World Vision

Timed And Targeted Counselling For Health And Nutrition

A Guideline for Supportive Supervision of ttC Programmes

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Managed by: Polly Walker. Contributors: Beulah Jayakumar, Michele Gaudrault, Sue England, Annette Ghee. Publishing Coordination: Katie Fike. Developmental Editor: Marina Mafani. Copyeditor: Audrey Dorsch. Proofreader: Melody Ip.

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ABBREVIATIONS

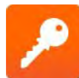
AIM	Assessment and Improvement Matrix
ADP	Area development programme
ANC	Antenatal care
CHW/V	Community health worker/volunteer
COMM	Community health committee
CVA	Citizen Voice and Action
HIV	Human immunodeficiency virus
HVs	Home Visitors
IDS	Immunisation, Deparasitisation and Supplementation
LBW	Low birth weight (baby)
MNCH	Maternal, newborn and child health
MoH	Ministry of Health
MUAC	Mid-upper arm circumference
NGO	Non-governmental organisation
NO	National office
PHU	Primary health unit
TBA	Traditional birth attendant
ttC	Timed and Targeted Counselling
ttC-HVs	ttC home visitors

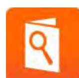
ICONS

Ask the group

Technical information

Summarise

 *Recap the key messages and objective*

 *Use job aids (materials)*

Activity

Discussion topic

INTRODUCTION TO SUPERVISION OF ttC

PURPOSE OF THIS SECTION

In this section we give an overview of this guide, its purpose and audiences, and briefly describe its contents.

What is this guide about?

World Vision's Timed and Targeted Counselling (ttC) is a key approach for delivering World Vision's 7-11 Health strategy. The ttC model promotes seven interventions during pregnancy and 11 interventions for the child up to 2 years of age, using an integrated lifecycle approach. ttC is a system of behaviour-change counselling delivered through home visiting by various cadres such as community health workers (CHWs), care group volunteers and/or community health volunteers, collectively referred to as ttC home visitors (ttC-HVs). Implementation of ttC involves these ttC-HVs having repeated interactions with families over a period of time.

Supportive supervision and monitoring of these ttC-HVs serves several related functions:

- **Data collection and review** – Collect and review data from communities on the uptake and coverage of the 7-11 health and nutrition practices
- **Supportive supervision** – Improve individual ttC home visitors' knowledge and skills in service delivery
- **Community accountability via community health committee (COMM)** – Provide good embedding and accountability of ttC activities within the existing community health support structures through the ttC-HV debriefing processes
- **Performance evaluation** – Motivate and stimulate ttC-HVs to remain active and effective over the project lifecycle.

This document accompanies World Vision's ttC Curriculum and serves as an orientation and training resource on support supervision methods and tools for ttC-HV supervisors.

Who is this guide for?

This guideline has been prepared for 2 audience groups and 2 purposes:

- Parts 1 and 2 – Decision makers within the health authorities and World Vision (WV) at national and district levels involved in contextualising ttC, to give them an overview of the entire supervision and monitoring system and helping them contextualise the system.
- Part 3 – Those responsible, within WV and Ministries of Health (MoH), for orienting and training supervisors of ttC-HVs, to provide them with guidance and instructions for the training sessions for ttC-HV supervisors.

The ttC-HV supervisors could include WV staff, MoH staff and local representatives of health authorities, health facility staff and community health committee members.

When and how should this guide be used?

This guide can be used during ttC facilitators' training, following ttC Module 1, or it can be used as a stand-alone training for supervisors who have previously participated in the complete ttC training. The time allowed to conduct this training should be 2 days plus a one -day field practicum and feedback. We recommend that

all supervisors go through the complete ttC training so that they are well versed in the methodology and the core competences that they supervise.

Contextualisation: This guide is intended to be contextualised for your country context before undertaking training of ttC supervisors in your projects. Under each section we provide in red a description of how to contextualise this part of the guideline for your country context. Please ensure that you have followed all prompts and deleted all sections not being used in your context before using the guide in classroom trainings. This guide presents a selection of possible tools that can be used and is therefore comprehensive of possible recommended approaches.

ttC monitoring and supervision tools

The full package of material for monitoring and supervising ttC contains six components. Field offices preparing to launch this programming should ensure that they have all six components:

- Guideline for Supportive Supervision of ttC (this document) – includes the ttC Core Competencies Framework
- Modular Supervision Tool for ttC (with collapsible sections)
- Data Audit
- Case Evaluation/Spot Checks
- Home Visit Observation Assessment
- Health Knowledge/Revision Needs Assessment
- Individual Performance Appraisal (of Core Competencies)
- Guidance on ttC Data Collection and Reporting
- ttC Registers for Pregnancy, Newborn, Infant and Child (ttC input sheets.xlsx) and ttC-HV Diary
- ttC Tracker – Data Monitoring and Reporting Spreadsheet (ttC Data Reporting Spreadsheet.xlsx)
- ttC Illustrative Logframe

Please note that this guide deals only with the **supervision of ttC-HVs**; another guidance document (#3 in the above list) is under preparation for monitoring and data collection in ttC.

Companion documents

Other documents which are important to adaptation and planning process include:

- World Vision's COMM Guidance Document
- Timed and Targeted Counselling: A Toolkit for Programme Planners
- Timed and Targeted Counselling: Facilitator's Manual for Training in ttC

Overview of this guide

In Part 1: An Overview of Supportive Supervision, we present the purpose of supportive supervision in meeting the needs of the ttC-HVs, so that they are enabled to perform to the best of their ability. We discuss **principles of supportive supervision**, **key challenges** in conducting supervision and alleviating strategies for each, and 2 key approaches to supervision: **individual and group supervision**.

Part 2: Supervision System for ttC is the heart of this document and will help national-level managers of WV and MoH make informed choices in adapting and contextualising a supervision package for ttC. It will also serve as background information for trainers of supervisors. We present **minimum standards** for supervision of ttC, **four strategies** for supervision of ttC and the contexts in which each works best, the **core competencies framework** for ttC and the **modular supervision system**. The five supervision

forms covered in Part 2 include Data Audit/Performance Assessment, Home Visit Observation Assessment, Case Evaluation or Spot Checks, Health Knowledge Assessment and Revision, and Individual Performance Appraisal (done annually).

In Part 3: Training Supervisors, we provide instructions and **guidance on training supervisors** in using the tools presented in Part 1 to supervise ttC-HVs. The training sessions are modular and can be adapted based on the supervision package and used directly by those facilitating training of supervisors.

In Part 4: Role of Community Health Committee (COMM), we present options for the **supporting role that COMMs** can play for ttC-HVs, recommendations on carrying out a **ttC debriefing meeting**, and the appropriate usage of ttC data through the **Community Health Board**. These are presented in the form of training sessions for supervisors of ttC-HVs. While the COMM members will undergo a parallel training, it is important that ttC-HV supervisors understand the process and purpose of the COMM debriefing and how community feedback processes contribute to a viable support system for the ttC-HVs.

Finally, in Part 5: Supervising the Supervisors, we present the process of **evaluating the progress** of ttC-HVs over the course of a longer period of time. This process may be nested within COMM activities or during supervision itself. It is recommended that once per year (or other agreed time frame) individuals be consulted on their progress, a review of existing data for at least four consecutive time series be done, and the core competencies required by the role of ttC-HV be assessed against the supervisor's reports. COMM, or other community-based actors with a supervisory capacity (e.g. lead ttC-HVs, others), may be invited to provide feedback and observations. In a group supervision context, discussed later, decisions need to be considered about where this can be done and how information can then be fed back to the community, potentially following a debriefing meeting or other community visit opportunity.

PART 1: AN OVERVIEW OF SUPPORTIVE SUPERVISION

PURPOSE OF THIS SECTION

In this section we give an overview of supportive supervision, based on existing knowledge on the supervision of Community Health Workers (CHW), common challenges in implementing supervision and ways of alleviating them, and two approaches to supervision. In this section we refer specifically to CHW, as this is based on CHW AIM assessments and programmes. The principles are valid when applied to other cadres such as Care Group volunteers who may be the implementers of ttC in your. Contexts. Part 1 provides the necessary background information before developing a contextualised supervision system.

A. Supportive supervision: A definition

Supportive Supervision has been defined as 'a process of **guiding, monitoring,** and **coaching** workers to promote **compliance with standards of practice** and assure the **delivery of quality care** service. The supervisory process permits supervisors and supervisees the opportunity to work as a team to meet common goals and objectives.'[1] The following are some of its characteristic elements:

Supportive and respectful: The notion of *supportive* supervision has been more emphasised in recent years as it was observed that supervisors' attitudes which are punitive or critical may in fact have limited impact on improving performance. Furthermore, the conditions under which CHWs work, often for little or no pay, require a supportive work environment to keep them motivated and active.

Promoting quality and standards of care: Quality care is a combination of factors, such as those defined by the World Health Organization (WHO), which describes six dimensions of quality.[2] An assessment of quality involves comparing current practices to a set of well-defined standards for the service itself. It is essential that both CHWs and supervisors are aware of and working to the same standards, and that supervision tools are designed to assess those processes with the objective of finding ways to help the CHW to improve their own quality of care. Acceptable and patient-centred care involves how the CHW relates to the household and the positive experience of care that will promote the demand and uptake of services.

[1] L Crigler, J Gergen, and H Perry, *Supervision of Community Health Workers*, 2014. http://www.mchip.net/sites/default/files/mchipfiles/09_CHW_Supervision.pdf.

[2] WHO, *Quality of care: a process for making strategic choices in health systems*, 2006.

6 DIMENSIONS OF QUALITY

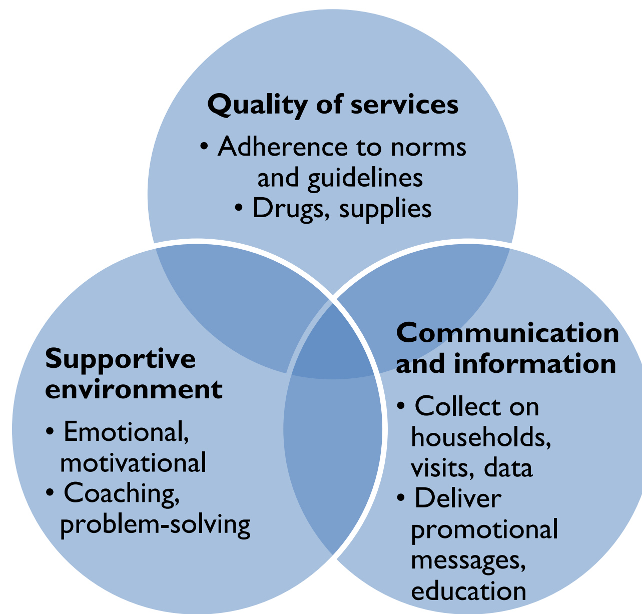
A health system should seek to make improvements in six areas or dimensions of quality, which are named and described below. These dimensions require that health care be:

- *effective*, delivering health care that is adherent to an evidence base and results in improved health outcomes for individuals and communities, based on need;
- *efficient*, delivering health care in a manner which maximizes resource use and avoids waste;
- *accessible*, delivering health care that is timely, geographically reasonable, and provided in a setting where skills and resources are appropriate to medical need;
- *acceptable/patient-centred*, delivering health care which takes into account the preferences and aspirations of individual service users and the cultures of their communities;
- *equitable*, delivering health care which does not vary in quality because of personal characteristics such as gender, race, ethnicity, geographical location, or socioeconomic status;
- *safe*, delivering health care which minimizes risks and harm to service users.

WHO, *Quality of care: a process for making strategic choices in health systems*, 2006.

Guiding and coaching: Good quality supervision is crucial for CHWs to remain motivated and active in their jobs, and to feel valued in their work. CHWs should always feel a 'value-add' for participating in a supervision exercise, and not come to fear or avoid it. It should be an opportunity to share their concerns, help them to overcome the challenges they have experienced in their work, and to learn more about the work that they are carrying out through the knowledge sharing and coaching of the supervisor. For many, supervision also means 'line-management', and therefore CHWs may feel reluctant to report the difficulties they have. This attitude will limit the effectiveness of the supervision in improving work quality and eventually lead to them becoming demoralised. Creating an **open dialogue** and a **mentoring relationship** will be most effective in helping them to report, identify and resolve the problems they have and will lead to genuine competency improvements over time.

Figure 1. Objectives of supervision of ttC-HV[3]



[3] L Crigler, J Gergen, and H Perry, *Supervision of Community Health Workers*, 2014. Reproduced with permission. http://www.mchip.net/sites/default/files/mchipfiles/09_CHW_Supervision.pdf.

B. Supervision as the backbone of a functioning CHW system

Supervision is central in the CHW AIM (Assessment and Improvement Matrix) functionality matrix[4] and is the 6th component listed among 15 components of effective CHW and therefore ttC programming. Eight of the CHW AIM functionality elements may in some way be linked back to a functional supervision system (figure 2). How they may be linked to supervision is described in Table 1.

Figure 2. CHW AIM Matrix

1. **Recruitment:** How and from where a community health worker is identified, selected, and assigned to a community.
2. **CHW Role:** The alignment, design, and clarity of role from community, CHW, and health system perspectives.
3. **Initial Training:** Training is provided to the CHW to prepare for his/her role in service delivery and ensure s/he has the necessary skills to provide safe and quality care.
4. **Continuing Training:** Ongoing training is provided to update CHWs on new skills, to reinforce initial training, and to ensure s/he is practicing skills learned.
5. **Equipment and Supplies:** The requisite equipment and supplies are available when needed to deliver expected services.
6. **Supervision:** Supportive supervision is carried out regularly to provide feedback, coaching, problem solving, skill development, and data review.
7. **Individual Performance Evaluation:** Evaluation to fairly assess work during a set period of time.
8. **Incentives:** A balanced incentive package includes financial incentives such as salary and bonuses and non-financial incentives such as training, recognition, certification, uniforms, medicines, etc. appropriate to job expectations.
9. **Community Involvement:** The role that the community plays in supporting a CHW.
10. **Referral System:** A process for determining when a referral is needed, a logistics plan in place for transport and funds when required, a process to track and document referrals.
11. **Opportunity for Advancement:** The possibility for growth and advancement for a CHW.
12. **Documentation and Information Management:** How CHWs document visits, how data flows to the health system and back to the community, and how it is used for service improvement.
13. **Linkages to Health Systems:** How the CHWs and communities are linked to the larger health system through involvement in recruitment, training, incentives, supervision, evaluation, equipment and supplies, use of data, and referrals.
14. **Program Performance Evaluation:** General program evaluation of performance against targets, overall program objectives, and indicators carried out on a regular basis.
15. **Country Ownership:** The extent to which the ministry of health has policies in place that integrate and include CHWs in health system planning and budgeting and provides logistical support to sustain district, regional and/or national CHW programs.

[4] L Crigler *et al.*, *Community Health Worker Assessment and Improvement Matrix (CHW AIM): A toolkit for improving CHW programs and services*, (USAID), 2013. http://www.who.int/workforcealliance/knowledge/toolkit/CHWAIMToolkit_Revision_Sept13.pdf?ua=1.

Table 1. Programmatic components of an effective CHW programme[5]

Continuing training:	The mentoring aspect that contributes to the up-skilling of the CHW, which can occur during an indivdual supervision visit, or the needs for which are identified by the supervisor.
Equipment and supplies:	Equipment, supplies (including medicine stocks in some cases) are typically checked during supervision visits.
Individual performance evaluation:	Individual performance evaluation or appraisal processes are informed by the supervision reports and data submitted.
Incentives:	Incentives may be given based on performance which may be informed by the supervision and reporting data.
Opportunity for advancement:	Advancement such as further training or promotion may be based on good performance amongst CHWs identified during supervision.
Documentation and information management:	Supervision is typically the point at which data is entered into the system (although now with mobile data entry, this process is being transformed to real-time data collection, freeing up supervision to be more focused on the data outcomes than the collection itself).
Linkages to the health systems:	The key way in which CHWs are linked to health facility staff, building (a) a mentoring relationship between them and individual health technicians in the facility and (b) a sense of accountability by the facility for the CHWs providing services in the community.
Community involvement:	Community recognition of the work of CHWs that could be fed into the supervision processes.

Note: When undergoing the country readiness process for ttC, it is important to conduct the CHW AIM assessment regardless of what cadre you intend to use. It is vital to understand the existing CHW system in order to effectively build upon it. In the event that ttC is to be conducted not by formally recognised cadres of CHWs but rather by care groups or volunteers, then those ttC-HVs should have a functional relationship with the CHWs in their community. ttC should ideally contribute to or support the existing CHW system functionality and not run as a parallel system.

Common challenges to a supervision system

As CHW AIM assessments have been rolled out across WV project areas, similar results have been found relating to supervision systems. Some of the identified key gaps and challenges in CHW functionality are linked to supervision efficacy, frequency and methodology:

- Limited availability of supervisors from primary health units (PHUs)
- Low capacity of supervisors
- Transportation costs and logistics as well as access to communities
- Access to appropriate tools to address qualitative/supportive elements of supervision
- Low data utilisation during supervision
- Attitudes of supervisors not consistent with a mentoring approach.

[5] L Crigler *et al.*, *Community Health Worker Assessment and Improvement Matrix (CHW AIM): A toolkit for improving CHW programs and services*, (USAID), 2013. P1-5. http://www.who.int/workforcealliance/knowledge/toolkit/CHWAIMToolkit_Revision_Sept13.pdf?ua=1.

WV and MoH decision makers are encouraged to use the analysis of supervision problems provided below and use these lessons in contextualising the CHW supervision package for their context.

