places baby on clean cover between mother's legs.				
4 Attends to umbilical cord:				
– washes hands before manipulating cord				
– tests cord for cessation of pulsations				
– avoids contamination of cord ties				
– applies clean cord ties				
– ties square knots in applying cord ties				
– checks knots for security				
– lifts scissors by handles, avoiding contact with blades				
– cuts cord between the two cord ties				
– observes cord stump for bleeding				
– touches only edges of cord dressing				
– applies dressing, with cord in "turned up" position				
– avoids unsafe practices in cord care such as application of unclean materials, earth, saliva, ashes.				
5 Prevents haemorrhage:				
– puts baby to mother's breast to stimulate uterine contraction				
– identifies separation of placenta by watching for small gush of blood from birth canal.				
– avoids pulling on placenta or membranes as placenta emerges				
– catches placenta in basin				
– inspects placenta carefully to see if it is complete				
– examines placenta for evidence of foul odour				
– inspects external genitals for fresh bleeding or lacerations				
– palpates uterine fundus frequently for hardness				
– massages uterus gently to control excessive blood loss				
– avoids unsafe practices such as packing vagina to stop bleeding.				

	Performance			Comment
	Plus	Minus	N.O.	
After-care of mother				
Promotes mother's comfort after delivery:				
– wipes perineum with clean swabs				
– uses downward strokes in wiping perineum				
– sponges mother				
– changes mother's clothing				
– provides clean mat to lie on				
– applies clean pad to perineum				
– offers food and drink				
– provides opportunity for rest.				

3 — Checklist for supervision of the use of essential drugs[1]

a. Does the centre have a standard list of essential drugs?
Yes ☐ No ☐

b. Discussion of the list with the head of the centre:
- Is the list appropriate?
- Does it enable the staff to follow the instructions they are given?
- Classify drugs by frequency of use during the past month.

c. Is the daily dose standardized? Yes ☐ No ☐
For what ages?

d. Have there been any shortages of drugs during the past month? If so, which drugs and how many patients had to go without? What is left in stock?

e. Is drug consumption in keeping with local epidemiological conditions?

f. Have any obvious failures of treatment been observed personally by the health worker during the past month? If so, what drugs and how many patients were involved?

g. Was any obvious intolerance to drugs observed personally by the health worker? If so, to what drugs, and how many patients were affected?

h. Comments. Discussion. Suggestions and decisions to be taken:

[1] It would be a good idea, before starting to supervise the use of essential drugs, to read or revise Part III, Chapter 2, of *On being in charge*, Geneva, World Health Organization, 1980, pp. 157–175.

Supervision instrument 7

Attitude rating for communication and promotion activities

Programme ..... PHC
Region ..... —
Institution/unit ..... Health centre No. 16
Staff member ..... Medical assistant or registered nurse

1 — Communication/interviewing skills[1]

While a medical assistant is interviewing a patient the supervisor will observe him, may rate him according to the following criteria and discuss his performance with him.

Interview critique sheet/attitudes rating

Directions: Anchor-point criteria are provided for each variable on a continuum from "satisfactory" (S) to "unsatisfactory" (U). Each medical assistant should be judged on every variable and a check (√) placed in the box which indicates the medical assistant's performance on the continuum. If you cannot rate a student on a variable, check the right-hand column.

Satisfactory (S) criteria	Unsatisfactory (U) criteria	Cannot rate
1 *Opening remarks* Greets patient by name with appropriate social gestures (handshakes, etc). Introduces self: explains purpose of interview. Time frame explained and patients consent obtained. Sufficient time spent to establish rapport. Attention paid to both comfort and privacy of patient and interviewer.	Brusque introduction. Insufficient time spent on social amenities. Unclear introduction and explanation of purpose of interview. Insensitive to patients anxiety or need for comfort and privacy. Authoritarian rather than collaborative role assumed by interviewer.	
Comments:	*Comments:*	

S ☐ ☐ ☐ ☐ U

[1] See: Katz, F. M. & Snow, R. *Assessing health workers' performance* Geneva, World Health Organization, 1980, pp. 108–109 (Public Health Papers No. 72).

Cannot rate

2 *Non-verbal communication*

Interviewer demonstrates an interest in what the patient is saying by eye contact, leaning forward, encouraging looks and nodding (where appropriate).

Comments:

Interviewer looks away from patient, turns back on patient, or stands up prematurely, cutting off patient. Manner and body language reflect lack of interest and concern with patient.

Comments:

S | | | | | U

3 *Questioning skills, types:*

Questions are simple and brief. Asks open-ended questions and progresses to focused and closed questions only when specific information necessary.

Comments:

Interviewer consistently asks closed questions, prematurely ending discussion. Asks confusing or compound questions.

Comments:

S | | | | | U

4 *Questioning-summary clarification:*

Summarizes interview content periodically. Asks questions to clarify meaning and to obtain a fuller understanding of the history.

Comments:

Fails to clarify confusing responses from the patient. Does not summarize,or uses summary only at end of interview.

Comments:

S | | | | | U

Cannot rate

5 *Questioning skills, control*

Interviewer is able to let the interview progress spontaneously to obtain the whole story, but redirects it when it becomes irrelevant or fragmented. Uses appropriate reinforcing cues (i.e. eye contact, leaning forward, nodding, smiling, repeating key words and phrases, etc.) or restricting cues (i.e. stops reinforcing cues, directs statements, etc.)

Interview is often unfocused and apparently out of the interviewer's control. Does not use restricting or reinforcing cues, or uses them inappropriately.

Comments: *Comments:*

S | | | | | U

6 *Listening skills, general*

Effectively uses silence to draw out patient. Uses active listening techniques when appropriate; such as restatement, summarizing and prodding statements. Uses interpretation when appropriate.

Interviewer talks too much; rarely restates what has been said, uses few or no summary or clarifying statements; uses misplaced or inappropriate interpretations.

Comments: *Comments:*

S | | | | | U

7 *Listening skills, empathy:*

Demonstrates ability to reflect back empathically to the patient what the patient has said: is sensitive to mood and feelings of the patient.

Makes statements that appear to lack empathy or appear hostile or abrasive in the context of the interview; is insensitive to mood and feeling of the patient.

Comments: *Comments:*

S | | | | | U

Cannot rate

8 Personal mannerisms:

Interviewer is relatively free of distracting personal mannerisms during the interview. Facial expressions convey acceptance. Body posture and position are appropriate.

Distracting personal mannerisms are present during the interview such as nail-biting, nail-cleaning, hair pulling, tooth picking, or slumping in chair. Interviewer seems unaware of these. Facial expression conveys disgust or annoyance. Body posture and position are inappropriate.

Comments: *Comments:*

S | | | | | U

9 Medical assistant's observations:

Medical assistant can accurately recall and report observations of the patients behavioural "physical status" (body posture and care, mood, speech, mannerisms, body position, and movement).

Interviewer does not notice and cannot discuss the behaviour of the patient

Comments: *Comments:*

S | | | | | U

10 Expression of personal competence:

Interviewer's conduct is characterized by consideration and respect; reports facts accurately, including own errors. Respects property of others and the confidence of the patient. Projects an attitude of confidence and ease.

Interviewer often inept and unsure; behaviour does not convey consideration or respect for the patient or the patient's property. Gossips about the patient. Interviewer falsifies information or defensively avoids accepting responsibility for own behaviour.

Comments: *Comments:*

S | | | | | U

Additional comments:

Evaluator's overall judgement

——— Performance definitely adequate
——— Performance (tape) should be reviewed by entire staff
——— Performance definitely inadequate

Further comments:

2 — Listening to/understanding a patient or other visitor
(attitude rating: observation, discussion)

The supervisor will observe the behaviour of the health worker towards:

- a patient at a critical period (e.g. mother of a malnourished child)
- an important person or local leader (e.g. a member of the village development committee)

and during a discussion of the problem affecting them, will take note of:

a. the signals (verbal or otherwise) whereby the patients express an appeal for sympathy or support;
b. the perception of these signals by the health worker;
c. the response by the health worker to this appeal for sympathy or support: content of verbal response, choice of words, facial expressions, gestures or body movements;
d. the assurance with which replies are given and the maturity shown in dealing with the situation;
e. the ability of the health worker to make use of sociocultural values so as to win the confidence of patients or other partners.

At the end of the interview the supervisor will ask how the health worker interpreted the situation. Will respond to requests made by the health worker, in particular in relation to skills in this area, and the need for additional training in carrying out this task.

3 — Promotion of ideas/health education
(method of supervision: critical review and discussion)

The supervisor will note the promotion and health education tasks/activities carried out by the health worker and discuss:

a. the availability (or otherwise) of relevant promotional or educational material (e.g. appropriate documentation on vaccinations, drinking-water, latrines, oral rehydration, etc.);
b. the health worker's knowledge of the content of this material;
c. the ability of the health worker to formulate the essential message of the promotional or educational material in simple terms and pass it on clearly;
d. the ability of the health worker to give a practical demonstration illustrating the content of the promotional or educational material, when possible;
e. the degree of understanding of the material by the target groups;
f. the degree of acceptance of the message by the target groups;
g. the practical application of the content (or the repetition of the procedures demonstrated) by the target groups.

The discussion will cover the relevance of the material, the skills of the health worker, and the reactions of the target groups, in order to identify the obstacles to the education process and likely ways of overcoming them.

4 — Development activities

(method of supervision: report and discussion)

The supervisor will note the development activities/tasks carried out by the health worker and inquire about:

a. the number of development committees set up in the district in relation to the total number of villages;
b. the frequency of their meetings, the dates and places of meetings held during the past four weeks;
c. their membership: names, position in society, views of influential members, regularity of attendance;
d. topics on the agenda of forthcoming committee meetings;
e. participation of health personnel in the various committees and their contribution to decisions;
f. assessments by committee members of participation by health personnel and conflicts that might result from such participation.

The discussion will cover the identification of obstacles to the smooth running of village development activities and other development activities, in order to get the health worker to suggest corrective measures.

Supervision instrument 8

Checklists for the supervision of managerial activities

Programme ..... PHC
Region ..... —
Institution/unit ..... Health centre No. 18
Staff member ..... Head/leader of health centre

1 — Management audit

Method of supervision: checklist.[1] This method can be used to review managerial activities and examine successes and failures.

Under the date of the audit, write Y(yes) or N(no) opposite each statement.

	Date	Action	Date	Action
1 — Planning and organization				
The health centre has one or more identified objectives	2.1.81 Y	Immunize 400 children	3.1.82 Y	Completed
These objectives are known to the health team				
Regular staff meetings are held				
A year-plan has been written and displayed				
There is a weekly timetable				
Staff duties are listed on a roster				
District activities are scheduled in advance				
Changes in rosters, schedules or other events are clearly communicated to the health team				
2 — Personnel				
Each member of the team has a written job description				
Each staff member knows to whom to report and from whom to receive instructions				
The team leader delegates work wherever possible				
On-the-job training is aided in different ways— by discussion, books or demonstration				
Good work is acknowledged by the team leader				
Opportunity exists for initiative and responsibility in the work				
Supervision takes the form of educating and helping and not criticizing				

[1] See: *On being in charge*, World Health Organization, Geneva, 1980, pp. 343–344.