Problem #1. Supervision coverage and frequency are too low

The availability of qualified supervisors is a major challenge in many settings. Health facilities have staffing problems just to run the centre's services, so having staff who can relocate to communities for supervision may be a challenge. The cost, transportation means, fuel supplies and (in some cases) seasonal weather conditions to access the communities are also challenging,

Key recommendations: Supervisors' coverage and availability

In the context of ttC it is preferable to use primary health unit (PHU) supervisors to strengthen links to the health systems. WV staff may be required to make up the shortfall of supervisors or take on certain roles in some contexts. Ensure that during project deployment the elected supervisors undergo training in ttC and in data collection and reporting at the health facilities. Where supervisors' availability is severely limited, consider some adaptations of strategy:

- **Division of labour:** Use health and project staff for technical and non-technical supervision, and use PHU staff only for the elements of supervision requiring high technical skills.
- **Task-shifting:** Promote highly skilled CHWs to be 'peer-counsellors' or 'lead CHWs' to give supportive supervision and skills mentoring. If data collection and audits can be done by a lower level of staff then shift this task to the next best equivalent, such as a 'lead CHW', with oversight by a more qualified supervisor.
- **Group supervision for data collection:** Data collection in the field is time consuming, and the interpretation of the data can often be limited. Preferably do this during group supervision exercises and meetings. Data interpretation and discussion can be done more effectively in groups.
- **Supervision of supervisors:** Supervisors themselves need to be monitored to ensure that their practices do not decline over time and that they remain motivated towards the supportive elements of supervision processes. This can be accomplished by providing them with the positive benefits of support supervision.
- **Advocate for improved supervisor allocation:** Supervision may come far down the priority list for understaffed facilities, but is a high priority for community health programmes. Advocating for improved supervision systems can be done through Citizen Voice and Action (CVA) and national advocacy approaches to improve allocation of supervision staff, or by assigning supervision duties to health facility staff.

Problem #2 Supervision is dominated by data collection

In addition to these logistical and human resources limitations on the provision of supervision, what supervision there is may fail to encompass the qualitative or supportive aspects that add value to the CHW's work. The table below shows some sample data from a CHW AIM assessment undertaken in Uganda. During this assessment the majority of the CHWs interviewed reported that in their recent supervision there had been some form of data collection exercise. However, only 6.3 per cent of them reported that the data collected had been used in any way which supported skills or performance development.

Table 2. Example of a ttC-HV AIM assessment of supervision activities

Activity	Per cent covered
Observation of service delivery (Job Aids, Rapid Diagnostic Tests)	18.8
Coaching and skill development	6.3
Hygienic practice	6.3
Troubleshooting (technical advice)	25.0
Problem solving (non-technical)	18.8
Home visiting	25.0
Record review (register, stock cards)	62.5
Supply checking (medicines, equipment)	18.8

Data collection is the most common activity of supervision, but most 'supportive and mentoring roles' are usually not completed.

Possible reasons for this might include:

- The data collection itself takes a lot of time/most of the available time.
- The supervisors' ability to interpret and use mathematical data is low.
- Supervisors don't know how to conduct performance development through coaching and mentoring.
- There is a lack of tools to do qualitative assessments which can support performance development.

Key recommendations: Burden of data collection

- Ensure that data collection/tallying tools used by supervisors are simple to use and are structured in the same way as the CHW data sheets to make it easy to extract data from the sheets. Field test the tools with supervisors from project areas to time how long it takes to tally data: if it takes more than 20–30 minutes to tally the data, then consider how to simplify the forms.
- Ensure that supervisors are well oriented and have clear tools to provide supportive supervision during visits to communities rather than depending on mentoring processes to take place 'naturally'.
- If data collection is arduous, shift this activity to debriefing meetings or quarterly activities to enable regular supportive supervision to focus more on improving quality of care, especially in the start up of a new CHW cadre or a new activity.
- Encourage supervisors to conduct data collection exercises at the end of a supervision visit so that data collection does not take away time from qualitative assessment and supportive coaching.

Problem #3. Data systems tend to be one-directional

In many systems, data collection sheets are the only form a supervisor is required to submit, although qualitative assessments are starting to be introduced in some places. There is a strong emphasis within existing supervision systems on the collection of data. However, once that data is collected it is not used appropriately: it's essentially a one-way data flow, and the CHWs gain little benefit from the data being collected.

This may be due to the design of the tools themselves. However, on-the-spot calculations of percentages and the interpretation of that data require a reasonably high level of mathematical education amongst supervisors, which is rarely the reality in the field. Data analysis often happens outside of the field/community, limiting the data usage.

Key recommendations: Data utilisation

- Ensure that supervisors are equipped with some form of 'scorecard' that will enable them to determine the performance level of a CHW 'on the spot'. In mobile systems this process can be done instantly if reported data are available on the phone (smartphone systems).
- All supervisors should know what threshold levels for performance indicators are considered 'good', 'needing improvement' or 'poor' and should be able to assess and share the feedback to identify the weaknesses and develop an action plan for the CHW to improve in that area.
- Design data collection tools that encourage on-the-spot data interpretation and feedback, such as automated data interpretation and usage with colour-coded auto-reporting (e.g. through mobile data systems or Excel reports).

Problem #4 Supervision promotes quantity over quality of the CHW's work

Many data tools themselves look only at the activity outputs (such as numbers of houses covered, number of home visits or treatments) rather than measuring quality of the CHWs work (such as how many took up services, what were the outcomes of treatment, etc.). This exacerbates the 'punitive' perspective of CHW supervision in which the supervisor is purely looking at numbers to encourage the CHW to work **harder**, and not looking at issues which encourage them to work **smarter and with greater effect** (i.e. it puts quantity over quality). In counselling projects such as ttC this is a key issue, because no number of poor-quality counselling visits would lead to an effective improvement of health outcomes in the population, whereas effective home-based counselling takes time to do well.

Key recommendations: Quality of service

- Supervisors should have tools that enable them to take into consideration the quality of the services being provided, which may include conducting an observation of their current practices or a retrospective case evaluation of a household where the CHW has delivered services and family members can give feedback.
- Design supervision tools that emphasise quality aspects of care and building skills.
- Ensure that supervisors are able to demonstrate quality of care themselves.

Problem #5 Qualitative support and competency-based assessments are unclear for supervisors

Shifting focus to support the up-skilling of ttC-HVs may also be unclear because there are poorly defined competencies for the CHW's work. Providing a well-developed competencies framework, with methods for assessing each element, is essential for supervisors to engage meaningfully with CHW skills development. Within ttC most of the skills involved are 'soft skills', such as the ability to listen actively, negotiate successfully and encourage participation through storytelling techniques. For supervisors to do this well, they need to have been trained in these skills and have them regularly reinforced. Assessment tools need to have elements that enable objective evaluation of these soft skills in more precise ways.

Key recommendations: Competency-based approach

- Train supervisors to take a holistic approach to the CHW's needs in building skills, confidence, and good attitudes and behaviours in their work.
- Focus on competencies and building skills in the design of qualitative supervision methods.
- Engage community health committees to provide additional skills-based support through team-based approaches (e.g. CHW debriefings 2 to four times per year).

2 approaches to supervision

There are 2 basic approaches to supervision: individual (one-on-one) supervision in the field and group supervision. These approaches are not specific to ttC but apply to any community-based intervention involving CHWs and volunteers.

Individual supervision

This is the norm for supervision and represents the ideal setting. one-on-one supervision is carried out in the field to understand through observation and tracking what CHWs are doing, when, where they are working and how they are doing their work. The following is an illustrative list of activities that can be carried out through individual supervision:

Table 3. Components of an individual supportive supervision

Activity and order	Process description	Time spent (illustrative)
• Troubleshooting (technical advice)	As required, offer the CHWs time to present issues they have found most difficult, cases requiring emergency referrals or adverse events	5–20 min
• Problem solving (non-technical)	As required	5–10 min
• Record review (register, stock cards)	Collect basic data; select cases for evaluation; audit record-keeping process and offer support as needed	10 min
• Observation of service delivery	Conduct a home visit that has been scheduled for that day and accompany the CHW; observe normal service *Not required every time, but is valuable at the beginning, perhaps 2 times per year*	Up to one hour
• Case evaluation/spot checks	Randomly select several cases from the records and conduct a home visit evaluation, without the CHW	40 min
• Coaching and skill development	Assess health knowledge and provide revision as needed Provide feedback on data Provide feedback on case management and observations Request COMM inputs	20 min
• Data tallying and audit	Collate the health outcomes data and give immediate feedback in terms of focus and priority cases to work with Assess workload and performance of the CHW in terms of carrying out the home visits	10–20 min
Total time spent		**2–3 hours**

Group supervision

Group supervision involves a group of CHWs coming together with a supervisor and conducting regular supervisory activities such as data collection and interpretation, problem solving and continuing education. This can be done in larger groups from multiple communities during supervision days at a health centre, COMMs office or even WV area development programme (ADP) office, or if the communities are large, it can be done in the communities themselves and include all the CHWs operating within that community.

The advantage of this method is that it takes a *team* approach, which has been shown to be more effective in many contexts; it relieves the 'solitude of working'; and it helps CHWs to feel like part of a bigger process and that they are working towards common goals. The notion of 'peer pressure' is relevant too, as public presentation of data and progress amongst team members can lead to public recognition of their efforts and is a disincentive for low performance. From the groups, typically more competent members will emerge, who can be strengthened to provide additional support to CHWs – becoming 'lead CHWs' over time, taking on roles such as data audit/support and troubleshooting, and conducting observational assessment or case evaluations in the community (after their skills are well developed).

The peer-to-peer learning process which inevitably emerges during group approaches also adds huge value to the project. Over time, CHWs will become true experts in delivering ttC, and many will encounter and overcome problems for themselves, using local knowledge. This peer support may be a better source of solutions for overcoming cultural and behavioural barriers to health than the supervisors themselves.

The group approach, however, comes with limitations, key amongst which is the inability to identify falsification of data and observation of a home visit and counselling. The table below lists what the group approach can and cannot assess:

Table 4. What can and cannot be assessed during group supervision

Can be assessed in group supervision	Cannot be assessed in group supervision
• Adverse events – emergency referrals, deaths • Data on CHW inputs (coverage, visits, timing) • Data on counselling health outcomes, tallying • Current technical difficulties, troubleshooting, problem solving • Discussion of commonly identified barriers to health in communities • Soft skills within a group setting • Observation of service delivery (simulations of practice) • Health knowledge	• Actual community practices of the CHW • Accuracy and reliability of data reported by the CHW Solution: in this event the community health committee would track the progress of the CHWs. The case evaluation assessment can be simplified to be conducted by a non-skilled, literate COMM member.

Combining group and individual supervision: The best of both worlds?

In the event that the individual supervision of CHWs is not possible every month, an alternative may be to combine the 2 approaches. Group supervision could be used for analysing broad trends and identifying weaknesses, whereas individual supervision is used for areas with difficulties. These combined scenarios are considered in more depth in Part 2 ('Supervision System for ttC').

PART 2: SUPERVISION SYSTEM FOR ttC

PURPOSE OF THIS SECTION

In this section we present: **minimum standards for supervision in ttC**; the **core competencies framework for ttC** and how supervision assesses and helps improve these competencies; and **four strategies for supervising ttC**. We also present the **modular supervision system for ttC**. This section is central to the country contextualisation process for national offices as they adopt and contextualise a supervision strategy and the related supervision forms for implementing ttC.

A. Minimum standards for ttC supervision

Table 5 identifies the minimum quality standards defined for ttC-HV functionality (WV's ttC-HV Programming Standards V.2). Of the 17 elements outlined under the standards, 2 of them relate directly to supervision. Although ttC is not always conducted by ttC-HVs, these standards are a good ballpark for the design of our supervision systems.

What training do supervisors need for ttC?

Ideally supervisors should be trainers/facilitators, or should have participated in the training alongside the ttC-HVs. If this is not possible, supervisors should undergo training that encompasses the full **methodology of ttC**, the negotiation and dialogue method used for behaviour change, the basic health knowledge and practices being promoted, and the elements of data monitoring and reporting essential to supervision.

Table 5. Minimum standard for ttC-HV supervisors (taken from World Vision's CHW programming standards[6])

Essential elements and recommended practices	Minimum standards for implementation
• CHW supervisors are trained, equipped and supported to conduct regular supportive supervision with at least four contacts per year. *Recommended practices:* • Supervisors are trained in supportive supervision methods and have basic supervision tools (checklists) to aid them, and sound technical knowledge. Community, CHW and PHU have clear guidance on supervisor role. • ***Frequency:*** A suitable time frame is established for supervision, with face-to-face contact regularly planned. Include more supervision in year 1. • ***Ratio:*** An appropriate supervision ratio of CHWs: supervisor is established – e.g. 30 CHW per supervisor. • ***Data sharing:*** Supervision data are made available to community members and community health structures.	• Supervisors have completed basic competence training on the programme model and are selected as those with a background in the technical area of implementation. • At least four face-to-face contacts with supervisor per year.

[6] See World Vision, *CCM Toolkit*, 2014.

How often should ttC-HVs be supervised?

Monthly supervision would be the ideal. However, once up and running, the ttC-HVs may need less supervision. (Four times per year is the minimum standard.) At the start up of the project (within the first one to 2 months), especially after the first training, supportive supervision in the community is essential to help the ttC-HVs get started: registering women, conducting home visits and troubleshooting any issues with process and quality. If ttC-HVs are not supervised in the community at this time, the risk is that they will struggle to get started or that they will begin with less-effective techniques. Once running, quarterly supervision could be interspersed with regular contacts by phone or ttC-HV debriefing meetings led through the COMM.

Table 6. World Vision minimum standard for component of supervision systems

Essential elements and recommended practices	Minimum standards
• Supervision activities are designed and implemented to identify and resolve individual performance quality. *Recommended practices:* Supervision, typically one of the weakest areas of programming, is essential for the learning progress of CHWs. Individual mentoring may have more impact on skills and quality than classroom training alone. Clinical models such as CCM and community prevention of mother-to-child transmission(cPMTCT) will require adequately trained clinical mentors. *Highly recommended* • ***Qualitative data review:*** Use of CHW diaries to review the information on the barriers to service access. • ***Troubleshooting***: (technical advice) offered during supervision (if supervisor is technically competent). • ***Problem solving*****:** (non-technical) offered during supervision. • ***Refresher training:*** Knowledge checking, revision exercises or additional training using the CHW manuals during supervision as required by ttC-HV.	• ***Case assessment:*** Home visit and assessment of at least three recorded cases to ensure service quality, focusing on adverse events, referrals and follow up for quality mentoring four times per year. Especially important in CCM and treatment programmes. • ***Observation of service delivery:*** Home visits done with CHW, providing skills coaching through observation. At least twice, as soon as possible following training as part of practical CHW training. • ***Record review, data collection and reporting:*** Data gathered is used for problem solving and coaching. Conducts at every supervision (four times per year).

B. Supervision of ttC-HVs and the core competencies framework

The core competencies framework consists of key areas of technical and non-technical (or 'soft') skills and knowledge that the ttC-HV needs in order to successfully carry out ttC. **The supervision process is built around assessing and helping improve these competencies**.

- **Effective communication and counselling skills**: The ttC-HV should be able to communicate key messages in each ttC visit, listen actively, involve the household decision makers, identify barriers and negotiate for change in practices. She or he must be able to effectively use the job aids, such as the storybooks.
- **Handling of referrals**: A necessary element of ttC is to help families seek effective, timely and appropriate care for complications in pregnancy, childbirth and childhood illness. The ttC-HV should therefore be able to recognise danger signs and symptoms of illness, refer the client and provide appropriate follow-up care.
- **Record keeping:** ttC records help track household-level behaviours and referrals and help the ttC-HV follow up appropriately. They are an integral part of ttC, both at the individual/household level and for communities. They also help ttC-HVs work with COMMs to identify and address community-wide issues related to key maternal, newborn and child health (MNCH) practices.
- **Health knowledge:** It is essential that the ttC-HV has up-to-date knowledge about MNCH technical issues, in line with national policy, in order to be able to effectively counsel families and facilitate behaviour change.
- **Community involvement**: Participation of communities is essential for a functional ttC system. These relationships can be useful in resolving issues, troubleshooting and addressing the ttC-HV's issues. Communities can work through COMMs and provide input into the ttC-HV's performance and also that of the supervisor. Insofar as the Citizen Voice and Action and COMM groups exist in the ttC project area, we should see the ttC-HV making concerted efforts to engage and share their findings with these groups and with other community health groups and actors.
- **Timeliness and completeness of ttC home visits and other activities**: Timing is paramount in ttC visits, and the extent to which the ttC-HV is able to carry out visits as scheduled is a key competency that will be tracked and supported through supervision.
- **Support for high-risk/vulnerable families**: ttC-HVs may have some formal process for providing additional support to those families at greater risk. (The ttC Facilitator's Manual[7] covers this in detail.) Higher-risk families may include those most isolated, those living in extreme poverty, those affected by HIV, adolescent mothers and those who have experienced health problems.
- **Initiative and problem solving:** The supervision process should be able to assess and support the development of these skills in the ttC-HV, as they represent critical leadership skills that make for effective delivery of ttC and bring about changes in behaviour.

The framework for ttC competencies can be found in Part 3 of this document.

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[7] World Vision International, *Timed and targeted counselling for health and nutrition: Facilitator's manual for training in ttC*, 2014.

Strategies for supervision

Contextualisation: The strategies described are options that national offices, along with the MoH, can consider as to which would be best suited for their context and serve to reach their supervision goals.

Who are the supervisors?

Supervisor responsibilities differ between project staff and MoH staff. Table 7 below recaps the different scenarios.

Table 7: Scenarios for MoH involvement as facilitators and/or supervisors[8]

Scenario 1: **Supervision done by MoH staff**	**Scenario 2: MoH staff carry out training, but not supervision**	**Scenario 3: MoH staff and WV share supervision responsibilities**	**Scenario 4: World Vision (and/or partners) do all supervision**
• ttC is an approved MoH project model. • MoH has sufficient manpower to institutionalise the programming within the ministry without further participation from WV. • WV will limit itself to an advisory and mentoring role.	• ttC-HV supervisors may be: (a) WV ADP staff, (b) lead ttC-HVs, (c) members of a 'Community Committee' (i.e. Village Health Committee or the equivalent). • ttC is an approved MoH project model, either in full or as in-service training. • Weak MoH supervisory capacity due to workforce issues; WV carries out supervision.	• ttC is an approved MoH project model, either in full or as in-service training. • MoH materials are chosen for use with ttC-HVs, per existing programming, but the MoH welcomes WV assistance with implementation. • WV supervises ttC-HVs.	• ttC is an approved MoH project model, but MoH does not have the manpower to either train or adequately supervise the ttC-HVs. or • WV implements ttC through a different cadre of volunteers with no MoH involvement.

In the above set of scenarios for country readiness, in many cases Scenario 2 is most common. This includes cases where the ttC cadres are not CHWs as such but community groups who are trained at least initially by the MoH.

Contact intensity environment for ttC-HVs

In order to effectively design a supervision strategy we must also consider the possible 'intensity of contact' with the ttC-HVs, which means taking into consideration:

- the geographic distribution of communities
- supervisor-to-ttC-HVs ratio

[8] See World Vision International, *Timed and targeted counselling for health and nutrition: A toolkit for programme planners*, Country Readiness Steps, 2014.

- availability of transport between supervisor and ttC-HVs.

Based on the principles of supervision, challenges, minimum standards for supervising ttC and the 2 approaches to supervision discussed in Part 1, we recommend four strategies that can be applied for supervising ttC-HVs, and the scenarios in which each works best. Please note: the strategies given below are combinations of the 2 approaches (individual supervision and group supervision) described in Part 1.

Table 8. Supervision solutions for low-contact environments

Level of face-to-face contact in the community	**High contact**	**Moderate contact**	**Low contact**	**Little/no contact**
Supervisor-to-ttC-HVs ratio	Low ratio – no more than 15 per supervisor, rational supervisor workload	15–30 ttC-HVs per supervisor, moderate workload for supervisor	High supervisor:ttC-HV ratio (1:30–50), heavy supervisor workload	Very high supervisor:ttC-HV ratio (e.g. 1 per 50 or more ttC-HVs per qualified supervisor)
Geographic distribution of communities	Close or clustered coverage areas less than 10 km apart	Some communities >10 km from supervisor location	Geographically very isolated communities >10km from supervisor location	Geographically very isolated communities
Availability of transport	Access to transport, no budget constraints for travel	Access to transport, budget constraints for travel	Limited access	Low/no access
Other considerations	Secure contexts	Secure contexts	In some fragile or insecure contexts	Highly insecure contexts
Supervision strategy	**Option 1. Individual supervision by supervisors (ttC standard supervision)**	**Option 2. Individual supervision by lead ttC-HV or COMM**	**Option3. Group supervision model with individual supervision as required**	**Option 4. Group supervision with remote support**
Explanation:	COMM debriefing meetings plus regular individual supervision by WV or MoH staff.	Group supervision and debriefing with regular individual supervision by lead ttC-HV/COMM, and occasional WV/MoH supervision	Group supervision and debriefing with individual supervision by COMM/lead ttC-HV, and WV/MoH supervision when necessary	Group supervision and debriefing with individual supervision by COMM/lead ttC-HV, and WV/MoH remote support
Component – **COMM debriefing meeting**	Standard ttC-HV debriefings	Standard ttC-HV debriefings	Combine ttC-HV debriefing with group supervision	Combine ttC-HV debriefing with group supervision
Component – **Group supervision**	None	Group supervision also done 1–3 times per quarter	Group supervision 1–2 times per quarter	Group supervision 1–2 times per quarter
Component – **Individual support supervision in the community (face to face)**	**and** • Individual supervision quarterly by qualified MoH/WV staff supervisor, including recommended supervision elements	**and either:** • Individual supervision 1–2 times per year by qualified MoH/WV staff supervisor **or** • Individual supervision by lead ttC-HV or COMM 1–3 times quarterly	**and either** • Individual supervision for ttC-HVs by qualified MoH/WV staff supervisor when needed **or** • Individual supervision by lead ttC-HV or COMM when needed	**and** • No individual supervision by project/MoH qualified staff **and** • Individual supervision by lead ttC-HV or COMM if possible
Adapting this guide	Delete session 'Supervision in the community' in Part 3	Do both of the following sessions in Part 3: 'Supervision in the community' and 'ttC-HV debriefing meetings'	Do both of the following sessions in Part 3: 'Supervision in the community' and 'ttC-HV debriefing meetings'	Do both of the following sessions in Part 3: 'Supervision in the community' and 'ttC-HV debriefing meetings'

Strategy #1: Individual supervision by supervisors

This is the ideal strategy, with the supervisor providing regular one-on-one supervision to all ttC-HVs in the field and quarterly debriefing with COMM. This strategy is best suited for contexts with sufficient numbers of qualified and available supervisors and unrestricted ability to do field visits. As outlined in Table 8 on the previous page, this strategy is well suited for a 'high-contact' environment, where the ttC-HV-to-supervisor ratio is not more than 15 and when target communities and households are clustered and are not more than 10 km apart. In this context, there would be little constraint on travel for the ttC-HVs and their supervisors. The supervisors could be MoH or WV, depending upon the national scenario for MoH involvement.

This strategy supports the full range of supervisory activities at the individual level and standard ttC-HV COMM debriefing meetings. At the individual level, the supervisor will be able to assess the performance of ttC-HV in carrying out ttC home visits (performance audit), evaluate completed ttC visits (case evaluation), assess competency by observing a home visit (home visit observation), assess health knowledge of ttC-HVs (health knowledge assessment and revision) and evaluate the overall performance (individual performance appraisal) over a longer period of time. (These components of supervision are discussed further in the session 'A supervision system for ttC'.)

This strategy also enables the supervisor to troubleshoot (offer technical advice) and problem solve (provide non-technical advice) as needed, review records, collect and tally data from ttC registers, provide feedback based on data and decide on what areas to seek input from COMMs.

This strategy also supports quarterly debriefing meetings of the supervisors with their ttC-HVs. During this time, supervisors are able to revise health knowledge issues, review qualitative information from ttC-HVs' diaries and facilitate discussions on household-level barriers and possible solutions to overcome them.

Modes of supervision

- Individual supportive supervision visits in community (quarterly to monthly)
- ttC-HV debriefing meetings (quarterly)

Components of supervision that this strategy supports	
Individual level	**Debriefing meeting level**
• Performance audit • Case evaluation • Home visit observation (at least twice per year) • Individual performance assessment • Record review and data collection/reporting • Qualitative data review (ttC-HV diaries) • Troubleshooting • Problem solving	• Discussion on household-level barriers • Health knowledge revision • Review of qualitative data

Strategy #2: Individual supervision by lead ttC-HVs/COMM

This is an adaptation of the individual supervision approach suited for contexts where the ttC-HV:supervisor ratio is 15:30 and where there are some constraints for the supervisor's travel to ttC-HV locations, as some of these locations might be farther than 10km from the supervisor's station. This strategy is also suitable when supervisors have a heavy workload. In this approach, highly skilled ttC-HVs are promoted to the 'lead ttC-HV' category, in the ratio of one for every five to seven ttC-HVs, and are trained to provide individual supervision to the ttC-HVs in the group. The supervisor provides supportive supervision to the lead

ttC-HVs and one or two ttC-HVs in each group, randomly chosen and rotated on a regular basis. The supervisors would aim to supervise all ttC-HVs at least once per year. The supervisor also leads quarterly debriefing sessions. The role of the lead ttC-HV can also be carried out by members of the COMM.

The supervision models would need to be simplified somewhat according to the level of the lead ttC-HV/COMM members. However, it is important that these supervisors are literate, competent and fully trained in the technique and a strategy is in place to increase their skills over time.

Modes of supervision

- Individual supportive supervision visits in community (quarterly to monthly)
- ttC-HV debriefing meetings (quarterly)
- Supervision of lead ttC-HVs done by the supervisor or MoH or project staff

Components of supervision that this strategy supports	
Individual level (lead ttC-HVs and supervisor)	**Debriefing meeting level (by supervisor)**
• Performance audit • Case evaluation • Home visit observation • Individual performance assessment • Record review and data collection/reporting • Qualitative data review (ttC-HV diaries) • Troubleshooting • Problem solving	• Discussion on household-level barriers • Health knowledge revision • Review of qualitative data

Strategy #3: Routine group supervision with individual supervision as required

In this strategy, the supervisor and lead ttC-HVs provide group supervision routinely and provide one-on-one supervision for those who have been found (through group supervision) to have performance issues or face other challenges. The group supervision meetings double as debriefing sessions, where data from ttC registers is collected and collated, qualitative data is reviewed and household-level barriers are discussed. Lead ttC-HVs conduct performance audits for the ttC-HVs in their respective ‘small groups’. The remaining components of individual supervision are carried out for those ttC-HVs who score low in the performance audit or who report significant difficulties in carrying out ttC home visits. The supervisor and lead ttC-HVs can divide selected individual supervision visits between them, ensuring that the supervisor visits the selected ttC-HVs at least once a year.

This strategy is suited for contexts in which supervisors are not adequately available, either due to high ratio of ttC-HV to supervisor (30 or more) or due to heavy workload (or both) and when communities are far apart and the supervisors have constraints in travelling to all target locations.

Modes of supervision

- All data collection is done in the group supervision setting.
- Lead ttC-HV may still be required to help collate data and do ttC-HV performance audits for ttC-HVs in their small groups during supervision meetings.
- ttC-HVs experiencing difficulties receive individual community visits (including full supervision components).

- Troubleshooting and problem solving over phone and/or mobile-phone–based data collection can be considered for this strategy.

Components of supervision that this strategy supports		
Debriefing meeting combined with group supervision (led by supervisor)	**Debriefing meeting/group supervision** (led by lead ttC-HVs in small groups)	**Individual level** (for select ttC-HVs only, by lead ttC-HVs and supervisor)
• Discussion on household-level barriers • Health knowledge revision • Review of qualitative data • Troubleshooting • Problem solving	• Record review and data collection/collation • Performance audit • Individual performance assessment	• Case evaluation • Home visit observation • Troubleshooting • Problem solving

Strategy #4: Group supervision with remote contact

The option of using only group supervision greatly limits the scope of the supervision and is recommended only for fragile contexts, remote locations and other significant limitations, such as a high ratio of ttC-HVs to supervisors (50 or above) and/or high workload for supervisors. As noted under the group supervision approach, this strategy renders observation of service delivery and verifying the validity of data very challenging. However, simulation exercises can be used to assess soft skills of the ttC-HVs. Under such contexts, providing additional remote support via telephone and mobile data upload might be particularly beneficial, if it can be provided.

Modes of supervision

- All data collection is done in the group supervision setting.
- Lead ttC-HV may still be required to help collate data and do ttC-HV performance audits for ttC-HVs in small groups during supervision meetings.
- Troubleshooting and problem solving over phone and/or mobile-phone–based data collection can be considered for this strategy.

Components of supervision that this strategy supports	
Debriefing meeting with group supervision (led by supervisor)	**Debriefing meeting with group supervision** (led by lead ttC-HVs in small groups)
• Discussion on household-level barriers • Health knowledge revision • Review of qualitative data • Troubleshooting • Problem solving	• Record review and data collection/collation • Performance audit • Individual performance assessment

C. A supervision system for ttC

Contextualisation: The supervision system is designed to be modular, and, depending on the level of supervisors, frequency of supervision, supervision approach (individual or group) and supervisor to ttC-HV ratio, the selected forms will be included in the final version of the supervisor tool for the country. All sections of the ttC Supervision Tool are intended to be contextualised and applied according to the supervision strategy adopted.

This model is based on the core competencies, and it provides ways of assessing them. The system is modular, so that countries can select one or more of the forms and adapt each form according to their context, while also conforming to the minimum standards for supervision outlined in Part 1. This section provides an overview of the system and the key features of each form, while Part 3 provides details of each form and guidance for training supervisors in them.

Form 1: Performance audit

This tool measures the extent to which the ttC-HV is able to accomplish tasks efficiently and effectively. This tool uses data from ttC registers and computes the proportion of planned visits that were completed and the proportion of pregnant women who received the first ttC visit in the first trimester. This tool is not intended to capture health data from the registers but only to capture the 'performance-based' information about the ttC-HVs services. It can be incorporated into all of the four strategies discussed above as it can be carried out during debriefing meetings. The data captured in this module are considered during a performance 'audit' as we use it as a quick assessment of the completeness of the performance of ttC activities, rather than looking at the outcomes of the counselling. By ensuring performance in key performance indicators we are ensuring that ttC is being carried out as intended.

Key performance indicators:

- percentage of planned visits that were completed in a given supervision period
- percentage of visits where male/birth partners participated
- percentage of referrals completed (i.e. the client was seen at the health facility)
- and possibly percentage of follow-up referral visits completed, depending on whether the national office strategy includes conducting home visits after referrals.

Form 2: Case evaluation/spot checks

Households registered for ttC are randomly selected from the ttC register and the mother is interviewed about the most recent ttC visit. This interview takes place in the absence of the ttC-HV, and the tool provides for up to five ttC clients to be interviewed during one supervision. Each item is scored on a scale (guidance is provided for scoring), and scores are summed up to give an overall performance score. Additionally, this tool helps identify falsified data and helps assess any adverse events which may have happened such as emergency referral-related issues. This tool can be used only through field visits; a strategy that relies only on group supervision cannot employ this form.

Form 3: Home visit observation and assessment

The interaction between the ttC-HV and the household is observed, and the ttC-HV is assessed for a list of competency-based items. Each item is scored on a scale (guidance is provided for scoring), and the scores are summed up to give an overall performance rating. This is possible only through a field visit; thus it will not be possible to use this in a strategy that relies solely on group supervision methods. In its place, a home visit can be simulated/observed during group supervision.

Form 4: Health knowledge assessment and revision

This tool contains open-ended questions related to the MNCH technical areas that ttC promotes, such as care during pregnancy and infant feeding practices. It helps the supervisor quantify the ttC-HV's knowledge level and take remedial action, such as on-the-spot revision or recommending a full refresher course. This tool can be administered as part of a field visit or during group meetings.

Form 5: Individual performance/competencies appraisal

This tool is based on the ttC core competencies framework, and brings together qualitative results from all other assessments (including self-assessment) over a longer period of time in order for the supervisor to determine the need for strengthening key competencies.

Table 9. ttC individual supervision forms

Form	Type of tool	Core competency assessed	Fit with supervision strategies	Comments
Performance audit	Assessment/calculation of percentages using data from ttC register	All competencies; performance and activity	Can be used in all strategies	
Case evaluation/ spot checks	Interviews with ttC clients about most recent visit; scoring a list of competency-based items; includes scoring guidance	All competencies	Requires field visit; cannot be used in supervision strategies 3 & 4	Helpful in identifying falsification of data
Home visit observation and assessment	Observation of a ttC-HV visit session and scoring on observed competencies; includes guidance on scoring	Effective communication; initiative and problem solving	Requires field visits	Alternatively, practice / simulate during group supervision
Health knowledge assessment/ revision	Questionnaire (open-ended questions) with answer key	Health knowledge	Can be used in all supervision strategies	
Individual performance appraisal	Synthesis of results of assessments done over a period of time using other forms	All competencies	Can be used in all supervision strategies	

The above forms are available on request, and discussed in detail in Part 3 of this guide.

Besides using the above supervision forms, supervision sessions should also cover the following, irrespective of the strategy selected. This is in line with the minimum standards for supervision:

- Review of data in ttC registers
- Discussion of successes and barriers to behaviour change
- Problem solving for non-technical issues, as required
- Troubleshooting – to present issues, cases requiring referral, adverse events
- Coaching and skill development as the focus for all the above activities.

PART 3: TRAINING ttC SUPERVISORS – A FACILITATOR'S MANUAL

PURPOSE OF THIS SECTION

In this section we present detailed sessions for training supervisors. These sessions include an introduction to support supervision, an overview of supervision skills and core competencies for ttC-HVs and the five forms in the proposed supervision system. Part 3 aims to function as a training manual for trainers within WV and MoH, and country offices can adapt this manual according to the ttC supervision strategy they choose. This manual may be used for facilitators and trainers together.

Contextualisation: Delete any of the sessions below that you have decided not to use in your context and based on the supervision strategy you adopt. If you have adapted sessions for a lower-educated cadre of supervisors (such as lead ttC-HVs or COMM members) ensure that all five forms are updated with correct versions. The 'Introduction to supportive supervision' and 'Supervision skills' sections are generic, skills-based training and will need less contextualisation. The 'Core competencies of ttC home visitors' section is applicable to all four supervision strategies. Adapt or remove the remaining sections based on the supervision strategy your national office decides on.