	Date	Action	Date	Action
Workers are using the skills for which they were trained				
Team members show concern for the welfare of patients				
3 — Resources				
The account ledgers are in order and up to date				
The petty cash balance sheet is correct				
There is sufficient equipment				
The stock ledger is balanced and corresponds to the store shelves and inventories				
Drug issues are recorded and reviewed				
The A/B shelf system is used for vital drugs				
There are minimum queues and "bottle-necks" in the outpatient clinic				
There are adequate and clearly marked maps of the district				
The transport system is well maintained				
4 — District and public				
There is a health centre committee made up of people living in the area				
Efforts are made to educate the public in health				
The health needs of the public are identified and discussed				
The health goals and activities relate to public health needs				
The following health activities are expanding: – maternal and child clinics – immunization – nutrition programme – sanitation programme				
5 — Control system				
There are monthly statistical reports				
There is an annual report				
The patient registers are clear and up to date				
Patient records can be found when necessary				
Carbon copies of letters are made and filed				
There is an index of files and registers				
There is a well-kept log in the transport vehicle				
There is a method to identify discrepancies in drug usage				

2—Annual performance assessment

The taking of administrative decisions—ranging from increments and promotions to sanctions and dismissal—should be based on continuous records of the performance of those concerned. Moreover, the development of the personnel's skills needs to be carefully planned. The supervisor is therefore expected to make an annual assessment of the performance of each worker for whom he is responsible so as to facilitate administrative and staff development decisions.

Various assessment instruments can be prepared, and in many cases one model has been adopted for use nationwide.

1 The *first example* contains 14 "performance indicators" suggested by Katz & Snow (see footnote 1, page 38) pp. 55–56.[1]

Assessment of professional competence

Staff member's name: Date:
Unit: Supervisor's name:
Town or village: Place of work:
Title or post:

Performance indicators	*Score (out of 10)*
Accuracy	
Efficiency	
Initiative	
Integrity	
Organization	
Problem-solving	
Ability to work with others	
Attention to safety regulations	
Care and use of equipment, materials, work area	
Communication (oral)	
Communication (written)	
Knowledge retention	
Knowledge application	
Promptness	

Comments: _____

Supervisor's signature

[1] This assessment instrument is based on a thorough knowledge and continuous observation of the staff member by the supervisor. Each assessment item can be refined by assigning criteria to it.

2 The *second example*[1] is applicable to all full-time employees and consists of two parts:

Part 1
(to be completed by supervisor before meeting with employee)

Name _____ Employee no. _____
Job title _____ Date of employment _____
Location _____ Date of this evaluation _____

EMPLOYEE'S STRONG POINTS

These strong points can be used more effectively by doing the following:

AREAS THAT NEED IMPROVEMENT

These areas can be strengthened by doing the following:

Part 2
(to be completed by supervisor and employee together)

PLAN FOR IMPROVING PERFORMANCE FOR THE COMING YEAR

[1] See: MEDEX Primary Health Care Series No. 27, University of Hawaii, Honolulu, Hawaii, 1983.

COMMENTS

PERFORMANCE REVIEW DATES FOR THE COMING YEAR

Signature of employee _____ Date _____
Signature of supervisor _____ Job title _____ Date _____
Signature of personnel officer _____ Date _____

3—Management of supplies and equipment [1]

Methods of supervision: review, together with the staff, of post descriptions, written procedures and available documentation.

Supervision of this activity is based on the existence:

a. of post descriptions specifying the responsibilities for ordering, storing, maintaining and controlling supplies.
b. of written procedures for:
   - ordering
   - storage
   - maintenance, and
   - control of supplies received and issued
c. of appropriate documentation on:
   - stock levels
   - order forms and delivery notes
   - issue vouchers
   - inventories and inspection checklists.

Supervision of this aspect of management consists in listing the difficulties experienced by staff and managers with regard to supplies, encouraging them to suggest possible corrective measures, and helping to see that such measures are put into effect.

[1] It would be a good idea—before starting to supervise the management of supplies and equipment—to read or revise Part III, Chapter I, of *On being in charge*, Geneva, World Health Organization, 1980, pp. 145–156.

4—Financial management[1]

Method of supervision: problem-solving.

The aim here is not financial control but the supervision of financial management, i.e. ways of identifying the difficulties encountered by staff and managers with regard to financial resources, getting them to suggest appropriate corrective measures, and helping to see that such measures are put into effect.

Delays in the transfer of funds allocated, insufficient petty cash for meeting minor items of expenditure, cumbersome procedures for obtaining very small items, etc. are problems that can seriously handicap health personnel and will need to be closely studied, as will the level of resources, the competence of the people involved and the measures proposed in the past to remedy such difficulties.

Problems diagnosed in this way will be discussed with the entire staff so as to decide what corrective measures to recommend.

[1] It would be a good idea—before starting to supervise financial management—to read or revise Part III, Chapter 3, of *On being in charge*, Geneva, World Health Organization, 1980, pp. 177–183.

Supervision instrument 9

Exercises for the design of training activities

Programme ..... MCH/FP
Region ..... ——
Institution/unit ..... Health centre No. 22
Staff member ..... Registered midwife

1 — For individual training, exercises and discussion will be used.

Exercises:

a. In the light of the objectives and recent performance of the programme and unit, some of your activities/tasks concerned with health care, promotion and management might be challenged. In your opinion, to which of your activities or tasks should you give your priority attention in order to improve performance? (list about 10)

	Health care	Promotion	Management
Activities or tasks (taken from your description of activities)	1 ..... 2 ..... 3	11 ..... 12 ..... 13	21 ..... 22 ..... 23 ....

b. Every task normally has three components: thinking, feeling and acting (also known as intellectual, affective and practical components). In any given task, one of these components will be the most important (for example, an injection is predominantly practical). For each of the tasks you have entered above, list which of the components (I, A or P) you consider the most important. Enter also the component you consider least important and the one you consider second in importance.

activity/task	1	2	3 . . .	11	12	13 . . .	21	22	23 . . .
most important component									
second most important component									
least important component									

c. Competence (or skill), i.e. the ability to perform a task, depends on mastery of the necessary intellectual, affective and practical components. Mark with a cross the tasks listed above for which you regard yourself as competent. For the others (if any) select the component (I, A, P) in which you think you are weakest, the one you would like to improve, and put a circle round it. It may well be that you would like to improve more than one component of certain tasks: in that case circle two or three components.

Discussions:

a. The supervisor will review with the person under supervision the list of tasks to be performed and the levels of performance observed. The supervisors own interpretation should be explained. Any tasks considered essential should be added to the list.
b. The supervisor will review the place assigned to the components (intellectual, affective and practical) of the tasks selected, and discuss and note the components of the tasks added to the staff member's list.
c. The supervisor will review the areas where the staff member's competence is satisfactory and those where further improvement is required. After supplementing the list of needs for improvement the supervisor will suggest discussing the individual's needs at a staff meeting, within the context of the needs of the other members of the health team.

2 — For mutual or team training, group work will be used.

At a staff meeting the supervisor will get all the members of the team to present their felt needs for skills: whenever an item is seen as a skill *already acquired* by one team member, and as a skill *still to be developed* by one or more other team members, an "exchange of experience group" will be set up under the responsibility of the skilled member. If skills for one or more items are not available locally, the supervisor will take note of the need, for a decision at a higher level. An "exchange of experience" programme will be drawn up as part of the weekly work schedule.

3 — For the training of auxiliaries,[1] a working group will be simulated.

(Here the word auxiliary denotes any person or category of people who contribute, formally or informally, to providing primary health care for the community. They may be Traditional Birth Attendants (TBAs), village health workers or even members of village committees).

[1] It would be a good idea, before starting to supervise training, to read or revise pages 3.41–3.48 and 5.02–5.33 of: Guilbert, J.-J., *Educational handbook for health personnel*, Geneva, World Health Organization, (revised edition) 1987 (Offset Publication No. 35).

The members of the health team, under the guidance of a moderator selected by themselves, will *simulate* a working group consisting of TBAs (for instance). The purpose of the simulated working group is to hear from the supposed TBAs, and to record:

- a list of their activities as the TBAs would see them
- a list of the tasks that the TBAs have difficulty in performing
- a list of such difficulties
- the TBAs' felt needs for training so that they can cope with some of these difficulties
- the other felt needs for overcoming the difficulties.

The aim of this simulation exercise is to learn how a working group operates, how to structure the group's work, and how to conduct the work so as to elicit the desired information.

Supervision instrument 10

Checklists for research work

Programme ..... PHC
Region ..... —
Institution/unit ..... —
Staff member ..... Project leader

---

1 — *For operational research,* checklists, ratings and discussions will be used.

List of points to be checked

a. Design/planning

	No	Yes
■ Is there a written research project (protocol)?	☐	☐
■ Is the study population precisely defined?	☐	☐
■ Have the various workers involved been given clear instructions?	☐	☐
■ Have the collection and statistical analysis of the data been specified?	☐	☐
■ Were the tables for presentation of the data designed in advance?	☐	☐
■ Has the timetable of operations been drawn up?	☐	☐
■ Who is responsible for reporting on this research?	_____	
■ Who makes the necessary funds available?	_____	

b. Implementation

	No	Yes
■ Is the project on schedule?	☐	☐
■ Has the study population been informed?	☐	☐
■ Do the project staff know what they have to do?	☐	☐
■ Have the data been collected?	☐	☐
■ Has the statistical analysis been completed?	☐	☐
■ Are the tabulations available?	☐	☐
■ Is the report ready?	☐	☐

c. Role of supervised staff member (yes or no)

design/planning	☐	coordination	☐
data collection	☐	interpretation	☐
statistical analysis	☐	publication	☐

d. Difficulties encountered

Discussions: with the responsible authorities ☐

with the project staff ☐

- Summarize the nature of the difficulty encountered .....
- Discuss its impact on the research findings .....
- Elicit suggestions for corrective measures .....
- Consider ways of implementing them .....
- Recommend the measure selected .....
- Decide on application .....
- Timetable for application: .....
- Person responsible for implementation: .....
- Scheduled date of next review: .....

2 — For epidemiological research

The reader will find it useful to consult the articles on "health surveys" in *World health statistics quarterly*, Vol. 38, No. 1 (1985).

Supervision instrument 11

Supervision report

Programme .....
Region .....
Institution/unit.....
Staff member .....

Purpose of visit
Working hypotheses and priority activities to be supervised:
- –
- –
- –
- –

Observations made, persons contacted, discussions and meetings held

Place	Date	Person contacted	Content

Needs identified:

		Measures taken
1 Objectives to be clarified	–	
2 Working instruments to be developed	–	
3 Skills to be acquired	–	
4 Working methods to be introduced	–	
5 Information to be conveyed	–	
6 Resources to be obtained	–	
7 Others	–	

Programme for putting the measures decided on into effect (see Instrument 12)

Support needed

(type)	(from whom)	(when)

Scheduled date of next supervision visit:

Date: *Signature:*

Supervisor's name:

Supervision instrument 12

Programme for putting the measures decided on into effect[1]

Programme.....
Region .....
Institution/unit.....
Staff member.....

Identified needs[2]	Measures to be taken	By (date)	Persons in charge
1			
2			
3			
4			
5			
6			
7			

Date: Signature

Supervisor's name:

[1] It would be useful to discuss this programme with the staff, get it approved by the team leader or head of the health centre, and distribute it to those concerned.

[2] Based on list in section 3 of Supervision Report—Supervision instrument No. 11, page 55.

4. How to supervise

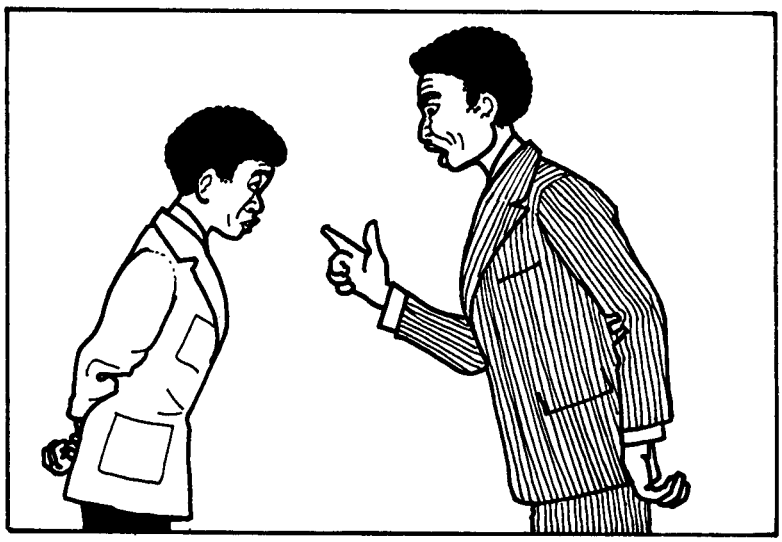
If supervision is the art of guiding, instructing and encouraging staff initiative, it must be seen to be of value and the worker supervised must regard it as a support and a way of improving competence. The style of supervision, and the development of the individual's personality and motivation, must be addressed right from the outset by a leader who must constantly bear in mind the human components so important in any supervision activities.

4.1 What style of supervision should be adopted?

Various methods of supervision are described in the literature: the direct methods that imply contact, interaction between "supervisor" and "supervisee", and the indirect methods based more on the analysis of documentation and on administrative-type action.

In practice a good supervisor at district level, as at any other level, will always have to choose the style of supervision that best suits each situation. The art of reconciling the authority of the superior with the freedom of the subordinate requires practice. As a simplification there are three main styles of supervision: autocratic, anarchic and democratic.

The autocratic supervisor is the one who says "Do what I tell you". Again as a simplification, this type of person tries to see everything, know everything, understand everything, be everywhere, does not delegate responsibility and often confuses authority with domination; and is content to give orders and see that the work is carried out by imposing discipline.

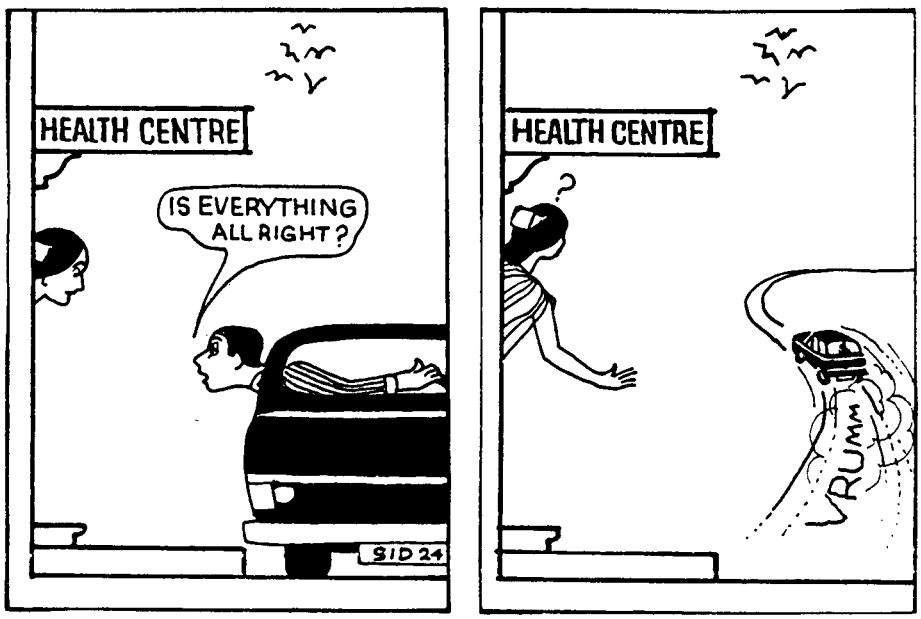


This style often results in a drop in efficacy and efficiency when the supervisor is away and in the frequent occurrence of difficulties of a psychological nature, such as fear, reluctance, lack of confidence, or feeling of insecurity. Use of this authoritarian style may be considered temporarily and cautiously:

- for tasks requiring coordination and consistency, particularly in the case of a programme employing a large number of staff;
- for tasks requiring immediate action, such as an emergency (epidemic, disaster, etc.);
- with staff who have limited skills or experience;
- with staff who are known to be unreliable.

It will also be noted that autocratic supervision generally succeeds only when the subordinate can be closely supervised, which is often not possible in rural health work where the staff may be remote and isolated from the district centre.

Anarchic or "laissez-faire" supervision corresponds to the motto "do as you like". The supervisor has confidence in his employees and in extreme cases lets them do as they like, with foreseeable consequences such as lack of coordination of activities, neglect of important tasks, duplication and a loss of interest in the work.



The democratic supervisor will say, "Let us agree on what we are going to do" and will seek a balance beteen the needs of users, the needs of the staff and the requirements of the programme. Democratic-type supervision is particularly suitable:

- for work requiring creativity, such as research;
- for highly competent and experienced people;
- for people who are known to be reliable;
- for people who are willing to accept responsibility and take decisions.

While the choice of style of supervision may be governed partly by the supervisor's personality, it should be governed mainly by the circumstances, working needs and abilities of the workers. Most people prefer to work under democratic management. This does not mean, however, that the democratic style is always the best. Under certain circumstances supervision has to be authoritarian inasmuch as the instructions given are not open to discussion. A certain amount of *laissez-faire* might also be recommended in so far as it is always a good idea to place confidence in employees and to leave them some room for manoeuvre in their work; this will give them a greater interest in and more motivation for their work. Indeed, to the three simplified supervision styles already mentioned it is generally necessary to add a fourth more realistic style: a cocktail made up by mixing the first three in different proportions as required, but giving preference to the democratic style whenever possible.

4.2 Trying to develop the supervisee's personality

The supervisor should also seek to develop the personality of those under supervision and to ensure that the process will exert a deep influence upon the worker's development—which involves a change, a continuous progression from a state of immaturity to a state of maturity.

These states of immaturity and maturity may be defined as follows:

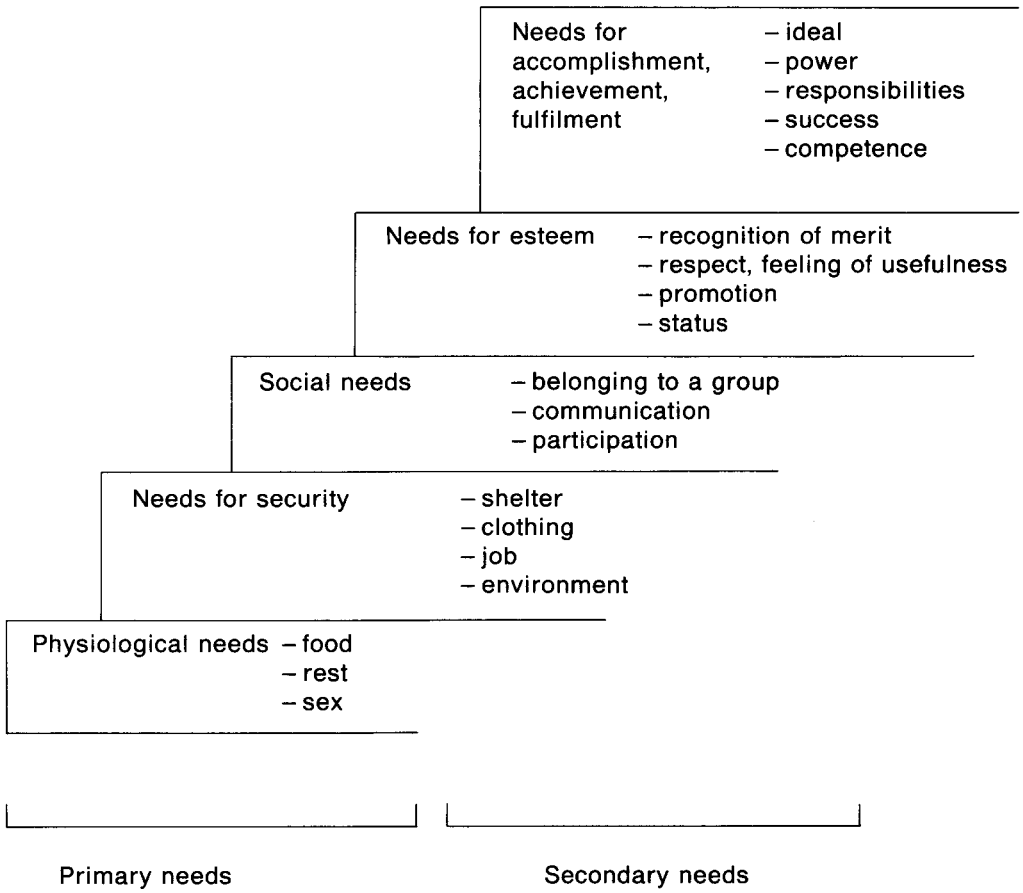
IMMATURITY (each item may be rated from 1 to 5 to facilitate comparisons)		*MATURITY*
– Passive	☐	– Active
– Dependent	☐	– Self-reliant
– Little variation in behaviour	☐	– Variety of behaviours
– Limited interests, superficial attention	☐	– Many interests, deep commitment
– Short-term view of the future	☐	– Long-term vision and objectives
– Subordination, need to be supervised and overseen closely	☐	– Position of equality or dominance
– Poor perception of himself/herself	☐	– Self-confidence and self-control

Maturity in the professional context may be summarized as the ability and willingness to assume responsibilities and to determine one's behaviour when faced with specific tasks. It is the supervisor's job, within the existing administrative and hierarchical framework, to ensure the gradual development of those being supervised to help them attain this state of maturity that enables them to fulfil their potential, obtain satisfaction in their work and makes them open to a high degree of motivation. At the district level, where there is some degree of isolation this will be a way of helping the health worker and compensating for any feeling of remoteness by providing guidance and support. The qualities required of the supervisor in this instance are no different from those of a leader. They are human qualities and the professional and managerial qualities that are outlined in the next chapter on the profile of the supervisor.