Overview of training sessions

Part 3 is a manual for training supervisors of ttC-HVs and covers the following training sessions:

- Introduction to supportive supervision and supervisory skills
- Core competencies of ttC-HV
- Performance audit of ttC-HVs
- Case evaluation/spot checks
- Home visit observation and assessment
- Health knowledge
- Supervision wrap up: feedback and follow-up action plan
- Supervision in the community
- Conducting a ttC debriefing meeting – this session will begin with an introduction to the supervision strategy of the country (an empty template)
- Conducting group supervision
- Individual performance appraisal

Session 1. Introduction to supportive supervision

Learning objectives	*By the end of this session participants will be able to:* • describe the concept of supportive supervision • explain what they should supervise and why • describe the supportive processes and standards • describe the tools that can be used to explore qualitative assessment of CHW work • explain the purpose of supervision and main components.
Materials and preparation	*Methods:* • Trainer presentation, discussion, role plays, simulations *Materials/preparation*: • Coloured paper • Coloured sticky notes

Supportive supervision focuses on meeting the needs of ttC-HVs, so that they are enabled to perform to the best of their ability. The supervision process not only assesses the performance of the ttC-HVs but also supports them by providing feedback on critical areas of their work, helps them to identify specific areas for improvement and demonstrates their improvement over time. Supportive supervision makes them feel that they are part of the health system and hence motivates them to give their best to the task.

Activity 1: Discussion in groups – Understanding supportive supervision

UNDERSTANDING SUPPORTIVE SUPERVISION

- Supportive supervision involves direct, personal supervisory contact on a regular basis to guide, support and assist ttC-HVs to become more competent and satisfied in their work
- Supportive supervision means building relationships that foster *support and encouragement* from the viewpoint and input of both the supervisor and ttC-HV but *does not neglect performance*

Best friend -- Police officer

(support) Teacher (skills mentoring) (compliance)

Read the information above. Emphasise the words 'support and encouragement', and 'does not neglect performance'. Introduce the idea of the supervisor as a '**best friend**' and as a '**police officer**'. Explain that these represent the two extremes of supervision, and that their roles as supervisors will probably be somewhere in the middle. They will be **friends** and supporters of the ttC-HVs, listening to their work-related concerns, helping to find solutions, assisting them with parts of their work that they may not understand, and paying attention to their well-being. They will also sometimes need to show some characteristics of a **police officer**, to verify that the ttC-HVs are doing their work and to confront issues of poor quality work if necessary.

Using coloured paper, place the words **best friend** and **police officer** on the wall at some distance apart (as if there were a line connecting them) to help visualise this idea of a continuum.

Now have a discussion with the participants about their own experiences of being supervised by others and about their thoughts on how they will act and need to act as they begin the work of being supervisors themselves.

Break the participants into groups, with each facilitator working with a group. You may use the following questions as prompts for this discussion.

Questions for discussion

- In your experience as supervisors, have you played the role of the police officer or the best friend? What experiences have you found helpful? What have you found most unhelpful?
- In your experiences of *being supervised* do you find that the supervisors behave in the role of police or the best friend? Which would you find the most helpful approach and why?
- Does it sometimes happen that supervisors worry only about the work performance and do not show support or understanding?
- Have you had supervisors who acted only as police and not as supporters? What do you think about that style of supervision?
- Is it possible to be concerned about performance in a way that is not like a police officer?

When the groups have finished discussing, have each group briefly present a summary of its discussion. Give participants coloured sticky notes to place on the wall somewhere between 'best friend' and 'police officer' to represent how they hope to be as supervisors. More emphasis on friendliness? More emphasis on control and discipline? Somewhere in between?

Activity 2: A supervisor wears three hats

Ask: Is it the supervisor's job to make the ttC-HVs feel supported or to make sure the ttC-HVs are fulfilling their responsibilities? What do you think the main roles of a supervisor are?

Collect comments on a flipchart and refer to them during discussion.

THREE FUNCTIONS OF SUPERVISION

Supporter

Making sure that ttC-HVs feel that you understand their needs and difficulties will ensure they trust you and ask for help when they need it. We all need encouragement to feel motivated in our work.

Teacher

Building the skills and mentoring on improved techniques is 1 of the key purposes of supportive supervision. It is a chance to observe and identify the knowledge gaps from the training and work towards improvements that will make their work easier and more effective.

Police officer

The 'compliance' element of supervision ensures that a person is carrying out the tasks **to the best of her or his ability**. This serves to discourage low performance (e.g. skipping visits, falsifying data or misusing medicines), which is important to make sure the programme is successful.

Explain the three functions of supervision (three hats the supervisor wears). Look at the table below, and ask the participants to discuss each column in turn.

Ask: Is it sometimes necessary to be like a police officer?

Ask: Do you think your ttC-HVs will perform better if they feel supported? How can you show support to your ttC-HVs?

Ask: What opportunities for skills development are presented in supervision?

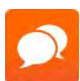
Write your additional ideas in the space provided.

	Supporter	**Teacher**	**Police officer**
What is the purpose?	Emotional support, encouragement, understanding and help	Skills mentoring	Compliance
What are the benefits of the approach? **When would this approach be most appropriate?**	*e.g. develops empathy, builds trust*	*e.g. finds out what the gaps in training are; especially important at project start up*	*e.g. discourages falsified data, ensures safe use of medicines, ensures everyone has access*
Are there any risks to this approach? **When would this approach not be appropriate?**	*e.g. perception of the supervisor*		*e.g. contributes to stress, discourages, shames*

It is important that supervisors balance their roles. It would not be good to focus *only* on the policing part of their role but rather to also be strong supporters of their ttC-HVs. If the placement of the sticky notes does not reflect this (that is, if most place their notes towards the 'police officer' extreme), you should spend more time discussing the concept of supportive supervision.

Activity 3. Components of supportive supervision

Contextualisation: Delete from the table below any activities not being used in your context



Present the table below and describe each component of the supervision, and discuss each with the participants in terms of what 'hat' they are wearing during that process.

Ask: What opportunities does each component present in terms of being a friend, a teacher or a police officer?

Supervision activity	**Description of the components**	**How does a supervisor use the information from this activity?**	**Compliance, skills mentoring or support?**
Review of data	Checking and tallying of the data on the health outcomes of ttC	To determine success of the approach	All
Performance audit	Assessment/calculation of percentages, using data from ttC register	To understand the case/workload of the ttC-HV To determine if the ttC-HV is doing active and timely ttC	Compliance

		visits and engaging family members	
Home visit observation and assessment	Observing a live ttC visit and scoring a list of competency-based items; includes guidance on scoring	To review how the ttC-HV does the work	Skills mentoring
Case evaluation/ spot checks	Interview with ttC client (in ttC-HV's absence) about most recent visit and scoring a list of competency-based items; includes guidance on scoring	Helpful in identifying falsification of data/validation of data	Compliance
Health knowledge assessment and revision	Questionnaire (open-ended questions) with answer key	Identify weak areas remaining after the training	Skills mentoring
Individual performance appraisal	Synthesise results of assessments done over a period of time using other forms	To understand additional needs for training/replace a ttC-HV not performing well.	All
Problem solving/ troubleshooting activity	Offering the ttC-HV time to present issues he or she has found most difficult, cases requiring referral, adverse events or non-technical issues	To help find solutions or share best practices	Support
Coaching and skills development	Using the tools above, allowing for time to review materials or demonstrate good practices		Skills mentoring

Summarise the session

- There are multiple roles for a supervior including teaching, mentoring and support as well as occasionally taking the role of 'policing' where required. A strong supervision should be able to ensure that the supervisee feels supported and gains knowledge and skills during supervision, whilst also ensuring that protocols and quality standards are being met.

Session 2. Supervision skills

Learning objectives	*By the end of this session participants will be able to:* • explain and demonstrate key skills that are conducive to a supportive supervision approach • explain and demonstrate good techniques for communicating effectively during a supervision.
Materials and preparation	*Methods:* • Trainer presentation, discussion, role plays, simulations • Duraton: twoto three hours *Materials/preparation*: • Coloured paper • Coloured sticky notes

Activity 1: Supervisory skills: Leadership

SUPERVISORY SKILLS: LEADERSHIP

To be a good leader, a supervisor needs to perform effectively in the following areas:

- Identify problems early and be a resource to help solve problems the ttC-HVs may be having.
- Be concerned about the ttC-HVs and look out for their welfare.
- Be a role model.
- Be confident about making decisions.
- Inspire and guide others towards accomplishing goals.
- Know and be able to use ttC-HVs' strengths.
- Grow and develop the ttC-HVs, while also getting things done.
- Mentor and coach the ttC-HVs for good performance.
- Allow ttC-HVs to manage their own time and workloads.
- Delegate some tasks to others, as appropriate.

- With the participants, read through each of the points in 'Supervisory skills: Leadership' and answer any questions they may have.
- Now have the participants work in groups of three. Assign each group one of the 10 leadership elements from the list. In their groups they should come up with an example situation that illustrates the point. It may be a real situation from their own experience or a situation that they could imagine happening.

  For example, the first bullet point reads *'Identify problems early and be a resource to help solve problems that ttC-HVs may be having'*. An example situation might be a ttC-HV telling the supervisor about a problem she is having with a family. The family is not accepting home visits. In this example, the supervisor might decide to go to the household with the ttC-HV and try to resolve the problem together. This is the sort of examples each group should come up with.

When the groups have finished discussing among themselves, one person from each group should explain the situation they came up with to the rest of the class. **Try to keep these presentations as brief as possible, because there will be 10 of them**.

- Now give participants two sticky notes of different colours. On the first note they should write which leadership element they think will be easiest for them to perform; on the second note, they write the one they think will be most difficult. Have an area of the wall for the easiest and an area of the wall for the most difficult. The participants will place their sticky notes in the two areas.

  Review the results. Do the participants all choose different things? Are their answers mostly all the same? Is there one area of leadership that stands out as seeming most difficult for many of the participants? Spend some time discussing with the participants some ways they can develop these skills.

Activity 2: Supervisory skills: Communication

SUPERVISORY SKILLS: COMMUNICATION

A good supervisor will demonstrate the following communication behaviour:

- Hold regular meetings to ensure that there is regular communication happening.
- Maintain regular contact with ttC-HVs.
- Create a welcoming environment for the free flow of 2-way communication.
- Demonstrate an accessible, approachable personality.
- Listen actively: show interest in what others have to say.
- Offer praise when appropriate.

Discussing supervisors' skills

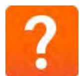
Read through each point in 'Supervisory skills: Communication'. The first two points refer to holding *regular meetings* with ttC-HVs and having *regular contact* with them. Explain that you will be talking very specifically about these points later in this training. In this part of the training you will focus on the remaining four skills and have the participants do a few demonstrations of them.

Now look at the second two skills: creating a *welcoming environment* for two-way communication and having an *approachable personality*. Have a short discussion with the participants asking what they think an approachable personality is like and how a welcoming environment can be created.

Ask for two volunteers to role play a supervisor-supervisee situation where the supervisor does *not* demonstrate these skills. What behaviours or attitudes can be off-putting?

Following that, ask for two volunteers to role play a situation where the supervisor *does* demonstrate the skills. The volunteers can use any scenario situation they wish. What behaviours and approaches can make a supervisor more welcoming and approachable? Wrap up with a brief discussion.

Activity 3: Supervisory skills: Active listening



Ask the participants if they can explain the difference between 'hearing' and 'listening'. Ask why they think it is important that they take the time to listen to the ttC-HVs they are supervising. Discuss.

Explain that people feel respected when they feel they are being listened to. There are many ways that a person can communicate that he or she is listening. You can show that you are listening even without saying anything, by using 'body language'.

Have you HEARD them?

Another aspect of active listening is that you will be able to demonstrate that you have understood. You can make sure of this by using restatement, paraphrasing and summarising techniques to check what you've heard. When they have finished speaking you could:

- restate the key points
- ask for clarification.

HOW TO SHOW THAT YOU ARE LISTENING THROUGH BODY LANGUAGE

- Sit opposite the person you are listening to.
- Lean slightly towards the person to demonstrate interest.
- Maintain eye contact as appropriate (without staring).
- Look relaxed and open. Show you are at ease with the person. Arms should not be crossed.
- Do not rush or act as if you are in a hurry.
- Use gestures, such as nodding and smiling, or saying 'mmm' or 'ah'.
- Restate or summarise what you have heard.

There are some behaviours and responses that *block good communication and active listening*. Some examples are:

- interrupting before someone finishes speaking
- expressing indifference or doing something else whilst the person is talking
- jumping in to tell someone what to do, or lecturing before you have got to the bottom of the issue
- moralising and criticising without understanding the circumstances.

Have the participants work in pairs. One person should talk about what he or she did the previous day, while the other person listens. The person listening should *show* that she or he is listening, using body language. Switch roles and then discuss as a group the ways they showed that they were listening to each other. Now try some of the blocking responses. How do they feel when they get this reaction?

Activity 4: Supervisory skills: Praising appropriately

Ask the participants why they think it is important to praise the ttC-HVs from time to time. Discuss.

Ask each participant to give an example of a way that she or he may praise a ttC-HV. What can they praise ttC-HVs for?

Working in pairs, have participants practise praising each other for something positive that they observe or know about each other. If you wish, you may then have participants share their praise comments with the plenary. Examples might include:

- You seem to be learning very quickly in this class.
- I notice that you wash your hands before we have our lunch breaks. That is very good.
- You have beautiful children.

Activity 5: Supervisory skills: Giving feedback

SUPERVISORY SKILLS: GIVING FEEDBACK

Telling a ttC-HV how he or she is performing on the job requires tact, sincerity and good supervisory skills to be effective. Giving specific information helps the ttC-HV to continue to deliver good service in the community or to improve:

Be specific

Providing specific examples helps the ttC-HV understand exactly what the issue is. You can then agree on the details and work on solutions:

Don't say: 'Your performance is below what I expect.' Say: 'Your monthly report is not complete.'
Don't say: 'Good.' Say: 'The way you helped that pregnant woman with her referral was very good.'

Do not criticise the person, criticise only the person's behaviour

Don't try to guess why a person did something, and do not criticise the person. Concentrate on the action and criticise the behaviour only. Remember, you are not trying to change who the person is, you are simply trying to improve the way that person carries out the work.

Don't say: 'You are not taking things seriously enough.'
Say: 'You have not been active for the last three weeks, and you did not inform us of your problems. Can you share the facts of the situation with me?

Be immediate

Feedback must be well timed. It should be given as soon after the event as possible. Don't save it for later. But also don't give feedback if you are angry or upset. Wait until you have cooled off and can be calm and objective about the issue.

Start on a positive note

When you have to give negative feedback to someone, begin by showing respect for the other person. Tell people what they did well in addition to what they did not do well. Start with something positive. This is less likely to cause resentment and defensiveness.

Criticise in private, praise in public

Avoid giving negative feedback in public. Announce good feedback more widely – but check with the person first (they might prefer to keep it to themselves).

Avoid unnecessary emotion

Don't lose your cool. Over-reacting will produce defensiveness. Talk when you are calm and objective.

Avoid giving too much feedback at any one time

When you give feedback, focus on one or two behaviours or issues, not a whole collection of them. Be sure you don't 'save up' all the things you want to say and then 'dump' it all on the ttC-HV. Feedback should be focused and given frequently rather than be overwhelming.

Avoid threats

If the behaviour merits discipline, take it promptly. But do not threaten anyone.

> *Don't say: 'Your behaviour has been unacceptable. Remember, I can influence your payments.'*
> *Say: 'The way you handled this issue is not acceptable for the following reasons [give the reasons]. I am now going to implement the disciplinary procedures.'*

With the group, read each point of the section above 'Giving feedback'. Try to give one or two examples, or demonstrate each of the feedback skills, as follows:

- Explain the first point: 'Be specific'. The trainers do a short skit demonstrating feedback that isn't specific, followed by a skit showing feedback that is.
- Explain the second point: 'Do not criticise the person, only the person's behaviour'. The trainers do a short skit demonstrating an example of criticising the person, followed by an example where only the behaviour is criticised.

Now ask for two volunteers to come to the front of the class to act out a feedback session. Give them Scenario 1 to act out. You may repeat the activity with other groups of volunteers using scenarios 2 and 3.

Scenario 1

Yesterday the supervisor accompanied a ttC-HV on a home visit to a pregnant woman. During the visit the ttC-HV told the problem story and the positive story, but did not negotiate using the household handbook. You should provide feedback to the ttC-HV about the home visit overall, using good feedback skills.

Scenario 2

You are carrying out a debriefing meeting with all ttC-HVs. Eight ttC-HVs completed all their work during the month, while two did not. Of the two that did not, one travelled to visit her son. The other ttC-HV gave no reason for not completing her work. How should the supervisor provide feedback in this situation? Demonstrate, using good feedback skills.

Scenario 3

Yesterday you accompanied ttC-HV on a home visit. The ttC-HV followed all of the steps correctly, but she spoke to the family in a very stern way, criticising them for not practising all the behaviours in the household handbook. Demonstrate how you would provide feedback to this ttC-HV, using good feedback skills.

Wrap up this session by explaining to the ttC-HVs that there will be an opportunity later in the training to practise giving feedback.

Activity 6: Problems

Explain to the participants that there will be times – even after they have displayed all of the effective supervisory skills – when they will still have problems with some of their ttC-HVs. Discuss some of the problems they may be having, or may expect to have, and provide any input you may have as a trainer or supervisor in the programme.

Summarise the session

- Each supervisor should develop the following supervisory skills: leadership, communication, active listening, praising appropriately and giving feedback.
- Mastery of these skills will ensure that good relationships and trust are built between supervisor and supervisee which will strengthen the outcomes of the supervision.