4.3 Trying to increase the motivation of the supervisee

Motivation is closely bound up with the process of personality development. It may be defined as an internal impulse that drives the individual to effort and to action by producing a particular frame of mind. Motivation affects attitudes by triggering behaviour appropriate to the motive.

It is generally held that all human behaviour is motivated in the sense that it is directed towards satisfying basic needs (whether physiological or psychological); these needs can be ranked as follows:[1]



Experience shows that the highest-ranked needs only become important as motivating factors when the needs at a lower level are relatively well met, since an individual is motivated by the first level at which needs are unmet.

In the job and in the working environment there are motivating factors reflected by what is called job satisfaction and the quality of performance. These factors, which it is important for the supervisor at district level to develop or promote, are as follows:

[1] Adapted from Maslow, A. H., *Motivation and personality.* New York, Harper and Row, 1954.

In the job itself

- Challenge, competition
- Increased responsibility
- Personal development and fulfilment
- Recognition of merits
- Attainment of good results
- Pursuit of an ideal

In the working setting

- Appropriate administrative rules and regulations
- Properly conducted supervision
- Favourable working conditions
- Good interpersonal relationships
- Satisfactory conditions of employment
- Stimulating future prospects (promotion, etc.)

From the viewpoint of the ranking of needs, these motivating factors should make it possible to satisfy the individual's basic needs.

4.4 The supervisor must be a leader[1]

At the local level of the health services, where there is often a severe shortage not only of qualified staff but also of financial resources, transport, drugs and facilities of all kinds, those resources that are available need to be strictly and effectively managed. The supervisor needs therefore to be a good manager who knows how to plan, organize and see to the implementation of primary health care activities in addition to management of the staff. Experience has shown that the support and supervision of health personnel are crucial factors determining the success of the staff in carrying out their duties. This support and supervision need to be provided continuously and followed up; they can be systematized and training programmes should be provided for supervisors. The fact remains, however, that the supervisor must also be selected on the basis of personal qualities, which another leader at a higher level will help to develop. Supervision is an undertaking that implies continuity in which people learn and improve every day, but it must always be based on knowledge, experience, enthusiasm and integrity, all of which are essential attributes for leaders . . . and for supervisors.

The human aspects of supervision have been mentioned in this publication on many occasions. It is important to stress them once more because the subject of supervision is the man or woman carrying out his or her daily health tasks. This man or woman often works under difficult conditions and it is the task of the leader and supervisor to try to improve things. Working premises must be adequate, working equipment—vehicles, drugs, stationery materials and supplies—must be satisfactory and in good condition, while the rewards—salaries, travel allowances, fringe benefits—should be fair and compatible with the available resources. Outside work, the worker also has a family life whose joys, griefs, difficulties and constraints have a

[1] *See* Flahault, D. & Roemer, M. I., *Leadership for primary health care.* Geneva, World Health Organization, 1986 (Public Health Papers No. 82).

direct influence and bearing upon work and performance. The supervisor cannot therefore afford to ignore the family background and the problems it presents for the workers under his or her responsibility. Without being indiscreet or interfering in the personal life of other people, the supervisor ought to display interest and understanding and tactfully provide assistance and support whenever possible.

5. Profile of the supervisor

5.1 Supervision at district level

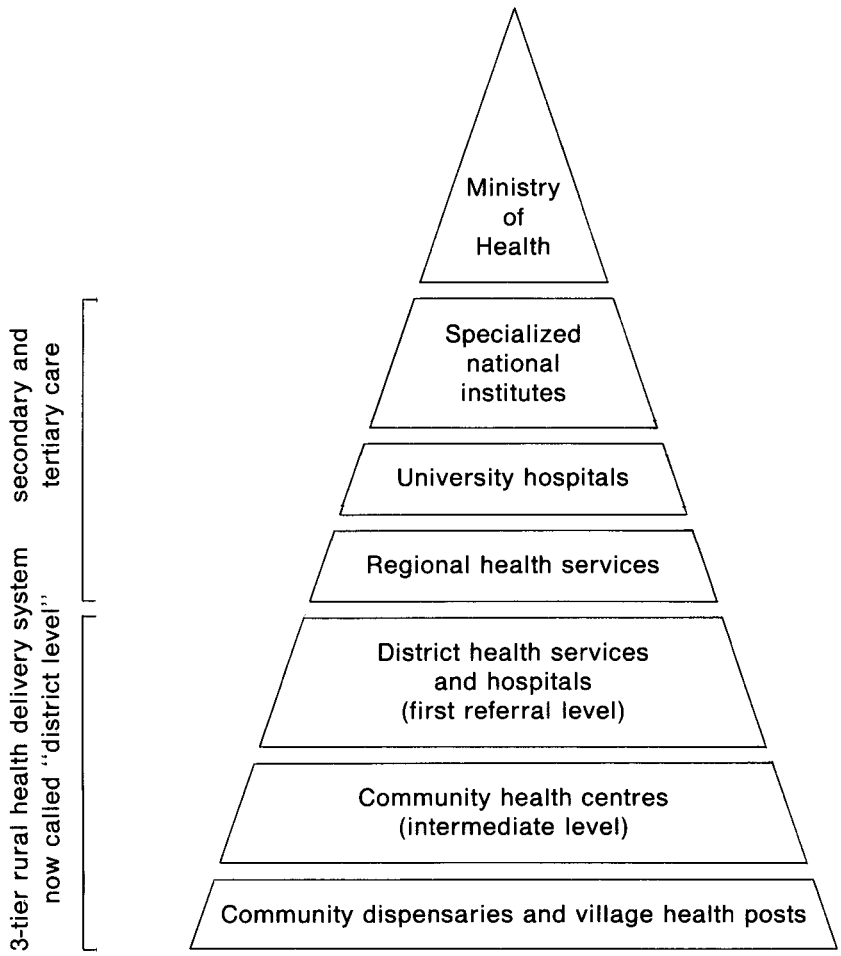
In earlier chapters we have seen that supervision consists of a series of distinct activities involving at district level a supervisor and one or more workers and, to a lesser degree, the "management" and the consumers. We have seen that supervision activities are carried out in the areas of health care, management, communications, training and even research and logistic support. Supervision activities therefore call for a whole variety of skills, knowledge, interests and experience. We have also seen that supervisory activities comprise a wide range of transactions, or exchanges, between the supervisor and the other people involved: these may be logical, rational exchanges aimed at solving problems, exchanges involving values and aimed at strengthening or modifying behaviour, or even exchanges within an emotional setting, such as the resolution of conflicts. The profile of the supervisor will therefore have to be defined on two different levels: on the level of professional skills and on the level of personality. In order to define the professional profile of the supervisor we shall follow good educational logic and proceed from the description of duties to the prescription of the required skills. In order to arrive at the personality of the supervisor we shall analyse the most important types of transactions, especially within the supervisor—supervisee relationship, in an attempt to define the psychological attributes required.

Before we do so, however, it is as well to clarify certain terms, and above all the word supervisor. In the previous chapters we used "supervisor" for the sake of simplicity. In practice in the health services at district level there are hardly any supervisors—people whose *only* function is to supervise—any more than there are "managers" whose only function is to manage. If we exclude the full-time inspectors employed by some health administrations, generally at a very high level, supervision is just one of a group of functions carried out by certain staff within an organization. Just like other managerial functions, supervision will be specified among the other duties of these staff in their job descriptions.

The relationship between the supervisor and the person supervised is generally interpreted within the framework of an organization's hierarchical structure, as represented, for example, in the form of an organization chart. The kind of relationship such charts suggest is a relationship between a hierarchical superior and a subordinate: supervision becomes merged with direction. Now the health services, and more especially the primary health care services at district level, adopt the functional concept of health team. This team is made up of people who may belong to different sublevels forming part of the same level. Thus the district level often consists of three sublevels: a local level, for which the front-line workers such as community health workers are responsible; they work in close liaison with the sublevel of the health centre, where medical assistants, nurses, midwives and other health personnel are based; these in turn work in close liaison with the district sublevel itself, where one or more physicians assisted by other health professionals are located.

The health team may also consist of people who belong to different structures (intrasectoral or intersectoral programmes, communities, etc.), and they do not need

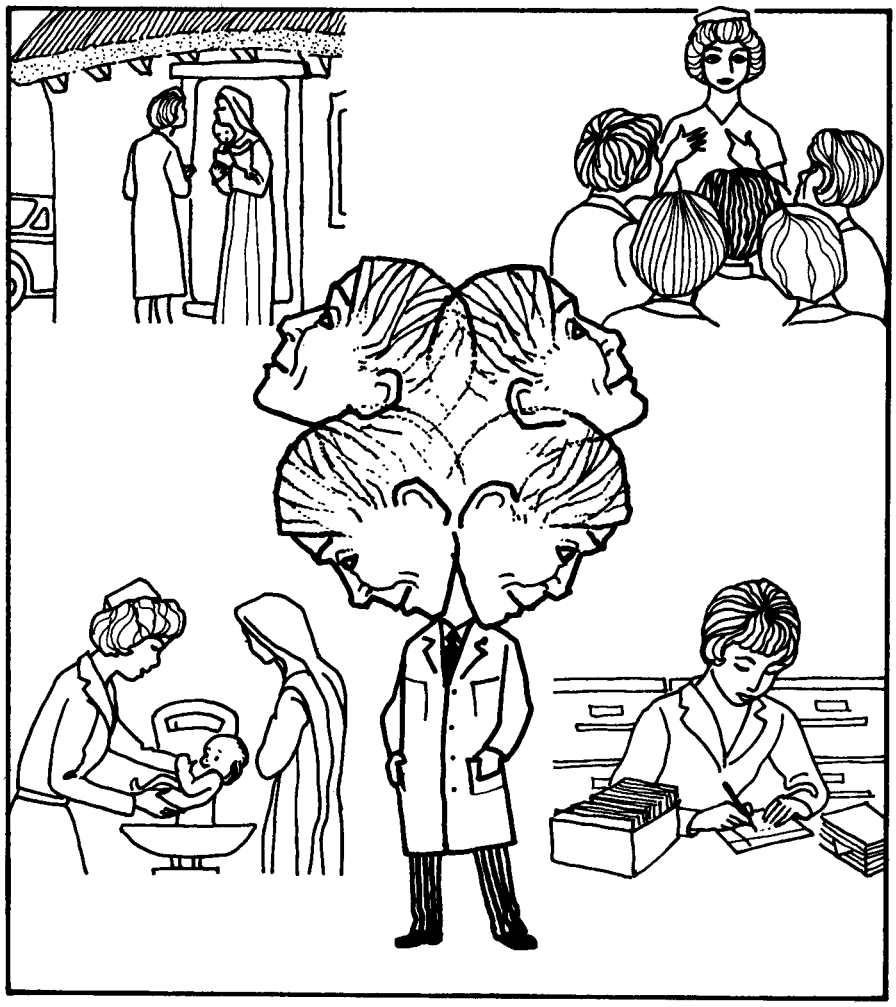
Pyramid of health services



directing so much as coordinating so as to make sure the services they provide for consumers are integrated.