Session 3. Core competencies of ttC home visitors

Learning objectives	*By the end of this session participants will be able to:* • explain the various objectives of supportive supervision. • list the core competencies required for ttC and how they can be assessed.
Materials and preparation	*Methods:* • Trainer presentation, brainstorming, discussion *Materials/preparation:* • Photocopies of the Core Competencies Framework • Flip chart or chart papers • Markers

Activity: Introducing the framework

- Begin by asking the participants what competencies a ttC-HV should have in order to effectively carry out ttC home visits. Record responses on a flip chart, taking care to *group the responses* by the competency area, as given in the framework. Fill in with any areas or specific elements that are not mentioned.
- Have the participants turn to the Core Competencies handout. Discuss briefly why each of these competencies is critical for doing ttC home visits and what part of the home visit schedule each competency contributes to.
- Explain that the task of supervising ttC-HVs is built around these core competencies. Each supervision task aims to assess and improve these competencies in the ttC-HV.
- Point out that they – the supervisors – will conduct performance appraisals of ttC-HVs [insert the frequency decided for your national office (NO)], based on these core competencies.

Summarise the session

- Reiterate that all the activities related to supervision of ttC should contribute to the development of one or more of the core competencies.

Core competencies for ttC		Supervision methods for individual assessment	Group supervision methods of assessment
Qualitative assessment areas			
1. Effective communication and counselling skills	Rapport building with families	Observation assessment	Practice in groups or simulation
	Active listening		
	Negotiation and dialogue		
	Use of job aids and materials during process		
	Barriers analysis		
2. Handling of referral cases	Recognition of symptoms and danger signs	Case assessment	Lead ttC-HV reports back
	Referral and follow up		
	Interpretation of counter referral		
3. Record keeping	Referral forms	Record check	Records assessment
	Record keeping and reporting		
	Use of the household handbooks	Observation assessment	Simulation or lead ttC-HV reports back
4. Health knowledge	Healthy pregnancy	Knowledge check and observation assessment	Post-training test only or group revision
	Essential newborn care, postpartum care and danger signs		
	Breastfeeding counselling and support		
	IDS and growth curve interpretation		
	Childhood illness		
	Complementary feeding and child nutrition		
	High risk children and households (HIV, TB, OVC)		
5. Other	Timeliness of visiting, punctuality	ttC-HV register	
	Supportive care for vulnerable families		
	Use of initiative and problem-solving skills	Qualitative assessment and COMM feedback	
6. Community involvement	Engagement with other Community health actors, COMM and others	COMM and community representative feedbacks	
	Community trust and value perception (feedback)		
	Community sensitisation and health promotion activities (group based)		

Session 4. Performance audit of ttC-HVs

Learning objectives	*By the end of this session participants will be able to:* • understand the purpose of the performance audit section of the individual supervision form. • explain the difference between performance information and health practice information they also need to collect. • extract the information from the record-keeping tools – adjust for what tools are being used in country.
Materials and preparation	*Methods:* • Trainer presentation, brainstorming, discussion *Materials/preparation***:** • Flip chart or chart papers • Markers • Copies of the supervision tool • Completed sets of ttC registers (one pack per group), that can be used to practise, or their equivalent used for ttC in your country. Ensure they include ratings 'poor', 'needs improvement', 'good' and 'excellent' • Completed Eligible Women and Girls Register, or an equivalent used for ttC in your country

Contextualisation: Not all countries will require all the indicators listed under the 'performance audit form' of the ttC supervision tool. In many cases, it might be too complex for supervisors to collect performance on all these areas. It is important that tools are modified to fit well with the capacity of the ttC-HVs and supervisors and that they are field tested rigorously before broad-scale deployment. Please be aware that the draft samples given are intended to be comprehensive of all the performance indicators possible.

Activity 1: Introduce the tool

Ask: what do they consider to be critical 'performance' issues in delivering ttC home visits? List answers on flip chart. Give a copy of the tool to all participants. Highlight the fact that these have to be areas of the ttC-HV's tasks (as in carrying out timely ttC visits) and not the outcomes of that work (such as changed household behaviour).

Form 1: Performance audit: This tool measures the extent to which the ttC-HV is able to accomplish the tasks. It uses data from ttC registers and computes the key performance indicators listed below. These are considered a performance audit as we use it to identify weakness in the performance of ttC activities, rather than the outcomes of the counselling, which are not under the ttC-HVs' control. By ensuring performance against these three areas, we are ensuring that ttC is being carried out as planned.

This tool is not intended to capture health data from the registers but only to capture the 'performance-based' information about the ttC-HVs' services. It can be incorporated into all of the four strategies discussed above as it can be carried out during debriefing meetings.

Key performance indicators:

- percentage of planned visits that were completed in a given supervision period
- percentage of visits where males/birth partners participated
- percentage of pregnant women who had the first ttC visit in the first trimester
- percentage of referrals completed (or follow-up referral visit completed depending on if the NO strategy includes conducting home visits after referrals).

Note: *A key aspect of ttC visits is that the relevant household members participate. During Visit 1 the ttC-HV should have identified one or more people in the home who will support her, including her husband and/or mother-in-law, mother or other friend she has identified.*

FORM 1 PERFORMANCE AUDIT

This form can be modified to include all the relevant data fields that need to be collected during supervision.

Basic Performance Data

Case Load	**Eligible women and girls**	**Current registered pregnancies**	**Births**	**Registered infants (1-<6m)**	**Registered children (6-23m)**	**Total case load**
Total number # (case load)						
# of cases referred			***Facility births***			
# referrals completed/ followed up						
# planned visits for this period						
# completed visits for this period						
# of visits in which male/birth partner present						
		# registered in early pregnancy (<16th week)	# visited 3 times in first week			

Reason for low activity	Activity level of ttC-HV during supervision period	
☐ Temporary absence ☐ Permanent absence/drop out ☐ Illness or travel ☐ Difficulties with ttC schedule ☐ other (indicate what)	0–50% = poor 51–75 % = needs improvement 76–100% =good >90% excellent **OR (delete as applicable)** *Less than half = poor* *About half= needs improvement* *More than half = good* *Nearly all = excellent*	☐ % completed ttC visits ☐ % male/partner participation ☐ % referral/follow-up completion ☐ % early registration in pregnancy
Overall Performance Level **(Excellent, Good, Needs improvement, Poor)**		

Contextualisation: If you are working with low-numeracy supervisors, use the second half of the process described below, which uses categories of 'almost all', 'half', etc. instead of percentages. You may need to simplify the layout of the form on the previous page. We do not recommend that you 'skip' performance indicators (e.g. male participation) as these are all central to the ttC methodology.

Activity 2: Explain the process of using Form 1

Distribute copies of the ttC Supervision tool. Point to form 1 in the tool and explain its layout:

- One form is used for every ttC-HV who is being supervised. The data to be entered will pertain to the supervision period (month or quarter).
- The first column in the table gives the data items that the supervisor will need to perform the performance audit. Read the items aloud.
- The remaining columns give the various population groups that ttC targets, and the numbers for each of these groups will be sourced from the EWG register, ttC registers (or other sources that the NO has decided to use).

PROCESS

- Extract the data from the registers on each case and count total numbers of cases.
- Define the supervision period (monthly, quarterly).
- Count the number of referrals made by the ttC-HV since the previous supervision.
- If they are conducting referral follow up in the home use this data point also.
- If they are monitoring referral completion (i.e. if the client was referred and ttC-HV confirms that they did in fact get seen at a facility, count this number).
- Count the number of planned visits according to your visiting protocol.
- Count the number of planned visits that were achieved *on time.*
- Count the number of visits where the ttC-HV has marked that the male or birth partner was also present.
- Total the numbers in the last column.
- Calculate, *if possible,* a percentage for each performance indicator and give an overall performance score in the ranges given below.

For supervisors who can calculate percentages

1. Percentage of ttC visits completed on time

Calculate using:

$$\frac{\text{\# of completed visits for this period}}{\text{\# of planned visits for this period}} \times 100 = \text{\% completed ttC visits}$$

Timely visits: what is an 'on time' visit

- Pregnancy, infant and child = within *two weeks* of scheduled visit
- Newborn = X visits within first week + before 1st month

Contextualisation: Consider for your context whether you are able to estimate timeliness accurately, given the numeracy/literacy level of your ttC-HVs. Timeliness requires literate ttC-HVs being able to put in projected and actual dates, and supervisors knowing what the dates *should* have been. It may be that this can be done accurately only by using the mobile application or where the ttC-HV is able to record the planned dates correctly.

2. Percentage of male/partner participation

Calculate using:

$$\frac{\text{\# of visits in which male/birth partner present}}{\text{\# of completed visits for this period}} \times 100 = \text{\% male/partner participation}$$

Note: *If you are using MoH reporting cards, there might not be a place for recording male participation, but you need to work with MoH to look at how you can record this because it is very important to ttC that family members, birth partners or other supporters are participating regularly as this is a key barrier to health and maternal well-being.*

3. Percentage of referral completion or percentage of follow-up completion if the ttC-HVs are also doing follow-up visits

Note: *Referral completion means that if a ttC-HV identified a problem during one of the visits and recommended the referral of a client to a facility, that the client was seen by the appropriate health provider. The ttC-HV must confirm this action and record it for all cases he or she refers.*

Calculate using:

$$\frac{\text{\# of completed referrals for this period}}{\text{\# of referrals recommended for this period}} \times 100 = \text{\% referrals completed}$$

Contextualisation: In some places ttC-HVs may not be conducting post-referral follow ups, in which case this could be cut; therefore, it is an optional performance indicator.

Note: *Whilst families take the decision on whether or not to refer, we consider completion of referrals as a measure of the success of the encouragement and counselling that the ttC-HV does with the family to attend the clinic when they need to do so. The logic is that a high-performing ttC-HV will achieve over 75 per cent of the referrals through supportive counselling for referral.*

4. Early registration in pregnancy

Calculate using:

$$\frac{\text{\# of early registrations (<16 week) for this period}}{\text{\# of current pregnancies for this period}} \times 100 = \text{\% early registration in pregnancy}$$

Performance score:

- 0–50% = poor
- 51–75% = needs improvement
- 76–100% =good
- >90% excellent

For supervisors who cannot calculate percentages

Once the totals are calculated for each row, the supervisor classifies the totals into one of four categories as follows:

- **Percentage of completed ttC visits**

  Compare the number of completed visits with the number of planned visits, and use the following categories instead of per cents:

  - Almost all planned visits have been completed: 'Almost all'
  - More than half planned visits have been completed: 'More than half'
  - Half of the planned visits have been completed: 'Half'
  - Less than half the planned visits have been completed: 'Less than half'
- **Percentage of male partner participation**

  Compare the number of completed visits in which the male partner was present and use the following categories instead of per cents:

  - Male partner present in almost all completed visits: 'Almost all'
  - Male partner present in more than half of the completed visits: 'More than half'
  - Male partner present in not more than half of the completed visits: 'Half'
  - Male partner present in less than half the completed visits: 'Less than half'
- **Percentage of referral completion (or percentage of referrals that were followed with a ttC-HV home visit)**

  Compare the number of referrals completed with the number of referrals made, and use the following categories instead of per cents:

  - Almost all referrals recommended by ttC-HV were completed: 'Almost all'
  - More than half the recommended referrals were completed: 'More than half'
  - About half the recommended referrals were completed: 'Half'
  - Less than half the recommended referrals were completed: 'Less than half'

Performance score:

- Less than half: Poor
- Half: Needs improvement
- More than half: Good
- Almost all: Excellent

Note: *If there has been low activity in this reporting period, ask the ttC-HV the reason and select one of the options above. Try to be understanding of circumstances, and look to see if you can help the person to meet the schedule by organising time and home visits better.*

two consecutive supervisions where the ttC-HV has been inactive means that you have to discuss the situation with the COMM. See the COMM manual process for dealing with a grievance.

Activity 3: Practise with the forms/calculate overall performance

During this session participants should have copies of the supervision form and copies of the ttC registers that they are using in their context (ideally already completed). One way to do this: organise them into groups of

three or four people and provide each group with a set of completed registers. They can work together in the group to count the number of registers/registered cases and the planned/completed visits, referrals and male participation rates. They can do this using a tallying method by marking like this:

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Calculating performance and giving feedback

In their groups they should then determine the performance scores of the individuals for each area and give an overall estimate of the effort for this supervision period. After they have done this they can practise giving feedback to the ttC-HV in groups, using skills they have learnt.

Scenario 1 (poor)

The ttC-HV has completed less than half of their visits on time. None of the visits had a male participant present. The ttC-HV made three referrals but never went back to check if the client had gone to the facility. The ttC-HV says that during this supervision period she had been very sick and had to travel to the clinic herself but plans to improve next month.

Scenario 2 (needs improvement)

The ttC-HV completed 60 per cent of the visits on time. Male/partners participated in most of the visits. He referred five cases and followed up on three of them, which went to the facility; the others did not go. He has struggled to make the visits because he is volunteering for many initiatives.

Scenario 3 (good)

The ttC-HV completed 75 per cent of the visits on time, mostly with men participating in the sessions. She referred three cases and did two successful follow ups. The visits she didn't make on time she says it's because the families were away.

Scenario 4 (excellent)

The ttC-HV did all his visits. All but one case had husbands present during visits. He made only one referral and followed up correctly.

Summarise the session

- Form 1 assesses whether the ttC-HVs are identifying clients early, going to the homes for the visits, capturing the right people and managing the follow up if referred (i.e. if the ttC-HV has been conducting home visits at the right time and to the right people).
- Supervisors will use data from ttC registers to calculate key performance indicators, using percentages or estimates, and then give an overall score for the ttC-HV as poor, needs improvement, good or excellent.

Session 5. Case evaluation (spot checks)

Learning objectives	*At the end of this session participants will be able to:* • Explain how and why they need to conduct a 'spot check' or case evaluation during a supervision visit.
Materials and preparation	*Methods:* • Discussion, group practice • Duration – 1.5 hours *Materials:* • Copies of the supervision form

Contextualisation:

Individual supervision methods – In supervision options #1 and #2 this method would be included in a supportive supervision conducted by either WV/MoH (#1) or by lead ttC-HV/ COMM (#2). If you are using lead ttC-HVs you might want to simplify language or extend the training time to include more practice so they can grasp the technique.

Group supervision methods – In the group supervision context this would be done *at random*, which is useful to discourage/prevent poor working practices as the ttC-HVs know that they might have a spot check at some point. Alternatively it could be done *only when a problem arises;* therefore, it is still very important to use this tool when you are evaluating a ttC-HV who is experiencing challenges. Only in option #4 would this method not be used at all.

Activity 1: Introduce Form 2

Case evaluation, or a spot check, helps the supervisor assess how well the ttC-HV has been delivering ttC home visits. It does so by reviewing with a household member what transpired during the most recent ttC visit, and assessing that against a standard set of items. The case evaluation also helps identify falsified data.

Hand out the supervision record and talk through each of the questions and steps.

Activity 2: Explain the process

- Use the register to select three to five cases that have been visited recently, making sure you select different types of cases (depending how far through training processes they are). If there is a high-risk case or an adverse event occurred such as a referral, this could also be a good option.
- Copy the information on the ttC registers from the most recent home visit for the woman you intend to visit. Go to the home to interview the mother. You might need the ttC-HV to help you find the house, but your interview should be conducted without the ttC-HV there. Ask the ttC-HV to wait away from the house so the client does not feel pressured to respond a certain way. Interview someone in the house, preferably the mother or someone who lives in the house; if neither of those is available, speak to someone who knows about what happened. Explain who you are and the purpose of the visit, and ask if they are happy to proceed.
- If no one is home, select another case.
- As you run though each question with the mother, score the finding according to 0, 1 or 2 as indicated.

- When you have finished, add up all the numbers and give a score out of 20.

After explaining the process, have a discussion with the participants about the logistics of the case evaluations. You should tailor the discussion to the individual situations of the lead ttC-HVs present. How widely dispersed are the ttC-HVs they are supervising? How widely dispersed are the families they are visiting? Is it possible to walk to the households? Is there a need for ttC-HVs to travel to the households and, if so, how will transportation be handled? Try to sort these issues out with the participants and respond to any concerns they might have.

FORM 2 CASE EVALUATION (Spot Checks)

Home Visit Interview of Mother Randomly select up to five recently visited families from the ttC register (one from each of the categories listed under 'client type' if possible) then conduct the home visit and interview the mother, about the ttC-HV's most recent visit to the household. Always ask for consent. If the family is not home or does not agree to an interview, select other cases for assessment.

Client type:		Pregnant woman = 1 Newborn= 2 Infant = 3 Child under 2 years = 4 High risk/referral case = 5					
Client No. or ID							
Mother or carer's name							
Age at time of visit (gestational age or age of child)							
Number of home visits completed to date							
1.	**Timeliness of visits** Q: Did the ttC-HV visit according to the schedule planned and when you expected them?	Visit not done =X Visit too early or too late = 0 Visit less than 2 weeks late =1 Visit done on time = 2					
2.	**Data validation** Q: For each recorded data point on the register ask the woman to confirm that the information is correct.	Data mostly wrong=X Data partially correct= 0 Data mostly correct =1 Data all correct = 2					
3.	**Topics covered during visits** Q: What stories were used during the visit? What topics discussed?	Inadequate/wrong topics = 0 Partially correct topics = 1 Correct topics for visit= 2					
4.	**Rapport with family** Q: Did the ttC-HV establish good communication? Did she or he listen well and engage well during the visit?	Poor = 0 Reasonable = 1 Good = 2					
5.	**Barriers identified** Q: Did the ttC-HV discuss any difficulties you were having in doing the recommended practices?	None identified = 0 Partial =1 Good =2					
6.	**Problem solving** Q: Did the ttC-HV try to help you find solutions to the problems you identified?	None attempted = 0 Partial =1 Good = 2					
7.	**Family participation** Q: Did the ttC-HV encourage influential family members to participate in discussions?	Key members not invited = 0 Key members invited = 2					
8.	**Use of visual aids** Q: What materials were shown during the visit? Did he or she talk you through the stories?	Visual aids not used = 0 Partially used =1 Correct usage = 2					

The sections in white are taken from the ttC

All the sections in grey are information collected about the interview with the mother/family.

9.	**Complications and Referral** Q: Did you report any health problems to the ttC-HV during the visit? If so, did the ttC-HV help you to access treatment you needed?	ttC-HV did not inquire = 0 Inquired and referred me= 2 Inquired but I had no health problems = 2					
10.	**Referral Follow up** Q: If you were referred by the ttC-HV, did she or he return to visit you after you returned from the facility?	Not referred by ttC-HV= 2 Referred but no follow up = 0 Referred with follow up = 2					
11.	**Service Satisfaction** Q: Did the ttC-HV treat you well and act supportively? Were you satisfied with the service?	Unsatisfied =0 Partially satisfied = 1 Satisfied= 2					
Evaluation	Performance total of treatment/follow up of ttC-HV (Count scores from questions 3–14 – grey areas)		/20	/20	/20	/20	/20
	If less than 16, or if response to Q #1 is X, then the score = poor (ttC-HV did not go but reported going) ***<10 or X response for Q1 Poor*** ***11–15 Needs improvement*** ***16–18 Good*** ***> 18 Excellent***						
	Average performance across the five clients			Comments:			

Activity 3: Practise the form using role plays

Divide participants into groups of 6. Each group will carry out the three role plays outlined below, with two members taking turns doing each role play (one as the supervisor and the other as a mother/pregnant woman) and the rest of the members observing the plays. By the end of the session, each group will have carried out all three role plays and each member would have had a chance to act in one role play and assess two scenarios played out.

Role play 1:

Pregnant woman says she was visited as noted in the ttC register. She is happy with the manner in which the ttC-HV communicated with her family and listened to them. She recalls the stories presented, and you judge that those were indeed the stories pertaining to that visit. The woman also recalls that the ttC-HV discussed the difficulties her family might have in doing the recommended behaviours and helped them find solutions. The ttC-HV used the storybooks and encouraged all to participate. She inquired about health problems, but the pregnant woman did not have any.

Role play 2:

Mother of a newborn baby says the ttC-HV last visited when she was pregnant and has not visited them since the baby was born. The ttC register, however, shows that two newborn visits have been made.

Role play 3:

Mother of a 6-month-old infant recalls that the ttC-HV visited her home as noted in the register, but she is not happy with that visit. The ttC-HV did not spend sufficient time explaining the stories. The mother does not recall any discussions related to difficulties the family has in practising feeding

behaviours or solutions to those issues. The ttC-HV did not ask the mother about any signs of illness in the child.

Summarise the session

- The case evaluation form helps supervisors assess the manner in which the ttC-HV has carried out past ttC visits and identify falsified data, if any.
- Remind the participants that they will practise this form in the field.

Session 6. Observation assessment of a home visit

Learning objectives	*At the end of this session participants will be able to:* • carry out an observation of an ttC-HV home visit using a standard checklist • provide feedback to the ttC-HV for skills improvement based on the observations.
Materials and preparation	*Methods:* • Discussion, trainer presentation, simulation, group practice • Duration -1.5 hours *Materials/preparation*: • Photocopies of ttC-HV Reference 10: Home Visit Observation Form, 1 per participant • Participants should have their Household Handbooks • Participants should have the Storybooks for Visit 3

Contextualisation:

Individual supervision methods – In supervision options #1 and #2 this method would be included in a supportive supervision conducted by either WV/MoH (#1) or by lead ttC-HV/COMM (#2). If you are using lead ttC-HVs you might want to simplify language or extend the training time to include more practice so they can grasp the technique.

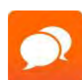
Group supervision methods – In the group supervision context, both options #3 and #4 would be done *as simulation exercises.* If you have participants working in groups with a lead ttC-HV in each group, then that person can run the assessment. Organise participants into groups and have them assess one another. If they are low literacy you may want to simplify the language; if illiterate, only the supervisor can do the assessment.

Activity 1: Introduce the form

When observing a ttC-HV carrying out a home visit, this form helps supervisors assess the extent to which the ttC-HV is conducting the visit according to recommended standards. The form guides supervisors to assess and score each step of the process. The supervisor will also use this opportunity to dialogue with the ttC-HV and help her or him improve performance and identify areas for further growth. Thus the tool serves an evaluative and a formative function.

Ask: Why is it important to sometimes accompany the ttC-HVs on the visits they make to the families?

Point out that the ttC-HVs' core activity is in the community and homes, and on-site supportive supervision becomes essential and should receive maximum attention by the supervisor. It is an opportunity for giving encouragement and feedback to the ttC-HV, and for strengthening the skills of the ttC-HV in carrying out the ttC methodology. In addition, during on-site supervision the supervisor and the ttC-HV are engaged in a 2-way process in which they grow to trust each other over time. The supervisor's empathy and praise of the ttC-HV leads to a solid supervisory relationship.



Have a short discussion about this, and then explain that it is recommended that they accompany each ttC-HV on a home visit at least twice per year (every 6 months).

Have a discussion with the participants about the logistics of the home visit observations. You should tailor the discussion to the individual situations of the Lead ttC-HVs present. How widely dispersed are the ttC-HVs that they are supervising? How widely dispersed are the families they are visiting? Is it possible to walk to the households? Is there a need for ttC-HVs to travel to the households and, if so, how will transportation be handled? Try to sort these issues out with the participants and respond to any concerns they might have.

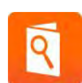
If you are facing a situation where it is clear that the lead ttC-HVs are not going to be able to keep to such a schedule of home-observation visits, ask them to brainstorm criteria for prioritising which ttC-HVs to visit first and which ones later, as possible.

Activity 2: Explain the process

Review together 'The Home Visit Observation from Start to Finish' (on the following page). This box summarises the steps and actions a supervisor should keep in mind when carrying out a home visit observation. Answer any questions the participants may have.

Activity 3: Provide an overview of the form

Distribute copies of the Home Visit Observation Form (one per participant) and explain that this is the checklist the supervisors will use when observing a home visit. Read through the checklist together. The participants should realise very quickly that the checklist focuses on the way the ttC-HV carries out the ttC methodology. In the same way that the supervisors needed to master this process 100 per cent in this training, so too will the supervisors want to see the same skill levels among the ttC-HVs over time. Answer any questions the supervisors may have about this form.



Activity 4: Simulate a home visit observation

For this activity the trainers will simulate Visit 2. One trainer will play the role of the ttC-HV, and the others will be family members. As preparation, turn to Visit 2 in the household handbook, and put in imaginary marks in pencil to reflect what the family said and agreed to in the previous visit. If you have enough trainers, you may select one trainer to run the projector and project the household handbook so that participants may follow along with the illustrations being discussed.

Explain that participants are to watch the simulation carefully, and each person will fill in a Home Visit Observation Form based on what they see.

Explain, too, that at the end of the simulation you will randomly draw four names; these four people will be asked to provide feedback to the trainers, one at a time, corresponding to Steps 1, 2, 3 and 4 in the Home Visit Observation Form. Since nobody knows whose names will be selected, everybody must pay close attention.

Trainers are to carry out the simulation rapidly and efficiently, building in mistakes that participants can pick up and record in the observation form.

When the trainers have completed the simulation, they will draw four participant names to give feedback on each of the four steps. Trainers can use this opportunity to hone the participants' feedback skills as well.

Finally, review in plenary the answers for the Home Visit Observation Form. Have a discussion with the group as a whole. Ask them how they feel about observing the home visits and filling out the form. If they have any remaining doubts or questions, carry out additional reviews and/or practise as needed.

THE HOME VISIT OBSERVATION FROM START TO FINISH

Prepare

- Plan to spend a minimum of one hour per family visit.
- Make sure that the ttC-HV is aware that you are visiting her to accompany her on a home visit.
- Arrive at the meeting site early enough to allow you to accompany the ttC-HV to the family she is going to visit.
- Show the ttC-HV the checklist you will use to observe, assess and guide her during the home visit. Give the ttC-HV a copy to keep (if she is literate) so that she can also conduct self-assessment.

Greet, introduce and reconnect

- Set the tone by greeting the family members. Allow the ttC-HV to introduce you to the family.
- Let the ttC-HV explain the purpose of the visit, as necessary.
- Ensure that the family members are comfortable with the visit.

Gather information

- Observe the ttC-HV as she carries out the home visit. Avoid interruptions, and use the Home Visit Observation Form in the presence of the family.
- Notice the ttC-HV's emotional response to the activities he or she is performing.
- Explore the family's participation in the home visit experience.
- Chat to the family members and praise them for their commitment to the programme.

Compliment through 'teachable moments' to improve skills

- Look for the unplanned opportunities to help the ttC-HV improve skills and knowledge.

Provide post on-site feedback to ttC-HV

- Discuss your observations away from the family, and use the Home Visit Observation Form to commend the ttC-HV on aspects that were satisfactorily done and to point out aspects that were omitted or not satisfactorily implemented.
- Analyse the Community Health Worker's Monthly Summary Sheet to ensure accuracy.
- Ask the ttC-HV what additional support she or he needs from you as a supervisor and make a note of it.

Plan for the next support session

- Set date for next meeting or home visit observation.
- Decide on aspects to be focused on based on findings of the visit.

FORM 3 HOME VISIT OBSERVATION ASSESSMENT

Scoring guide: *0 = action contained in the item is not carried out; 1= action contained in the item is carried out to some degree; 2 = action contained in the item is carried out fully in accordance to guidelines; NA = not applicable*

#	Item		Score			
		Scoring guide	Case 1	Case 2	Case 3	Average
1	Greets family and builds rapport	Does not greet = 0 Greets hurriedly/insufficiently = 1 Greets sufficiently = 2				
2	Gives opportunity for mother and family to raise any immediate concerns	Does not give this time at all = 0 Gives time but hurries = 1 Gives sufficient time = 2				
3	Reviews previous meeting (Step 1 of Home Visit Sequence) and assists the family to update household handbook	Does not review = 0 Reviews but not all actions = 1 Reviews all agreed actions of previous visit = 2				
4	Tells Problem Story and asks Guiding Questions (Step 2), if applicable. (If no Problem Story for the Visit, indicate N/A.)	Does not do this step = 0 Insufficiently covers story = 1 Tells story in sufficient detail = 2 No problem story for this visit = NA				
5	Tells Positive Story and asks Guiding Questions (Step 3a)	Does not do this step = 0 Insufficiently covers story = 1 Tells story in sufficient detail = 2				
6	Carries out Technical Session (Step 3b), if applicable. (If no Technical Session for visit, indicate N/A.)	Does not do this step = 0 Does incompletely = 1 Covers sufficiently = 2 No technical session for this visit = NA				
7	Reviews illustrations in the Household Handbook corresponding to the Visit, and conducts negotiation process referring to the correct negotiation illustrations (Step 4)	Does not do this step = 0 Does insufficiently= 1 Carries out sufficiently = 2				
8	For behaviours already practised, circles the tick mark and praises the family. (If the family is not currently practising any of the behaviours, indicate N/A.)	Does not do this step = 0 Completes this step = 2 Family does not practise any behaviour = NA				
9	If the family says they *do not practise* a behaviour, puts down the Household Handbook and discusses with the family, tries to identify the	Does not identify barriers = 0 Does the step insufficiently = 1 Sufficiently identifies barriers = 2				

	barriers that the family is experiencing. (If the family is already practising all behaviours, indicate N/A.)	Family practising all behaviours = NA				
10	Circles the correct symbol beneath each negotiation Illustration in the Household Handbook (Step 4)	Does not do this step = 0 Circles correctly = 2				
11	After a complete discussion, asks family if they will agree to try the behaviour (or negotiated practice) and encourages the family member to write his/her initials. (If the family does not agree to try any of the behaviours, indicate N/A.)	Does not ask for initials = 0 Asks for writing initials = 2 Family did not agree to any behaviour = NA				
12	Demonstrates active listening and good communication skills	Ignores family's statements = 0 Listens insufficiently = 1 Listens actively = 2				
13	Asks open-ended questions	Does not ask questions = 0 Asks closed-ended questions = 0 Asks open-ended questions = 2				
14	Shows good understanding of all of the health and nutrition information related to the visit	Very little understanding = 0 Insufficient understanding = 1 Good understanding = 2				
15	Carries out all other actions required for the visit (*context*)	Does not carry out any action = 0 Carries out some = 1 Carries out all actions = 2				
16	Plans date for next visit	Does not plan = 0 Plans = 2				
17	Accurately fills out the ttC register for this visit	Does not fill register at all = 0 Fills incompletely or with errors =1 Fills accurately = 2				
Score	Ignoring NAs, please review the scores of each case: Score of 2 in most or all items and 0 in none: Excellent Score of 1 or 2 in all items, no score of 0: Good Score of 0 in some items: Needs Improvement Score of 0 or 1 in most items: Poor					
	Feedback to the ttC-HV:					

Session 7. Health knowledge and revision

Learning objectives	*By the end of this session participants will be able to:* • assess the health knowledge of and individual ttC-HV • carry out a revision or recommend a refresher training.
Materials and preparation	*Methods:* • Discussion, trainer presentation, simulation, group practice • Duration–1.5 hours *Materials/preparation*: • Photocopies of the Health Knowledge and Revision Form

Contextualisation:

Individual supervision methods – In supervision options #1 and #2 this method would be included in a supportive supervision conducted either by WV/MoH (#1) or by lead ttC-HVs/COMM (#2). If you are using lead ttC-HVs you might want to simplify language or extend the training time to include more practice, so they can grasp the technique. If the lead ttC-HVs/COMMs are not literate, it may not be possible to do this.

Group supervision methods – In the group supervision context options #3 and #4, this would be done only as a revision exercise. During revisions, first ask ttC-HVs about any areas of weakness from the training that they would like to brush up on. If they do not identify any, use this list of questions to prompt discussion amongst the group. You will not be able to assess individually but will gauge generally the areas that need revision. Alternatively organise them into groups and have them assess one another.

Activity 1: Introduce the form and the process

Distribute the appropriate forms. Explain that these forms will enable the supervisor to assess the health knowledge of ttC-HVs. Remind them that adequate health knowledge is a core competency for delivering ttC.

Explain the layout of the form, including its sections (healthy pregnancy, childbirth and essential newborn care, and child health and nutrition), the questions on the left and the responses on the middle and right-hand columns. The intervening column in yellow gives the maximum possible score for that question.

During each supervision session, the supervisor will select at least eight questions to test the ttC-HV's knowledge. The supervisor will not prompt any response but will wait for the ttC-HV to respond to the question as fully as possible. The supervisor will then score the response based on the maximum score allowed. At the end of the session, the supervisor would total 1.) the maximum possible points for the questions asked and 2.) the total points that the ttC-HV scored. Then the supervisor can compute a percentage as follows:

$$\frac{\text{Total score of test}}{\text{Maximum score for the questions}} \times 100 = \%\ \text{score}$$

Performance score:

- 0–50% = poor

- 51–75 % = needs improvement
- 76–100% =good
- >90% = excellent

Or, the supervisor can assess the ttC-HV's score as follows:

- Nearly all answers are correct: excellent
- More than half the answers are correct: good
- Less than half the answers are correct: needs improvement
- Very few answers are correct: poor

At the end of the session, the supervisor provides feedback on the level of knowledge and the extent of improvement needed, and also suggests ways to improve knowledge.

Contextualisation: Contextualise knowledge items to MoH policy and guidelines in the health knowledge questionnaire.