In this context supervision, as a responsibility, may be delegated differently from the other managerial functions: thus a programme director will delegate supervisory authority to the person in charge of a particular establishment or region, while retaining his or her own decision-making powers.

Supervision is sometimes looked upon as a task for the specialist. The historical development of the health professions has led to a proliferation of specialists and to the jealous defence of their specialties. But obviously an integrated concept like



primary health care calls for supervisors who take a broad and general view of the services provided: for example, the supervision of MCH-FP is not a task for the gynaecologist or the paediatrician (any more than for the demographer), but a task for the general practitioner, or for the nurse, midwife or medical assistant.

In certain cultural settings it is customary to think of supervision in terms of seniority: but skill and responsibility do not necessarily go hand in hand with age. Again, the supervisor–supervisee relationship is not infrequently taken to imply a difference in terms of salary scale. In a multidisciplinary system, like the health services system, members of some professions tend to find their way to the top of the salary scale because they have technical skills that are in great demand. However, their training may not provide them with experience of work at district level or prepare

them for supervisory duties. Inasmuch as supervision calls for special skills, the salary scale must of course take this into account, just as it takes technical skills into account. The level of remuneration is not a criterion for choosing the supervisor, but should be the outcome of a choice based upon skills.

Finally, supervision is all too often regarded as an instrument of administrative authority. When this happens there is a danger of supervision becoming formal, giving prominence to the promotion/sanction aspect of staff relations, on account of the power the supervisor derives from taking such decisions, instead of promoting the programme objectives, i.e. the quantity, quality and efficacy of services.

5.2 Profile of professional skills

The difficulties that these traditional interpretations are liable to lead to can be avoided by defining the *profile* of the supervisor, first of all in broad outline by specifying his or her activities, then in detail by specifying tasks, which will then be used for defining the objectives of his or her training programme.

A. In a job description, the paragraphs dealing with supervision as a function could be drafted in terms of the following *activities* (groups of tasks):

- maintaining delivery of services at a high level;
- promoting good performance by the programme staff (specify their number and titles);
- assisting the staff in health care, promotion and management techniques;
- guiding and supporting the continuous training of the staff;
- helping to establish the credibility of the staff within the community;
- settling the complaints, conflicts and disciplinary problems of the staff;
- acting as an intermediary between staff at different levels and between them and management;
- providing the staff with logistic support;
- evaluating the services provided.

B. The *tasks* (components of activities) of a supervisor might, for example, be grouped and detailed as follows:

B.1 Preparation for supervision:

1 Summarize and explain the objectives, operational targets and work norms applicable to a programme, a district, an establishment or a centre and to a given staff.

2 Interpret the data collected in the course of continuous surveillance and during supervision visits and the data available in the evaluation reports in terms of the efficacy of services, productivity of activities, economy of resources and staff performance.

3 Identify the priorities for supervision by programme, district, institution and professional category, and draw up a checklist.

4 Plan a supervision programme for a district.

5 Organize a supervision visit to a district, an establishment or a health centre.

6 Draft a post description, an annual performance appraisal form and other supervision instruments.

7 Establish the necessary contacts with local authorities.

B.2 Implementation of supervision:

1 Explain the description of duties, activities and tasks specific to each category of personnel.

2 Analyse the use made of working time by the supervised personnel in terms of the duties, activities and tasks they should carry out.

3 Modify their work plans and their distribution of tasks as required, in the light of the objectives, targets and norms and the performance observed.

4 Observe and criticize the way the supervised personnel carry out the tasks from the point of view of technique, organization and human contacts.

5 Identify, by critical observation of the performance of tasks, any shortcomings the staff member may have in technical, managerial or promotional skills.

6 Analyse the intellectual, affective and practical components of the skills required by the staff.

7 Consolidate the training needs of the health team and draw up a continuous training programme that meets these needs.

8 Provide instruction in technical subjects, management and promotion within the limits of his or her ability.

9 Explain the teaching methods appropriate to different subjects and assist in selecting them.

10 Organize the technical, material and personnel support for the continuous training programme.

11 Evaluate the results of a continuous training programme in terms of improvement in performance.

12 Identify any lack of motivation in the staff member by critical observation of the performance of tasks and discussion of shortcomings noted in skills.

13 Analyse the lack of motivation in terms of satisfaction of the staff member's basic needs, the motivating and demotivating factors in the environment and the working conditions.

14 Consolidate the motivation needs of the health team and draw up a programme of intervention at the management and leadership levels to meet these needs.

15 Evaluate the results of changes in managerial methods and style of leadership in terms of staff morale and working discipline.

16 Analyse, by personal contacts with representatives of the community, how the objectives, targets and norms of the services are seen by the users.

17 Identify the faults in the performance of PHC staff as seen by the users.

18 Identify the shortcomings in information and motivation among the users.

19 Formulate a programme for promotion of services on behalf of village committees and users.

20 Evaluate the results of a promotion programme in terms of user participation in health services activities and the users' subjective assessment of the services.

21 Identify, by critical observation of the performance of tasks, any inadequacies in interpersonal communications within the team.

22 Draw up a programme for developing appropriate communication mechanisms (including documentation).

23 Evaluate the results achieved by introducing new mechanisms for communication.

24 Identify, by critical observation of the performance of tasks and by study of documentation, any shortcomings in the logistic resources, equipment, supplies or funds needed for supporting the delivery of services.

25 Draw up a programme for administrative and financial intervention at different hierarchical levels so as to correct the observed shortcomings.

26 Organize logistic support for such intervention.

27 Identify, by critical observation of the performance of tasks and by the discussion of demotivating factors in the work environment, any actual or potential conflict situations.

28 Formulate mechanisms for resolving conflict situations.

29 Evaluate the efficacy of the mechanism set up in terms of improvement in working relations.

B.3 Follow-up of supervision:

1 Complete an annual performance appraisal form for each staff member under supervision.

2 Discuss the assessments frankly with the staff member.

3 Draw up a staff development programme.

4 Evaluate the progress made by the staff member.

5 Draft documented recommendations to the administration.

6 Keep up to date the files of the staff under supervision.

N.B. The teacher in charge of training staff for supervisory duties will extract from the above list the various intellectual, affective and practical components so as to develop an appropriate learning programme. The experienced supervisor will be able to make use of this list as a tool for self-evaluation. This list is simply an example, and is not exhaustive: it should not be adopted but adapted as required.

What the person responsible for supervision should be capable of doing—in other words, what it is necessary to learn to do—is now clear. The field is very broad, the skills required are varied and difficult, and we can now more readily understand why supervision is not always carried out satisfactorily: responsibility for supervision is generally assigned without any appropriate prior training.

5.3 Personality profile

The personality profile that the supervisor should have still needs to be defined. In other words, what psychological, affective and moral qualities or values are necessary in order to be able to acquire the varied skills and carry out the tasks listed above? An analysis of the different supervision situations will bring out the salient features of the personality that the supervisor ought to have.

It will be remembered that preparation of a supervision tour at district level implies assimilating programme objectives and analysing data that reflect the performance of staff. At this stage the leading features of the supervisor's personality are an ability to identify with the objectives of primary health care and personal commitment to them, which implies a set of values such as a sense of fairness and social justice and a sense of personal responsibility towards the user communities. However, this does not mean having blind faith in what might be merely well-intentioned statements or even, at worst, ranting demagoguery. Identification with the objectives and personal commitment must be the outcomes of a clear-sighted analysis of the aims of the programme. It is therefore the capacity for personal and reasoned *commitment* that emerges as the leading psychological attribute of the supervisor.

At the stage when data are analysed and working hypotheses are formulated it is necessary to interpret a mass of data of varying consistency in order to identify priorities. This process calls for both imagination and the ability to call on experience. In interpreting the data the supervisor must be able to take past experience into account, must have the ability to imagine different scenarios, without believing in any of them *a priori*; and therefore, must also display a self-critical attitude. *Imagination and a critical attitude* must be balanced in the supervisor.

At the implementation stage the supervisor becomes involved in many transactions of a highly variable content. At this point *open-mindedness, helpfulness* and the *ability to listen* are required. A commitment to the objectives and the exercise of imagination in formulating supervision hypotheses must not prevent the supervisor from seeking, listening to and trying to understand the point of view of the staff and other people concerned. On the contrary, an effort must be made to encourage them to express their ideas and feelings.

During the countless dialogues that go to make up a large proportion of supervision it will be necessary to compare and contrast facts, interpretations and values. To keep the dialogue meaningful the supervisor needs to communicate effectively. While expressing ideas may be a technique that can be learnt and improved in practice, this is not true of understanding what the other person says, which calls for a personality trait close to what is called "being a good listener". The supervisor should be able to establish a rapport that goes beyond the discussion and the topic discussed; a capacity for *empathy* is needed. At the same time there needs to be some degree of discipline in the dialogue, the essence of which is the ability to keep *his / her own emotions under control*—which may present problems for someone who is both committed and imaginative! After all, the dialogue will be all the more useful if it leads not only to agreement on the intellectual level but also to trust in each other's honesty and to an understanding of other people's motivations.

The interpretation of the facts in the dialogue between supervisor and supervisee is based on an objective analysis, serious discussion and the application of criteria of judgement. The basic features of the good supervisor's personality in this respect are intellectual *honesty* and *integrity*. However, these characteristics must not be accompanied by intransigence or rigidity. Indeed, a major component of interpretation of facts will be the perception of the cultural, social, psychological and political setting within which the observed facts take place, a setting that must be taken thoroughly into account before arriving at any judgement on a particular form of behaviour by another person. It may seem contradictory to mention *flexibility* immediately after honesty and integrity—inasmuch as frequent changes of course generally reflect a lack of principles—yet it is in fact the moderating characteristic that is needed here. Perception of the limits within which other people's behaviour can be expected to change does indeed require some degree of flexibility in applying the principles involved.

A glance at the terms used in the job description and the list of supervision responsibilities suggested above reveals the words "guide, promote, assist", all of which relate to exerting influence. What we are concerned with here therefore is leadership, for leadership has been defined as the "art of influencing". Influence can be exerted at different levels: you can convince people intellectually, you can motivate them by gaining their confidence, you can lead by example—here again therefore we find the intellectual, affective and practical components. The personality traits of the leader include most of those that have already been mentioned, in particular commitment, imagination, empathy and flexibility. To these must be added enthusiasm (literally "having God inside oneself"), confidence in oneself and in mankind in general, and perseverance. Not missionary zeal but clear-sighted drive, that is drive tempered by realism.

The personality of the supervisor is now gradually taking shape in the light of the various activities involved. The reader will no doubt have noted that most of the attributes mentioned are tempered by others. It is this balance between complementary or even opposing attributes that ensures the quality and success of a supervisor, as indeed of any leader, and especially at the district level where the health personnel often feel isolated, ill-equipped and even a bit neglected at the outermost fringe of the health services.

6. How to organize a workshop for training in supervision[1]

6.1 Definition and aims of the workshop

A workshop for training in supervision is a working meeting that enables the participants, with the aid of an organizer, to improve their skills by seeking solutions to their supervision problems.

The general objectives of such a workshop will be to:

- inform the participants of the reasons why supervision is necessary;
- enable the participants to identify the activities that supervision entails;
- familiarize the participants, through practical exercises, with the preparation and use of simple supervision instruments;
- develop the motivation and skills of the participants.

This chapter is intended for use by participants who already have or will have responsibility for supervising one or more health teams at district or regional level.

6.2 How to plan the workshop

The duration of the workshop may vary from three to five days; for the purposes of this chapter it has been fixed at four days.

For a first workshop 15 participants divided into three or four working groups would be a good number. As the organizers gain more experience the number could be increased to 20 or 25 participants for subsequent workshops.

There should be one organizer for every five participants.

The participants should as far as possible be of similar educational level, but this certainly does not rule out staff of different professions or the simultaneous participation of young people and experienced older people.

The following checklist is provided to help organizers avoid forgetting certain tasks that are essential to the preparation, running and follow-up of a workshop, bearing in mind that the success of a workshop depends to a large extent on its planning and on the arrangements made *before* the opening session.

The person responsible for the workshop should keep up to date the timetable for carrying out the activities appearing on the checklist.

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[1] This chapter is an adaptation to the theme of supervision of Chapter 5 of Guilbert, J.-J., *Educational handbook for health personnel*, Geneva, World Health Organization, revised edition, 1987, pp. 5.01–5.34.

Checklist

No. of days before or after the workshop	Action to be taken	Planned date	Actual date
Before			
365–180	– Decision to organize a mini-workshop – Appoint an organizer – Open a file – Define the general objectives and aims of the workshop – Find a source of funds – Have a draft budget approved – Set the dates for the workshop – Choose the place to hold the workshop – Book a meeting room and accommodation for the participants – Define the criteria for selecting participants – Choose the assistant organizers – Take account of the working language		
120	– Start the procedure for inviting participants, informing them of the aims of the workshop, the working methods and the programme of work – Seek applications, and as far as possible establish the applicants' individual objectives		
60	– Select the participants from those applying		
45	– Inform participants that they have been selected, and send them the documentation (especially *The supervision of health personnel at district level*)		
30	– Arrange for document reproduction equipment to be available – Prepare a checklist of the equipment required – Inform the press		
8	– Review the list of participants		
2	– Arrange the room and inspect the premises (with equipment checklist) – Call a meeting of the assistant organizers and review the programme for the workshop		
1	– Have a friendly drink		
During			
	Background organization of the workshop – timetable of work – functioning of the workshop – organizing the breaks – group photograph – immediate evaluation		

No. of days before or after the workshop	Action to be taken	Planned date	Actual date
After			
10	– Send a letter of thanks to the assistant organizers		
15	– Prepare a report on the workshop		
30	– Send the report to the participants to the responsible authorities		
180–365	– Start long-term evaluation – collect data – visit the participants – organize an evaluation meeting – publish an evaluation report		

Some important comments

- In estimating the budget for a training workshop in supervision, include the cost of return travel and the cost of board and lodging for each participant. Add 20% of the total thus arrived at to cover other expenses: room rental, document reproduction, etc.
- It is recommended that the first day of the workshop should not immediately follow a non-working day, so as to ensure that at least one working day will precede the opening of the workshop.
- The place chosen for the workshop should preferably be secluded (so that the participants cannot return to their everyday work after the working sessions) but agreeable (so that they will recall it with pleasure).
- One of the selection criteria for participants will be awareness that the workshop requires their *active* full-time participation throughout its duration and a commitment to meet this requirement.

6.3 Working methods of the workshop

The working methods proposed for this workshop lay emphasis on active participation and the development of a critical and constructive attitude whereby the participants are encouraged to find the solutions to their own problems by themselves (through exchange of experience). There will therefore be no formal lectures or teaching by the organizers.

(a) Choice of personal objectives

A list of objectives is given below in order to ensure that the workshop adequately meets the needs felt by all the participants in carrying out their supervisory activi-

ties. This list refers of course to the text of the present publication, *The supervision of health personnel at district level*. Each participant in the workshop is invited to choose from these 28 objectives—which in fact amount to skills—those he or she gives priority to achieving, acquiring or improving by the end of the meeting. The programme of work will be organized on the basis of the choices made by the participants.

List of objectives[1]

The need for supervision

1 Define the following terms: supervision, leadership, health system, primary health care, district, objectives, performance, maturity, motivation.

2 Give four reasons why supervision can help to improve staff performance and briefly describe an example from your own experience.

3* Specify the risks that lack of supervision and poorly conducted supervision entail for the communities served, for the health system, and for health personnel; describe briefly an example from your own experience.

4* Identify methods other than supervision that can improve staff performance, specifying their advantages and limitations.

5* Investigate and analyse the kinds of opposition and difficulties that supervision may arouse on the part of the staff under supervision; describe briefly an example from your experience.

Supervision activities

6 Name the three stages involving supervision activities.

Preparation for supervision

7* Identify and locate the documents and reference texts for giving supervision a clear and precise foundation.

8* Determine the priority areas that supervision should be concerned with.

9* Draw up a supervision progamme specifying the working hypotheses, activities for priority supervision, and the planned route, timetable and frequency for supervision visits.

[1] The objectives marked with an asterisk are concerned with skills that require practical exercises within working groups.

Supervision proper

10 Specify the contacts to be made: official contacts, individual contacts with the workers carrying out the supervised tasks, group contacts with the health team.

11* Together with the workers, review their objectives, post description and time-table.

12* Observe the workers while they carry out their activities, making sure that they actually do everything they ought to do.

13* Identify the shortcomings and follow-up needs of the workers.

14* Talk with the community representatives in order to get their comments on the services provided by the health team and on the way these services are delivered.

15* Explain to the health team the salient points of the supervisory visit in order to motivate them and improve their performance.

Follow-up to supervision

16 Clarify the objectives and targets of the programme with the health team.

17* Together with the health team, review its plan of work.

18* Together with the health team, redesign its time table in accordance with the needs.

19* Draw up a continuous training programme with the health team.

20* Together with the health team, modify the logistic support as required.

21 Draft and circulate a supervision report.

Development of motivation and skills

22* Define the role and place of each member of the team within the health system at district level and at national level.

23 Define a profile of professional skills for the supervisor.

24 Define a personality profile for the supervisor.

25* Identify the components enabling each member of the team to reach a level of maturity that provides full development, satisfaction and motivation.

26* Identify the motivating factors likely to contribute to the improvement of performance.

27 Specify the various human aspects that every good supervisor should possess and should take into account.

28 Decide upon the supervision style or styles to be adopted.

(b) Reading matter relevant to the selected objectives

Once the main objectives have been selected all the participants will benefit from acquiring the theoretical knowledge they may need in order to find solutions to their problems. It is therefore suggested that they study this book, especially the following pages:

For objective no.:	Study the following pages:	For objective no.:	Study the following pages:
1	Glossary, and pp. 1–5, 58–64, 65 and 71–73	15	pp. 12–13 and 50–52
		16	pp. 14 and 20
2	pp. 3–5	17	pp. 14–15 and 23–28
3	pp. 3–18	18	pp. 15–16 and 29–31
4	pp. 3–18	19	pp. 14–15, 46–48 and 50–52
5	pp. 3–18	20	pp. 16–17, 37, 44–45 and 48
6	p. 18	21	pp. 17 and 55–57
7	pp. 6 and 20	22	pp. 23–25 and 65–68
8	pp. 7, 8 and 21	23	pp. 68–71
9	pp. 6–9 and 20–23	24	pp. 71–73
10	p. 9	25	pp. 61–64
11	pp. 10 and 23–31	26	pp. 61–64
12	pp. 11 and 29–43	27	pp. 38–43 and 61–64
13	pp. 10–12 and 44–49	28	pp. 58–64
14	pp. 11–12		

(c) Plenary clarification sessions

At the start of each day all the participants should meet in a plenary session so as to make sure that they all have a clear idea of what they need to do. These plenary sessions are not intended for discussions of substance, which will take place either during the group meetings or at review sessions.

(d) Practical exercises

Some of the 28 objectives in the above list are preceded by an asterisk. These are the ones requiring practical exercises. The exercises should be prepared by the organizers and should relate as far as possible to the local situation and conditions.

In some cases the organizers may find it helpful to make use of the examples of supervision instruments given in Chapter 3 of this book and adapt them as required. In other cases they will need to arrange *role-playing* sessions (e.g. simulation of a discussion between a health worker and community representatives) or *group work* in which the participants record their ideas (on flip charts, transparencies, etc.) and

compare and supplement them with the ideas of others. They may also have to prepare *case studies* for discussion by the participants. The discussions could begin with a comparison of the individual participants' results, two at a time, and then extend to all the small groups. It is not the job of the organizers to guide the destinies of the groups; instead they should allow group dynamics to operate, with its highs and lows.

For studying the objectives marked with an asterisk it is suggested that the following techniques or facilities should be used or made available:

For objective:	Use or make provision for:
3	Group discussions: small groups record their ideas, which are subsequently presented, supplemented and discussed in plenary.
4	As for 3.
5	As for 3, or else get each group to draft a letter informing the next higher level of the opposition and difficulties encountered.
7	Practical exercise in small working groups. On the basis of Instrument 1 (page 20) draw up a list of the objectives, operational targets and working standards relating to the principal components of PHC in a given health district or region. After that study the available data concerning performance of PHC in the same health district or region and identify any shortcomings in information and any inadequacies of the services.
8	Practical exercise in small working groups (based on Instrument 2 (pages 21–22)). Since there are certain inadequacies in the services as compared with the above-mentioned targets and standards for PHC, and shortcomings have been noted in information, formulate hypotheses as to their possible causes and draw up a list of points for priority supervision during the next visit.
9	Practical exercise in small working groups: on the basis of a list of points for priority supervision in various components of PHC, draw up a supervision programme for the health district or region studied.
11	Practical exercise in small groups: (1) On the basis of Instrument 3 (pages 23–25) prepare post descriptions for the staff of a rural dispensary—if appropriate, revise the existing post descriptions. Each group should deal with one category of personnel. After the presentations in plenary, identify the shortcomings and the conflicts of skills. (2) On the basis of Instruments 4 and 5 (pages 26–31) each participant should fill in a form for analysing the theoretical and real use of time; in plenary discussion, identify the steps that could be taken to put right any distortions observed. Draw up a list of these steps.
12	Case study or role-playing to be prepared in small groups and presented in plenary: on the basis of Instrument 6 (pages 32–37) prepare the appropriate supervision instruments and assess the performance of a traditional birth attendant/midwife, simulating the taking of a case history from a primipara, the supervision of a home delivery, a postnatal visit to the mother and her child (and so on, using a different situation for each group).

13 Practical exercise in small working groups: on the basis of Instrument 8 (pages 44–49) check on the management of the health centres in the health region studied. Identify any shortcomings and suggest the needs for follow-up of staff in regard to managerial activities. After the presentations in plenary, draw up a full list of the follow-up measures that could be applied.

14 Role-playing: one participant plays the role of supervisor, others play community representatives and the remaining participants evaluate the performance of their colleagues.