FORM 4 HEALTH KNOWLEDGE AND REVISION NEEDS ASSESSMENT

Knowledge test *(Select at least eight questions each time, and circle the number. DO NOT provoke the response.)*						
Healthy pregnancy (following Training Module 1)						
P1	What should a pregnant woman do to ensure an adequate diet in pregnancy?	5		Eat more than usual, additional meal/snack		Use iodised salt
				Have dietary diversity		Eat foods that are rich in vitamin C and vitamin A
				Eat iron-rich foods		
P2	What is anaemia and why is it dangerous? How can it be prevented?	4		Weak blood or lack of iron; causing breathlessness fainting		Take iron-folic acid tablets in pregnancy and postpartum period
				Risk of miscarriage and labour complications		Eat iron-rich foods
P3	What is tetanus and why is it dangerous? How can it be prevented?	2		Life threatening infection acquired during delivery if unclean place of birth or dirty cutting of cord, causing death of newborn or mother		Have 2 tetanus vaccines in pregnancy
P4	Why is malaria dangerous for a pregnant woman? How can it be prevented in pregnancy?	4		Risk of miscarriage, premature and stillbirth		Sleep under a mosquito net every night
				Seek immediate help for symptoms of fever, chills, headache and muscle aches		Take 2 or more doses of Intermittent preventative treatment (IPT) during ANC
P5	What measures does a pregnant women need to take for her birth plan and birth preparation?	6		Identify preferred PHU, hospital or clinic		Identify transport means to facility.
				Know due date, plan travel before labour		Prepare materials: birth kit, cloths, blade, soap
				Build up savings to cover costs		Have a skilled birth attendant
P6	What health services are essential for every pregnant and postpartum woman?	5		Have four antenatal consultations during pregnancy		Have 2 postpartum consultations
				Take STI/HIV testing and treatment for HIV+ mothers		Get timely diagnosis and treatment of TB
						Have access to postpartum family planning.
P7	How should an HIV-positive mother breastfeed her baby?	2		Exclusive breastfeeding to 6 months		Continue breastfeeding to 12 months then stop
P8	What are the danger signs during pregnancy?	10		Fever/high temperature		Severe headache
				Abdominal pain		Vaginal bleeding
				Swelling/oedema of face, hands or feet		Premature rupture of waters or, if full term, no labour within 24 hours of rupture
				Convulsions/fainting		Breathlessness, dizziness
				No baby movements for 24 hours (in 3rd trimester)		Vaginal irritation or discharge
P9	What additional care and hygiene should a pregnant woman take? What should be avoided?	6		Rest more than usual		Avoid heavy exercise, lifting and carrying
				Wash hands with soap or ash after latrine use, before preparing food or feeding		Avoid alcohol and smoking
				Deworming, wearing sandals to avoid catching worms		Avoid medicines from unofficial sources

P10	What are danger signs during labour?	4		Excessive bleeding		Prolonged labour/birth delay (>12 hours)
				Fever and chills		Fits or loss of consciousness
P11	What are the guidelines for birth timing and spacing?	2		Best child bearing years are between18 and 35 years of age		2 years between birth of one child and the start of the next pregnancy
Childbirth and essential newborn care (following Training Module 2)						
N1	What are the major guidelines for breastfeeding?	6		Initiate in first hour of life		Exclusively breastfeed for 6 months
				Feed on demand as much as baby wants		Continued breastfeeding until 2 years
				Avoid bottles and formula		Increase feeding during illness
N2	What are the care procedures for the newborn in the first hour of life?	6		Clean and care for the cord stump		Dry and wrap baby, covering head
				Initiate breastfeeding.		Monitor breathing
				Carry out eye care		Encourage skin-to-skin contact of mother and baby
N3	What are the danger signs for the newborn?	10		Lethargic, unconscious/reduced activity		Unable/reduced breastfeeding
				Seizures, muscle tension		Vomits everything
				Rapid breathing		Chest indrawing
				Wheezing/grunt/stridor		Jaundice
				Fever		Cold body
N4	What is appropriate care for the umbilical stump? What signs indicate umbilical cord infection?	6		Clean with chlorhexidine or soap and water		Pus/bad smell/wet cord stump
				Do not bandage		Skin pustules
				Redness extending to the skin		Swelling
N5	What is low birth weight (LBW)? What is appropriate care for LBW babies?	4		Babies under 2.5 kilos birth weight		Refer to the health facility as soon as possible
				Provide 'kangaroo care' during first weeks of life		Breastfeed or feed expressed milk as frequently as possible
N6	What are appropriate hygiene and health practices with a newborn?	4		Wash hands before handling or feeding		Take baby for vaccination as soon as possible
				Bathe baby daily after first day		Change and clean soiled clothes regularly
N7	What are danger signs in postpartum woman?	5		Fever		Bleeding
				Abdominal pain		Severe anaemia
						Convulsions
N8	Which are the most highly vulnerable mothers and newborns?	6		Teenage mothers		Preterm or LBW babies
				Women with high obstetric risk		Disabled mothers and children
				HIV-positive women and their infants		Orphans

Maximum possible points in the questions asked	Points achieved in questions asked	% or
		Nearly all answers: excellent About half the answers: good Less than half the answers: needs improvement Very few answers: poor

Child health and nutrition						
C1	At what ages should a child receive vaccinations after delivery? Which vaccines are given?	6		As soon as possible after delivery, or before 15 days		6 weeks
				10 weeks		14 weeks
				9 months		Oral polio vaccine (OPV)
				Diphtheria, Tetanus, Pertussis (DTP) or Penta		Measles
				BCG (Bacillus Calmette-Guérin, against TB)		Other (e.g. yellow fever, rotavirus vaccine)
C2	How often should an infant eat complementary foods from 6–24m of age?	3		2-3 times daily between 6 and 8 months		3-4 times daily between 9 and 11 months
				3-4 times daily between 12 and 24 months plus nutritious snacks 1 or 2 times a day		
C3	Name the four food groups needed for a balanced complementary diet	4		Body-building foods (fish meal, egg, beans, pounded meat or lentils)		Protective foods (fruit and vegetables)
				Energetic foods (rice meal, maize, sorghum, bread)		Super-energetic foods in small amounts (peanut, oils, fats)
C4	What are the (general) danger signs in a child with fever that indicate urgent referral?	4		Unable to drink/breastfeed		Vomiting everything ingested
				Unconscious/lethargic		Convulsion
C5	What are the danger signs for fever which might indicate a serious infection (such as measles or meningitis)?	4		Skin rash		Stiff neck
				Swollen fontanel		Mouth ulcers/cloudy eyes
C6	To care for a child with fever in the community, what advice should you give the family?	4		Provide Coartem/antimalarial treatment for children with a positive test for malaria		Give more to drink than usual and increase breastfeeding during and after illness
				If malaria, don't wrap the child; keep the child cool		Increase feeding during and after illness, with additional meals including nutritious foods
C7	What is diarrhoea? What can be done to prevent a child getting a diarrhoeal disease?	6		Three or more watery stools per day		Breastfeed exclusively to 6 months and continue to 2 years
				Wash hands with soap before preparing food, feeding and after changing nappies		Prepare and store food safely; feed only fresh, cooked foods
				Never give unsafe water to drink		Dispose of stools in latrine, and clean baby carefully
C8	What are the danger signs for a child with diarrhoea?	7		Sunken eyes, loose skin		Unable to breastfeed or feed
				Vomiting everything ingested		Lethargic or unconscious
				Convulsions		Blood in the stool
				Stool with rice-water/cholera appearance		
C9	What care guidance would you give a mother of a child with diarrhoea to treat and prevent dehydration and death?	4		Breastfeed frequently and more than usual		Give more fluids than usual
				Give an extra meal a day during and after illness		Give ORS and zinc from a reliable source

No.	Question	Points		Answer		Answer
C10	What danger signs in a child with cough may indicate pneumonia? What should you do?	4		Fast or difficult breathing		Noisy breathing or grunting
				Chest draws inwards when infant breathes in		Take the child immediately to a health centre
C11	What care guidelines should you give a mother of a child with a cough/cold to prevent the child from developing pneumonia?			Wrap the baby warmly		Clean mucus from the nose frequently and wash hands with soap after handling
				Give more to eat – an additional meal of nutritious foods per day during and after illness		Give more to drink and breastfeed more frequently than usual
C12	What signs in the curve of growth indicate that a child may have malnutrition?	2		Reading in the yellow zone, red or below red zone		A flat line or downward curve
C13	What colours in the range of MUAC indicate severe and moderate malnutrition?	2		Yellow = moderate		Red = severe
C14	What are the signs of complicated malnutrition?	2		Marasmus = wasted, baggy pants		Kwashiorkor = Oedema, of extremities or in both legs and feet
C15	Why do children need vitamin A? When should Vitamin A be given?	2		Vitamin A deficiency causes blindness and reduces immunity to disease		Give vitamin A every 6 months from 6 months of age
C16	Why and when do children need deworming medication (Mebendazole)?	2		Worms can cause anaemia, poor growth and disease		From one year old, children need a deworming tablet every 6 months
C17	Why do children need iron-rich foods? Give examples.	2		Children need iron-rich foods to prevent iron deficiency anaemia, 'weakness' of blood		Iron-rich foods include eggs, red meat, green leafy vegetables and iron-fortified grains
C18	What kind of children might you consider to be high risk?	4		Malnourished or low weight children		Children with chronic/recurrent illness such as HIV
				Orphans		Twins
	Maximum points to be gained		Points achieved in questions asked			

Maximum possible points in the questions asked	Points achieved in questions asked	% or Nearly all answers: excellent About half the answers: good Less than half the answers: needs improvement Very few answers: poor

Activity 2: Practise in pairs

Divide the participants into pairs and ask them to practise using the form on each other. Be sure to emphasise that they should not prompt or help but allow the ttC-HV to give the responses. At the end of the session the person acting as the supervisor should also provide feedback on areas of good performance and areas for improvement, and suggest ways to improve the knowledge level.

Summarise the session

- The health knowledge and revision form helps the supervisor assess the health knowledge level of ttC-HVs and suggest ways to improve the knowledge level.

Session 8. Supervision wrap up: Feedback, action plan and follow up

Learning objectives	*By the end of this session participants should be able to:* • demonstrate how wrap up a supervisory session and provide feedback and help the ttC-HV make an action plan. • explain and demonstrate good techniques for communicating that they can use during supervision.
Materials and preparation	*Methods:* • Trainer presentation, discussion, role plays, simulations • Duration – 3 hours *Materials/preparation*: • Coloured paper • Coloured sticky notes

Contextualisation:

Individual supervision methods – In supervision strategies #1 and #2 this method would be included in a supportive supervision conducted by either WV/MoH (#1), or by lead ttC-HVs/COMM (#2). If you are using lead ttC-HVs you might want to simplify language or to extend the training time including more practice so they can grasp the technique. If the lead ttC-HVs/COMMs are not literate it may not be possible to do this.

Group supervision methods – See 'ttC-HV Debriefing Meetings' session.

Activity 1: Introduce the form

Begin by explaining that it is important for the supervisor to conclude the supervisory session by summarising key findings, praising the ttC-HV on areas where performance has been good and helping the ttC-HV make an action plan to improve on areas where performance was below average.

Remind participants that the cases they have supervised must be signed off on the ttC Registers so that they are not taken up again in a subsequent supervision session and also to help cross-verify supervision findings with data in the registers.

Activity 2: Explain the review and feedback process

Carrying out the supervision helps understand the ttC-HVs' home visiting and follow-up procedures, and should guide you through which sections you need to revise.

- Repetition! Repetition! Repetition! Go over each form and repeat, in summary, the feedback you give the ttC-HV.

Giving feedback

- Thank the ttC-HVs for the work they have put in, and remember to give positive feedback. It's important to highlight the good things they have done, whilst not losing the emphasis on incorrect treatment or evaluation.
- Ask them for their own ideas about weakness and improvements they could make.
- Be specific about where you have observed difficulties in their technique, and if possible demonstrate how they can improve.
- Identify other sources of support nearby – another ttC-HV, or support with reading training materials.
- Before you leave, ensure that you have agreed on an action plan for how you wish to proceed, and how the action plan will be assessed.

Feeding back to community representatives

Before leaving the community, ensure that you report to the COMM (where there is one) or to the committee of elders/community chiefs (if there is not). Share with them (if the ttC-HVs are happy for you to do so) the outcomes of the supervision and the actions that you have agreed upon.

Summarise the session

- The feedback session helps the supervisor and the ttC-HV to recap key findings from the supervisory session, both positive and negative. It helps both to agree on a follow-up action plan in areas that need improvement.
- Remind participants that they will carry out the feedback session during the field visit as part of this training.

Session 9. Supervision in the community

Learning objectives	*By the end of this session participants should be able to:* • correctly conduct the supervision using the releavant forms in the context of real ttC-HVs and households. • understand practical issues and ways to resolve them.
Materials and preparation	*Methods:* • Simulation of an individual supportive supervision visit in a nearby community. • Duration- 3 hours *Materials/preparation* • Identify a nearby community where ttC-HVs are active. • Inform community leaders/COMM members about the nature of the visit and what it will involve. • Plan logistics to get the group to the community. • All participants to bring their own manuals • One set of ttC supervision forms per person • Clipboards and pencils • Notebooks

Activity 1: Pre field-visit briefing

- Brief supervisors about the logistics of getting to the community.
- Give supervisors a set of forms to take, and clipboard.
- Describe the process and how long it will take: The entire group will travel to the selected community, meet with the COMM and tell them about the supervision in brief, then meet with the ttC-HVs. They will then carry out the supervision using all the five forms, and end with providing feedback to the ttC-HVs.

CONSIDERATION FOR PREPARING A COMMUNITY:

- Select a community close the training venue that has multiple ttC-HVs operating (at least 3-4), depending on your training group size. You need onettC-HV per 6 supervisors to do this well.
- Travel to the community in advance, or call and request that 3-4 ttC-HV participate in the supervision training, explaining that this will take 3-4 hours of their time, for which they should be compensated.
- Preferably select ttC-HVs that are reasonably comfortable with the ttC approach to participate.
- Materials needed**:** clipboards and pencils, erasers, flipchart and stand, camping chairs if available, water and refreshments, good shoes and appropriate weather clothing.

Activity 2: Supervision visit process *in situ*

THE SUPERVISION VISIT FROM START TO FINISH

- Arrive in the community and find the ttC-HVs you will be supervising.
- Collect their registers.
- Conduct a performance audit using the registers.
- Conduct a single spot check (in normal context they will do 3–5 cases).

- Conduct a single observation case assessment with the ttC-HV.
- Conduct a health knowledge check.
- Carry out data collection (not including in these guidelines).
- Give feedback and make an action plan.
- Share the outcomes of the supervision with the COMM or chief.

Debriefing for trainees: After each section have a feedback session and discuss how things were done.

Instructions for carrying out the activity

Before starting:

- Break out into groups of *no more than* six supervisors per trainer.
- Speak with the ttC-HVs and community representatives and explain the purpose of the exercise: i.e. that there will be a large number of observers for each demonstration, and that this is to help build the supervisor's skills. If they are not comfortable, select one of the *supervisors* to perform the role of the ttC-HV for an observation of service delivery, as this may be too terrifying to work in front of so many supervisors. Similarly, ask the ttC-HV to select a household that they feel would be comfortable participating in the training exercise.

Conducting the demonstration:

- Begin the training exercise by simulating the supervision as it should happen, with the ttC-HV. Choose an appropriate location for each group either near the ttC-HV's home, or in a school or common space. Always return to this space for the debrief.
- Create a time for troubleshooting by asking questions about the issues that the HV has encountered or any difficult case they need help with. (Explain – you don't need to actually do the troubleshooting at this time, but if urgent issues emerge take appropriate actions to ensure support).
- **Performance Audit** – conduct together in the group using the registers that the HVs have currently.
- **Conduct Case Spot Checks** together in a group. Select a *different* household that has recently had a ttC-HV visit. Select one person to interview the family, but have *all of the supervisors* complete the checklist whilst listening to the family member report. Importantly – do not allow any chatting or conferring when this is happening and make sure they listen well. Return to the central location to debrief.
- Conduct one **Observation of a Home visit**, but have *all the supervisors* complete the checklist as they observe. Return to the central location to debrief, compare the results and clarify any issues.
- If included, conduct a brief **Health Knowledge Check** (no more than five questions on this occasion) and demonstrate how this activity is useful to pulse-check the HV's knowledge on specific topics.
- Note**:** If you are collecting data and analysing in groups (which most will be), data analysis will happen in a group setting, and will need to be *learned by doing*.
- **Give feedback:** This individual feedback should be based on the observations in these activities. Refer to the guidance on 'giving feedback' under supervision skills to make sure they are able to demonstrate those skills in action. Ask the group to consult together, and to select their top priority feedback points for 'what went well', then ask a volunteer to come up and present each positive feedback point and encouragement to the HV. Ask the HV how that went, how it made them feel. Then ask them to identify

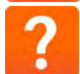
any IFAs- Improvement Focus Areas, identifying what the HV might be struggling with. Resume the 'What-why-what-how' dialogue approach. Selecting one of the IFAs per volunteer, get a supervisor to engage the HV in a discussion about that area. Ensure they identify any problems, root cause, and that the HV themselves propose the solutions, then concur an action point for each IFA. Have the group agree on the action plan together.

- **Feedback to the COMM representative or chief:** This may be contextual, but it is good courtesy to invite the chief or COMM representative to know the outcome / action plan. Ask for volunteers to demonstrate sharing the positive feedback and action plan in a group setting.
- **Debrief** the activity and return to the training venue to close.

Session 10. ttC-HV debriefing meetings

Learning objectives	*By the end of this session participants should be able to:* • write a plan for monthly debriefing meetings with their ttC-HVs. • describe the components of report-back and discussion, data collection and record keeping, and supportive problem solving and issues resolution.
Materials and preparation	*Methods:* • Discussion, brainstorming, group work, individual practice, role play • Duration – 1-2 hours *Materials/ preparation:* • Sample agenda • Blackboard and chalk or flipchart

Activity 1: Planning the debriefing meeting: logistics



Ask: Why is it important to meet with the ttC-HVs the participants are supervising regularly?

Have a discussion with the participants about the logistics of the debriefing meeting. Tailor the discussion to the individual situations of the supervisors present. **The purpose of this discussion is to find out if the supervisors will have difficulty organising the debriefing meetings, so that solutions may be proposed.** The purpose is **not** to 'train' the ttC-HVs in logistics. Find out the following:

- How widely dispersed are the ttC-HVs that they are supervising?
- Where will the debriefing meeting be held?
- Is there a need for ttC-HVs to travel to the meeting, and if so, how will transportation be handled?
- How far/how long would the most distant ttC-HV need to walk to attend the meeting?

Debriefings should ideally be done quarterly. Try to sort out these issues with the participants.

Activity 2: Planning the debriefing meeting: agenda

Ask the participants what they think should be covered during the meeting, and list their ideas. For the most part, you should accept the ideas that participants come up with in terms of what to include in the sample agenda, as these will be their meetings and they should feel empowered and in control of them. Although the COMM may lead on certain elements of debriefing meetings, the supervisors will be able to influence the supervisory elements. ***Then have the participants look at the* Sample agenda *on the next page.***

SAMPLE AGENDA FOR DEBRIEFING MEETING

Part I : Group meeting

- Welcome and announcements
- ttC-HVs' reports and discussion
- Successes
- Challenges
- ttC-HVs' reports on household-level barriers
- ttC-HVs explain the barriers
- Group discussion about possible solutions or actions
- Any other business
- Date of next meeting
- Closing and prayer

Part 2: Supervisor meets individually with ttC-HVs

- Collect Data Collection Tools (if this is not done in group setting or community visit)
- Support the ttC-HV and assist with problems, as necessary
- Any disciplinary issues
- Set date for supervision, as necessary

Activity 3: ttC-HV report-back, issues and support

Explain: one of the purposes of debriefing meetings is to provide an opportunity for the ttC-HVs to talk about their experiences during the reporting period. Refer to the agenda(s) that developed, and point out the items that in some way refer to ttC-HV report-back.