15 A presentation that may be purely fictitious or based on a case study. Critical evaluation should cover all the supervision activities. Alternatively, a practical exercise to be performed in small working groups: prepare the agenda, item by item, for a staff meeting under the chairmanship of the "supervisor", taking into account the results of the previous exercises and the supervision instruments.

17 Practical exercise in small groups. On the basis of Instrument 12 (page 57) and the given shortcomings and needs (see objective 8) draw up a list of the measures that should be taken to put them right, plan their timing, decide who will be responsible, determine the support and resources needed, and prepare a specimen plan of the work that will be subject to monitoring.

18 Group discussion on the learning methods that are appropriate to various shortcomings in the areas of knowledge, attitudes and practical activities. All participants will individually prepare their own continuous training programmes on the basis of the needs perceived by themselves.

19 Practical exercise in small groups. On the basis of a programme of work consisting of the measures recommended in 17 and 18, and the results of the time-table analysis (example 11), recommend a redistribution of working time designed to meet the needs and to correct the imbalances noted.

20 Practical exercise in small groups: on the basis of Instruments 6.3 (page 37) and 8.3 (page 48) draw up a list of the steps to be taken to remedy given difficulties with the supply, storage and utilization of essential drugs; draw up a programme for implementation and a timetable, and designate the person or persons who will be responsible for each of these steps.

22 Role-playing: simulate a staff meeting for looking into staff complaints about their role and place in the health team and the conflicts that may arise. Several moderators will attempt in turn to get the participants to reach a consensus on one or more measures aimed at correcting sources of frequent conflicts. The various approaches adopted by the moderators will be used to deduce general rules for conducting a staff meeting aimed at reaching consensus decisions.

25 Group discussion aimed at drawing up a list of factors that help individuals to become mature within the context of the health team.

26 Plenary discussion on theories X and Y.

28 Case study (see the case of George, given as an example in the appendix to this chapter, pages 89–90).

(e) Plenary sessions for presentation of work

The results of the participants' work and the conclusions reached in their working groups will be presented in plenary sessions, which will be organized whenever necessary. If appropriate, one of the participants, or in exceptional cases an organizer, will attempt to present a summary.

(f) Evaluation

Every day all the participants should make an evaluation of their own individual progress: this will give them an opportunity to modify the choice of objectives made on the first day, if they so wish.

At the end of the last session on each day about 20 minutes will be set aside for joint assessment of the extent to which the working methods used have helped towards reaching the objectives selected, and for suggesting any changes in the running and the programme of the workshop.

Shortly before the end of the workshop the participants will be handed an evaluation questionnaire so that they can give their views on the running of the meeting. The results will be analysed during the last session.

"Long-term" evaluation will be carried out one year after the workshop to measure its real impact. It will be based upon the professional objectives set by each participant at the end of the workshop.

(g) Preparation for the following day

At the end of each day's meetings a short period should be set aside for presenting the next day's activities, and particularly for suggesting any necessary advance reading. The participants will be reminded of any changes in the programme of work.

6.4 Preparation of the workshop programme

It is essential for all the organizers to be present at the place where the meeting is held at least two days before it starts so that the work can be properly coordinated.

All the organizers need to be fully conversant with the documentation for the meeting and these two days should provide an opportunity for an exchange of views between the organizers so as to ensure harmonious coordination.

Although a workshop by its very nature should not have a strict timetable it is often possible to give some guidance as to the course it should take, at least for the first day.

FIRST DAY: OPENING SESSION
08h 00—10h 30

1 Opening. The workshop organizer will of course begin by formally welcoming the participants, thanking those who have made the workshop possible and summarizing the general aims.

2 Clarification of documents. Go on without a break to this item. Ask the participants to turn to the documents in the order in which they received them. Go through the documents one by one. If any questions are raised by participants, other participants can be asked if they would like to clarify the point concerned.

3 Individual programme preparation. Each participant should refer to the list of 28 objectives given above and confirm his or her choice of about 10 of them, endeavouring to put them in order of priority.

The first plenary session is now over. The participants have until the break at 10h 30 to hand to the organizers their lists of selected objectives. During this period the role of the organizers is limited to replying individually to queries from participants.

BREAK
10h 30—11h 00

This is when the organizer will draw up the list (on a flip chart) of the participants who have selected identical objectives so that they can form groups for joint discussion. The list will enable the organizer to prepare a draft programme of work for the rest of the workshop. Any objective that has attracted the interest of about half the participants should be dealt with in plenary session. Since each preparation will require preparatory work by small groups of three to five participants, enough time should be allowed for this. A specimen draft programme, prepared on the basis of the objectives (*with* asterisk) chosen by the participants, is given on p. 84 by way of example.

Specimen draft programme

Objectives[1]	Participants who selected this objective		Draft programme of work		
	Names	No.			
3		8	Group work Plenary	Tuesday Tuesday	11h30–12h30 12h30–13h00
4 and 5		Less than 8	Individual work		
7 and 9		More than 7	Group work Plenary Group work Plenary	Tuesday Tuesday Tuesday Tuesday	15h00–16h00 16h00–16h30 17h00–18h00 18h00–18h30
8		Less than 8	Individual work		
12 and 13		More than 7	Role-playing Group work Plenary	 Wednesday Wednesday	 08h00–10h30 11h00–12h00
14		More than 7	Role-playing	Wednesday	12h00–13h00
15		More than 7	Practical exercises	Wednesday	15h00–16h00
17 and 18		More than 7	Group work Plenary	Wednesday Wednesday	16h00–17h30 17h30–18h30
20		Less than 8	Individual work		
19 and 22		More than 7	Group work Role-playing Plenary	Thursday Thursday Thursday	08h00–10h30 11h00–11h30 11h30–13h00
25 and 26		More than 7	Group discussion Plenary Group work Plenary	Thursday Thursday Thursday Thursday	15h00–16h00 16h00–16h30 17h00–18h00 18h00–18h30
28		More than 7	Group work Plenary	Friday Friday	8h00–9h00 9h00–9h30

[1] When the same objective is selected by at least eight participants (in a workshop of 15 participants) it should be dealt with in group work. Otherwise it should be the subject of individual work, as for the objectives *without* an asterisk.

FIRST DAY: SECOND SESSION 11h 00—13h 00

The draft programme drawn up by the organizer during the break is presented to the participants. As soon as it is accepted (around 11h 30) the participants can start working individually or in groups, taking the objectives selected in order. They can then present their results and discuss them in plenary before breaking for lunch. The organizer simply remains available and intervenes only on request. There is likely to be some confusion among the participants: but things will gradually improve!

FIRST DAY: AFTERNOON SESSION

The organizer will start by reminding participants of the time of the next plenary session and making sure that each small working group understands what it is supposed to be doing. The organizer should take a friendly interest, but should intervene only on request.

During the plenary session the organizer will merely ask the participants to present their work group by group and will encourage discussion.

About 20 minutes before the end of the last session of the day the organizer will ask participants to discuss the positive and negative aspects. of the first day and ask for a verbal report from a spokesman for each group. The organizer will end the day by going over the programme for the next day and any necessary reading.

SECOND AND THIRD DAYS

The participants will start organizing their work themselves and the organizer's task will be to help them do this. The day should start with a short clarification session (about 15 minutes) and this time it will be a good idea to begin in small groups and finish in plenary session. Then the organizer will mention that as on the previous day there will be a plenary session at the end of the afternoon for evaluation of the day's work. Everyone will set to work, aware that in the event of one or more working groups wishing to present the results of their work to the others, short plenary sessions may be held on request. A group photograph could be taken during a break.

LAST DAY

First of all complete the programme and the work in progress. Then ask the participants to prepare the professional objectives they hope to be able to achieve within the next year in the light of what they have learned during the workshop. These objectives should be discussed by the participants within working groups before being handed to the organizers. The last half-hour of the last day could be given over to an evaluation session, ending with a few closing remarks dealing mainly with the future.

Specimen questionnaire to be handed to the participants at the final evaluation session

Use the following code—circling the figure that corresponds to your choice—to indicate the extent to which you agree or disagree with each of the statements made below:

1 = Strongly disagree

2 = Disagree

4 = Agree

5 = Agree strongly.

1 *Aspects relating to the planning of the workshop*

Q.1	I was given sufficient information on the aims and methods of the workshop before my arrival.	1 2 4 5
Q.2	I feel that the programme drawn up during the first session took my own choice of objectives into account.	1 2 4 5
Q.3	The goals of the workshop appeared to me to be of great relevance to my supervisory activities.	1 2 4 5
Q.4	It was clear to me from the start of the workshop that I was expected to play an active part in it.	1 2 4 5

2 *Aspects relating to the relevance and utility of the working methods*

Q.5	I found the documentation provided of an acceptable quality.	1 2 4 5
Q.6	The information given in this book helped me to reach the objectives I had chosen for the workshop.	1 2 4 5

Q.7	The working methods used during the workshop encouraged me to take an active part in it.	1 2 4 5
Q.8	Spending time on individual work during the workshop helped me to learn.	1 2 4 5

3 *Aspects relating to the way the workshop was run and to the attitude of the organizers*

Q.9	The organizers displayed a satisfactory open-mindedness.	1 2 4 5
Q.10	The general atmosphere of the workshop was conducive to serious work.	1 2 4 5
Q.11	The organizers gave me the opportunity for critical comment.	1 2 4 5

4 *Aspects relating to the organization of activities in the time available*

Q.12	Enough time was devoted to clarifying documents.	1 2 4 5
Q.13	Enough time was given for group discussion.	1 2 4 5
Q.14	Enough time was given for the presentation of work in plenary session.	1 2 4 5
Q.15	Enough time was given for individual work.	1 2 4 5

5 *Aspects relating to the benefits gained by the participants*

Q.16	The workshop enabled me to achieve the four objectives listed in section 6.1. (p. 74)	1 2 4 5
Q.17	The workshop helped me to improve my knowledge of supervisory theory.	1 2 4 5
Q.18	The practical exercises helped me to develop my skills and motivation.	1 2 4 5
Q.19	The workshop should enable me to attain my personal objectives as a supervisor.	1 2 4 5
Q.20	I found the evaluation sessions useful.	1 2 4 5

6 *Other aspects/comments*

(a) Which aspects/components of the workshop impressed you *most* favourably?

(b) Which aspects/components of the workshop impressed you *least* favourably?

(c) Total length of the workshop:

Too short Adequate Too long

(d) Further comments and suggestions:

6.5 After the workshop

The organizer's role is not yet over. As mentioned in the checklist in section 6.2 (p. 76) it is important to thank all those who helped with the organization, those who provided the funds for the workshop and any assistant organizers. A report should also be drawn up describing how the workshop went and listing the participants' names and addresses.

Finally the organizer should make sure that the efforts made all bear fruit by following up the participants, encouraging them and assisting them as far as possible to continue to improve their performance as supervisors.

Appendix

Specimen case study of supervision[1]

George is the supervisor responsible for leprosy care in Beda District. Some time ago he attended a course in supervision and learned that, to obtain the full co-operation of his staff, he should consult with them and let them contribute to planning.

A few weeks ago George received written instructions from the regional leprosy officer that the dose of dapsone was to be changed to 100 mg daily for all adult patients, that treatment was to be continued throughout reactions, and that all new cases were to be given 100 mg of dapsone daily from the day of diagnosis.

This was completely contrary to previous custom. For as long as George could remember, adults received 300 mg of dapsone once a week, treatment was stopped during reactions and treatment began with low doses and built up gradually to the maximum dose of 300 mg a week. George called his dispensary attendants to a conference to discuss the new drug dosage with them.

When they assembled they began to question the wisdom of these new ideas. They said "We have always given patients 300 mg once a week; 100 mg a day is far too much. How do we know that if we give patients 100 mg a day they will take it? Patients cannot come to the dispensaries every day to collect their medicine. We are not even sure that they take 300 mg; some keep the tablets in their mouths and then spit them out and sell them. We have always stopped treatment during reactions. This is the only thing we can do for a reaction except to give aspirin. What are we going to do for reactions now? We have been told to build up the dose slowly because many patients are sensitive to dapsone, and if we give a high dose to a sensitive patient he may die. Who is the chap that sent out these instructions? We have never seen him. What does he know about leprosy?" These were only some of the arguments they raised. There seemed to be no end to them.

George said that the instructions had come from the regional leprosy officer, who was an expert in his work. The dispensary attendants would not accept this and the arguments went on for most of the morning. George was unable to answer many of their questions and in his own mind, although he did not say so, he shared their feelings and could agree with much of what they said.

However, George had his instructions. Also, he had met the regional leprosy officer and knew him to be rather hot-tempered. Therefore to hold his position as supervisor he would have to put the new instructions into effect. So, after hours of heated discussion, he closed the meeting by saying to the dispensary attendants, "Well, anyway, you must do what you are told. These are the instructions; carry them out!"

A discontented group of dispensary attendants dispersed with the new instructions. Later, in his supervisory visits, George found that several of the dispensary attendants continued to give dapsone according to the former instructions. One gave 50 mg

[1] From: *On being in charge*, Geneva, World Health Organization, 1980, pp. 84–86.

instead of 100 mg daily, on the grounds that 300 mg divided by 6 gives 50 mg; the patient was therefore getting the same amount as before. A few even continued to give the old treatment, but recorded it as the new treatment in their registers.

Questions:

- Considering both the job factors and the personal factors in this story, was the best type of supervision used here?
- For which objective(s) do you suggest this case study should be used?

Conclusion

All too often the way in which health personnel carry out their duties in the field does not come up to the expectations of the population and those responsible for their health. Many reasons have been put forward for this: lack of funds, shortage of qualified personnel, inappropriate training, the scattered nature of the population, inadequacies of the communication networks, and so on. Each of these reasons certainly has its share of responsibility, so there is no ready-made answer to the problem, but this must not stop us from trying to improve the present situation.

Everyone agrees that you cannot have good health services without staff who are properly trained in the jobs they have to do: performance is linked to competence, and the services provided are linked to the quality of the people providing them. Performance, competence and quality are therefore not constants but are eminently variable in time and according to the teachers, the learners, the conditions of work, and the physical, psychological, family and community environment.

This really comes down to saying that while adequate prior training is essential for all personnel it is by no means enough. This training must be supplemented and adapted to the environment and the circumstances, it must have some degree of continuity and provide opportunities for correcting shortcomings and also for monitoring, supervising and guiding the person concerned. This supplementary training, adapted on the job, continued and preferably continuous, corrective and stimulating, is one aspect of supervision.

Everyone acknowledges that supervision — a dynamic process intended to educate much more than to investigate or control — is essential, yet it is still done badly or not at all, especially in places where its inadequacy or its absence are almost visibly felt: at the district level. It is here therefore that the efforts of the national health services and any bilateral, multilateral and international contributions must essentially be directed.

While the authors of this book have set out to define the why and wherefore of supervision, the activities it involves, and ways of facilitating it, while they have sketched out the way to supervise and the profile of the supervisor, they have not touched upon the many measures and initiatives that can also help to develop supervision in the field: provision of transport facilities appropriate to the local conditions and resources, distribution of simple guides or practical instructions on supervision, provision of equipment, supplies and essential drugs, exchange of experience, etc.

If the responsible authorities seriously believe that supervision is one of the main components, though often neglected, of the development of their health personnel, they should give supervision the priority it deserves in action plans and programmes, in national, regional and district budgets, and in their evaluation surveys at the local level.

With the approach of the year 2000 many people are conscious of the urgent need to speed up the process of developing primary health care, and there can be no doubt that the development of supervision at district level is the aspect they must tackle as soon as possible. If they do not, it will not be surprising if populations continue to be disappointed by the poor performance of their health services and by the poor quality and mediocre skills of some health personnel.

Glossary[1]

Account A record of money received or of money spent, or both.

Activity A group of tasks with a common purpose.

Authority The power or right to make decisions and enforce them when necessary.

Budget A detailed estimate of the cost of a programme during a specific period. The amount of funds at the disposal of a programme.

Checklist A list of items or description of actions to be looked at, one at a time, to ensure that no item or action is overlooked.

Communication The transmission of information from one individual or group, by any means, to another individual or group.

Competence The professional ability required to carry out a task.

Constraint Restriction or limitation of freedom. See *limitation* and *obstacle*.

Control The cost-effective utilization of mainly material resources. Overseeing the activities of a programme, and verifying the results, to ensure that it is achieving its defined goals.

Coordinate To relate the activities of different persons in the same or connected programmes with one another in such a way that their common goals can be effectively and efficiently achieved.

Criterion (plural: criteria) A guide or standard on which something is judged, or which is used as a basis for making a decision, an assessment, or an evaluation.

Critical attitude The capability to look for shortcomings and insufficiencies, and also the ability to determine what is good.

Death rate The proportion of deaths that occur in a population of specified size during a specified period of time. The population size and the period of time may vary.

Decision A choice made between two or more alternatives.

Decision-making chart A chart showing different possibilities for action, intended to assist in decision-making.

Delegation of authority The action of a person in entrusting authority, for a specific purpose, to another person.

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[1] These definitions are intended for use with this publication. They may not necessarily apply in another context.

Development The economic growth of a society together with social improvements (for example, in health, education, and housing).

Discrepancy The difference between what is expected and what is found.

District A clearly defined administrative area (population between 50 000 and 300 000) at which some form of local government or administratation takes over many responsibilities from central government departments.

Duty roster A time plan showing the distribution of work, in turns, among staff members.

Educational objective (learning objective) A statement describing what the learner should be able to do at the end of a period of instruction that he/she could not do before.

Empathy The ability to understand someone else's problems or behaviour.

Evaluation The measurement of performance, based on established criteria, to ensure that the objectives set have been attained.

Facilities The buildings and material goods available for a programme or activity.

Felt needs See *needs*.

Flexibility The giving in or adapting of oneself to new, different, or changing situations.

Follow-up Maintaining contact with a person (e.g., patient) or watching over the development of a process.

Form A document with blank spaces for putting requested information in a prescribed arrangement.

Function A group of activities with a common purpose.

Functional chart See *organizational chart*.

Goal The intended or expected result or achievement of a programme or activity.

Guidelines A number of suggestions or indications outlining a policy or how to proceed with a plan of activity.

Health centre The place where a health team is based and from which health services are given to individuals and small communities in rural and urban areas.

Health unit Any distinct section of a health service, such as a dispensary, a health centre, or a hospital.

Health planning The process of defining community health problems, identifying needs and resources, establishing priority goals, and developing programmes and plans (setting out the administrative action) needed to reach those goals.

Health policy A general plan or course of action to be followed for dealing with health problems or promoting health.

Health status (or level of health) The degree to which the health of a specified population meets accepted criteria.

Honesty (intellectual) The quality of someone who is sincere, fair, loyal to his or her convictions or commitments, and who keeps his/her word.

Implementation Putting a programme into action; doing the work.

Incentive Something that incites a person to take action.

Incidence (of disease) The number of *new* cases of a specified disease that occur in a given population during a specified period of time (for example, a month or a year). (Incidence is often expressed as a rate, that is, as a proportion of the total population during the specified period of time.)

Indicator (health) Statistics (usually expressed as a rate or ratio) that show the level of community health (e.g., an infant mortality rate of 90/1000 indicates a low level of community health; a fall in the neonatal tetanus rate from 40/1000 to 10/1000 indicates an improvement in community health).

Information system A group of people, procedures, methods, and perhaps machines and other equipment, for the collection, processing, storage, and retrieval of information.

Integrity The quality of someone who is honest, incorruptible.

Leadership Art of influencing, guiding, managing effectively.

Limitation A deficiency of a necessary resource (manpower, materials, money).

Management The planning, organizing, directing, and supervising of something.

Monitoring Looking at the way activities are being implemented to meet objectives set and correcting any deviations.

Motivation A drive that impels an individual to make an effort and take action.

Needs – felt needs: needs recognized by an individual or a community
– real needs: needs recognized as a result of professional or technical survey.

Norm Authoritative standard or model; the expected amount of work to be done; typical pattern of behaviour of a group.

Obstacle A difficulty preventing a programme activity from being implemented.

Objective The intended result of the achievement of a programme or activity. An educational objective defines what students should be able to do at the end of a learning period that they could not do beforehand.

Open-mindedness The quality of someone who is ready to understand and listen to someone else, and to accept new ideas.

Organizational chart A chart showing functions and lines of authority and communication within an organization.

Organizational structure The formal defined relations between people who work together.

Output The result of an activity. In a factory, the output is a product; in health work, the output is a health care service.

Performance The result of carrying out a task, depending largely on aptitude and motivation.

Personal commitment An agreement to involve oneself to do something that aims at achieving an objective or goal.

Personality The complex of characteristics and patterns of behaviour that distinguish an individual.

Plan A statement of goals and objectives, and a description of the courses of action and resources necessary to achieve them.

Post description A document indicating what a worker is expected to do, the extent of his/her authority, and working relationships.

Primary health care Essential health care, accessible at a cost that the community and country can afford, based on practical, scientifically sound and socially acceptable methods. It includes at least eight components: health education, proper nutrition, basic sanitation, maternal and child health care, immunization, control of common diseases and injuries, prevention of local endemic diseases, essential drugs.

Priority A preferential rating that indicates importance or urgency, according to given criteria.

Problem An unsatisfactory or distressing situation that is difficult to change.

Processing information Collection, analysis, storage, and retrieval of information for decision-makers.

Productivity The state of being productive, i.e., furnishing results.

Profile (job) The qualities, capacities, and experience needed by a person to carry out a specific function.

Programme A plan of activities, together with the resources required, to achieve an objective or goal.

Resources The available means (manpower, equipment, time, money) to supply or achieve what is needed.

Responsibility A task or duty for which one is liable to be called to account.

Supervision Watching and directing staff to ensure that they perform their duties effectively and become more competent in their work.

Systematic problem-solving process A step-by-step method of looking for a solution to a problem.

Target A goal to be achieved, within a certain time, and which can be measured.

Task An assigned piece of work to be done within a certain time. Component of an activity.

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