- Here they will see that the ttC-HVs should be asked to relate not only their challenges and constraints, but also their successes! In fact, they should try to always begin with positive experiences, before getting into the problems. Ask one or 2 volunteers now to share something positive that has happened to them during their work as ttC-HVs!
- Finally, have a brief discussion with the participants about the types of problematic issues the ttC-HVs might raise, and the ways that the supervisors might respond.

Activity 4: Review of household-level barriers and response

Explain: ttC is about identifying the barriers to healthy practices that households experience. ttC-HVs will collect the information about significant barriers, or report these to supervisors verbally.

Ask the participants to give eight to 10 examples of barriers they have identified in their work already.

WHEN TTC-HVS REPORT A BARRIER TO THE SUPERVISOR THERE ARE SEVERAL ACTIONS TO BE TAKEN:

If the barrier pertains to only a few cases

- Help the ttC-HVs identify possible solutions to individual barriers.
- Potentially help them speak to the family if there are difficult issues.

If the barriers are not solvable in the family and pertain to many cases

- Give feedback to the COMM about common or difficult barriers.
- Give feedback to the CVA or the health facility if the barriers pertain to them.

The table below has some sample cases. Work through these and ask participants to determine a possible response. Then go back and review the examples they have given.

Example of a barrier	Supervisor's response
A woman cannot go to ANC (antenatal care) because the husband will not agree to pay the transportation costs; the ttC-HV has not been able to convince the husband.	a) and b)
A woman will not take iron tablets because they make her constipated and uncomfortable.	a)
Many women in the community refuse to deliver their babies at the local health facility because they say that one of the midwives has been abusive in the past.	c) and/or d)
The ttC-HV reports that after several referrals they have found that children are not always getting medicines they are prescribed when they are sick because the clinics and pharmacies are out of stock.	d)

For each of these actions above, also ask the participants to think of some instances when they have taken these actions from their own experiences. Ask for volunteers to present their cases and how they addressed them. Ask them to explain what the outcomes were.

The idea is that difficult barriers are addressed during the debriefing meetings. During the meetings, it is important that the ttC-HVs report on the barriers that the households are experiencing – especially those that are difficult to address. This is a good opportunity to talk about them together and decide if there is any action they can take as a group to help out.

Activity 5: Role play debriefing meeting

For this activity, you will need eight to 10 volunteers who are willing to do some preparation and practise overnight. Explain that you would like them to role play a debriefing meeting of the supervisor with the ttC-HVs. They should select one volunteer to play the role of the supervisor, while the others play the ttC-HVs.

- Tell the volunteers that they should look at the Sample Agenda. They should carry out Part 1 , the group meeting, all together. Then they will select one volunteer for Part 2, individual meetings.

Note: *Although the supervisor will role play collecting the forms from the ttC-HV, she will not actually do all of the record keeping, as that would take too much time. In the role play, they can pretend that they are filling in her forms, and then discuss the results with the ttC-HV.*

The volunteers will carry out the role play in front of the rest of the group at the beginning of the next day. **Have them write the agenda on a flip chart.** Remind them of the following points that help to make a role play effective:

- They should not have their backs to the audience. This means they cannot sit in a circle but rather, probably, a semi-circle.
- They should speak very loudly! In a real meeting with only a few people it might not be necessary to speak loudly, but in this case they want to make sure that the audience can hear them clearly.
- The role play can be funny, but they must make sure that they are demonstrating a meeting accurately.

After the role play, debrief with the participants. What did they learn from the role play? How do they feel about their ability to hold debriefing meetings with the ttC-HVs they will be supervising? Answer any questions they may have with regard to the structure of the meeting or, indeed, to anything that was covered in this session.

Summarise the session

- The debriefing session is a regular meeting by a group of HVs which is designed for participatory learning and planning as well as management of home visitor's work plans and a chance to interact with COMMs.

Session 11. Group supervision

Learning objectives	*By the end of this session participants should be able to:* • Describe how they will conduct a group supervision meeting together with the lead-ttC-HV • Describe how the components of reporting and discussion, data collection and record keeping, and supportive problem solving and issues resolution will take place.
Materials and preparation	*Methods:* • Discussion, brainstorming, group work, individual practice, role play • Duration – 1 hour *Materials/preparation:* • Group Supervision tool – 1 copy per participant

Contextualisation: This session is not required for those NOs opting for supervision strategies #1 and #2. This can be a 'soft' rollout, as the lead ttC-HVs will need practical experience in a real-life situation. There may not be a need to conduct a training session/practical on group supervision but the first event will be more of a learning exercise conducted alongside project managers/supervisor of supervisors.

Activity 1: Introduce the topic

Review with participants the challenges of individual supervision in their contexts. Introduce the concept of 'lead ttC-HVs' and how the task of supervising will be shifted partly to them.

A LEAD TTC-HV:

- is an experienced ttC-HV who has a proven track record of good practice and understanding
- may have some additional skills such as literacy and numeracy which enable her or him to provide data monitoring and support, e.g. tallying data from groups
- may have been elected by the group to perform the tasks
- may have undergone special training and mentoring to fulfil this role well.

Activity 2: Review key recommendations

Organise small groups: five to 10 per supervisor

For the process to be of value to the supervisees, ensure that group sizes are small, with between five and 10 supervisees per supervisor if possible. In a group of more than five people it becomes progressively more difficult to engage each member in a meaningful way.

Allow sufficient time for each member of the group

Consider that if the process were to take one hour, for a group of 10 that means only six minutes per supervisee, which is not sufficient to cover all elements of supervision.

Take a basis of 20 minutes per person for meaningful supervision:

- Group of 5 ttC-HVs ➔ 20m per ttC-HV ➔ 1h40m supervision

- Group of 10 ttC-HVs → 20m per ttC-HV → 3h20m supervision
- Ensure good moderation skills of the group supervisor

To provide valid feedback at the level of the individual in a group context you will need to create an environment in which input and feedback can be moderated effectively, nurturing the exchange of ideas and sharing better practices amongst groups. This in itself requires the supervisor to be a talented mediator. In practice, supervising in groups can mean that those most in need of supervision will not be heard above those most vocal. Supervisors require good mediation and moderation skills to ensure that all ttC-HVs have the chance to feed into discussions equally.

Identify issues in a group setting: follow up individually

The supervisor needs to ensure that when issues are raised in the group setting (such as identified issues with current practices or techniques, or problems they might be experiencing with cases), those issues will be followed up with a programme of individual support where needed. If someone is struggling, it's not good to make an example of that person before the group; offer additional time for one-to-one discussion if that's required. Another way this can happen is to schedule a follow-up phone call, or arrange for a lead ttC-HV to give additional support in areas where someone is struggling.

SAMPLE AGENDA FOR GROUP SUPERVISION

Activity and order	Process description	Time spent (depending on group size)
Arrival and group allocation	Each individual is allocated to a group; each group will nominate one or two 'lead ttC-HVs' or allocate a ttC-HV who will collect the completed reporting forms. The HVs will stay in these groups every supervision meeting.	NA
Data submission audit and verification	If able, lead ttC-HVs will tally the completed forms for each supervisee, using the ttC tally sheet, audit the record-keeping process and offer support as needed. This would be a literate or more experienced person. If this is not possible then the supervisor would need to support this role. Data entry starts at this point and should be completed in time for the report-back (using a wall chart). * In the 2nd and 3rd supervision events, the lead ttC-HV from each group should complete this process before the meeting starts, in order to save time.	20 min*
Report-back (case load)	Each supervisee has five minutes to give a brief summary of progress during the previous supervision period: • new registrations • planned and completed visits • referrals • deaths	30–60 min
Barriers and challenges discussion (troubleshooting),	As required, each ttC-HV has time to present one ttC practice he or she has found has significant barriers, and one key challenge experienced in the previous supervision period. Ideas may include: *Difficult ttC practices:*	20–40 min

<table>
<tr><td>better practices identification</td><td>uptake of family planning/birth spacing
voluntary HIV testing
skilled birth attendance in a health facility
Key challenges:
reaching households and coverage
family/male participation
ttC techniques
referrals and linking services
high-risk cases and how to work with them
The supervisor will use these challenges to foster discussion amongst the group members, encouraging the sharing of ideas and better practices.
Supervisees are encouraged to report any better practices or ideas they have had from their experience. Supervisors are to moderate discussion and highlight positive approaches.</td><td></td></tr>
<tr><td colspan="3">Break – 30 min</td></tr>
<tr><td>Simulation and practice</td><td>Depending on the needs of the groups, this process may be most valuable at the start up of the programme. The supervisor will nominate pairs to give and receive counselling in a simulated context. Use the observation assessment tool to assess individuals, and use group discussions to share better practices and techniques.</td><td>30 min</td></tr>
<tr><td>Health knowledge and skills coaching</td><td>Use the health knowledge assessment tools to quiz individuals in the group on health knowledge.
Use this method and the requested themes of the group to identify weak areas of skills or knowledge; then use this section to do revision and practice. If individual needs are greater, arrange for follow up or support, or plan to do individual support supervision in the community.</td><td>30–40 min</td></tr>
<tr><td>Data interpretation and action planning</td><td>By this point the tallied data will have been collected.
Collate the health outcomes data and give immediate feedback, in terms of focus and priority cases to work with.
Feedback on COMM reports.
Collective identification of priority areas, and planning for action.</td><td>10–20 min</td></tr>
<tr><td>Any other business, close</td><td>Offer a time for any other issues to be discussed and close the meeting as appropriate.</td><td></td></tr>
<tr><td colspan="2" align="right">Total time spent</td><td>2–3 hours</td></tr>
</table>

Activity 3: Introduce and review group supervision tool

Contextualisation: Adapt this template to include only those forms that you have selected for your NO, particularly if you are using supervision strategy #3.

Explain to participants that this is a tool for summarising findings for each ttC-HV following group supervision. This serves as a record and a reminder of follow-up actions based on findings from the supervision. Read through the tool, along with participants, pointing out the forms that are covered during group supervision.

Sample tool for group supervision (enlarge for printing)

Section	Item	Result and comments

• Identification	Name of ttC-HV		
	ID number		
	Location of service		
• Performance	Data audit score		*Observations in data management/reporting*
	Current case load #		
	Schedule visits last period #		
	Completed visits for the last period #		
• Report-back	New registrations		*Observations in report-back*
	Emergency referrals		
	Deaths		
• Barriers and challenges discussion	Barriers to health		
	Challenges		
	Positive experiences/practices		
• Simulation of home visit observation	Use observation assessment tools. Overall score		*Observations in simulation practical exercises*
• Health knowledge and skills coaching	Use health knowledge tools. (Give score or comment if done in group.)		*Observations in health knowledge and skills*

Summarise the session

- Group supervision involves active or lead ttC-HVs supervising small groups of ttC-HVs. This approach can include performance audit, discussion on barriers and solutions, simulation of a home visit and its observation, and health knowledge assessment.

Session 12. Individual performance appraisal

Learning objectives	*By the end of this session participants should be able to:* • explain the purpose of annual performance appraisal of individual ttC-HVs • demostrate correct use of the tool used for the purpose of assessment of competencies during the appraisal period.
Materials and preparation	*Methods:* • Group practice and discussion • Duration – 1 hour *Materials (for each participant):* • Individual Performance Appraisal tool • Filled out supervision forms from previous sessions

Activity 1: Introduce the topic

In keeping with standards, individual performance appraisal should be done once per year. The performance appraisal should include both a review of quantitative performance data – using the data from consecutive supervisions over that period of time. It should also include a qualitative component which looks at the competencies of the individual to perform their tasks. The supervisor should take the reports from previous individual supervisions and use them to complete the competencies assessment below.

The appraisal process has three parts: The ttC-HV does a self-assessment of the various components of the tool, followed by an assessment by the supervisor, using data from all supervisory sessions. As the final step, the supervisor and ttC-HV make a joint assessment of each component and arrive at a performance score.

Activity 2: Review the tool

Explain the format of the tool, pointing out that the tool is organised around the core competencies as the ultimate purpose of ttC supervision is to assess and improve core competencies in ttC-HVs. For each competency, the ttC-HV gives a self-assessment score of 0 to 3, where 0 = poor, 1 = needs improvement, 2 = good and 3 = excellent. The next column is for noting which supervision form was used to assess the competency area. This is followed by a column for noting the most common performance score taken from the supervision sessions of the appraisal period. The last column to the right is for a joint assessment by the supervisor and the ttC-HV, using the same performance scale of 0 to 3. The most useful supervision forms and methods for assessing the competencies, listed in order of appearance of the competency areas, are:

- Home visit observation assessment
- Home visit observation assessment and performance audit
- Review of records
- Health knowledge assessment and revision
- Case evaluation/spot checks
- Feedback from COMMs
- Participation in debriefing meetings/group supervision.

At the end of the tool, there is space for noting observations from COMMs and specific areas for improvement.

FORM 5 INDIVIDUAL PERFORMANCE APPRAISAL (competency assessment)

Core competencies for ttC 0 = poor; 1= needs improvement; 2 = good; 3 = excellent		ttC-HV self-assessment 0–3	Observed in supervision form ✓×	Supervisor's assessment 0–3	Overall performance assessment
1. Communication and counselling skills	Building rapport with families				
	Active listening				
	Negotiation and dialogue				
	Use of job aids and materials during process				
	Barriers analysis				
2. Handling of referral cases	Recognition of symptoms and danger signs				
	Referral and Follow up				
	Interpretation of counter referral				
3. Record keeping	Referral forms				
	Record keeping and reporting				
	Use of the household handbooks				
4. Health knowledge	Healthy pregnancy				
	Essential newborn care, postpartum care and danger signs				
	Breastfeeding counselling and support				
	IDS and growth curve interpretation				
	Childhood illness				
	Complementary feeding and child nutrition				
	High risk children and households (HIV, TB, OVC)				
5. Other	Timeliness of visiting, punctuality				
	Supportive care for vulnerable families				
	Use of initiative and problem-solving skills				
6. Community involvement	Engagement with other Community health actors, COMM and others				
	Community trust and value perception (feedback)				
	Community sensitisation and health promotion activities (group based)				

Summarise the session

- Individual performance appraisal of ttC-HVs is to be done annually and is based on the results of supportive supervision sessions carried out through the year. It helps to bring recognition to the role of the ttC-HV and keep ttC-HVs motivated to continue.

PART 4: ROLE OF THE COMMUNITY HEALTH COMMITTEE (COMM)

BACKGROUND FOR THE FACILITATOR

Part 4 reviews the responsibilities of the community health committee (COMM) with regard to support and oversight of ttC-HVs (and other community health actors). All COMMs will carry out the basic functions reviewed in this part.

This section follows the outline of the ttC-HV Programme Functionality Matrix. The COMM has a direct role to play in most, but not all, of the matrix components. The purpose of this section is to review each matrix component so that the supervisors can understand the COMM's roles and responsibilities in supporting ttC-HVs for each component, and to identify areas of overlap and interaction between the supervisors and the COMM.

Contextualisation: You will carry out Part 4 when the ttC-HVs' supervisors – the participants in this training – are not the COMM. If the COMM is directly supervising ttC-HVs – and the COMM members are the participants in this supervision training – you will not carry out Part 4. The COMM will have already been trained in the responsibilities detailed in this section, using separate training resources.

COMMs have an oversight function for all ttC-HV-based programming, supporting all community actors in health. In their larger role of supporting ttC work, the supervisor connects with COMM at several points:

- sharing the results of the supervision and outcomes
- sharing data from the ttC programme with the community
- dealing with an inactive ttC-HV
- dealing with grievances raised by households
- assuring follow up of action plans after supervision
- assuring follow up of action plans after performance appraisals
- informing COMM of recurrent barriers to health encountered by ttC-HVs so COMM can address them
- informing ttC-HVs about other community health actors and activities and enabling cross-programme integration at community level.

The training sessions that follow address the specific roles of the COMM in terms of its contribution to the supervision of ttC-HVs. It does not capture their roles in terms of other community health actors and programmes, all of which are detailed in the COMM training documents themselves.

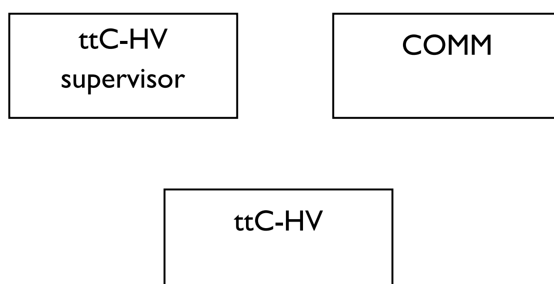
Session 13: COMM support to ttC-HVs

Learning objectives	*By the end of this session participants will be able to:* • understand the role of COMMs in supporting the supervision and strengthening of ttC-HVs.
Materials and preparation	*Methods:* • Discussion, brainstorming • Duration – 1 hr 30 mins *Materials:* • COMM Guidance document or relevant sections

Contextualisation: If another terminology is used for COMM, such as village health committee or a local word, please replace COMM with the appropriate word throughout.

Activity 1: Discuss what participants already know

Explain that supervisors and COMMs have different responsibilities regarding the ttC-HVs. It is important to know what these are and understand when the supervisors and the COMMs will share responsibilities, and to interact together in support of ttC-HVs. Set the stage for this activity by writing (or drawing) the following diagram:



Ask the participants to draw arrows amongst these three and describe:

- what their relationship is, division of responsibilities amongst them
- how they interact
- what process is involved.

Explain that ttC-HVs are accountable to, and supported by, their supervisors – and that has been the topic of this training. At the same time, however, ttC-HVs are also accountable to, and should be supported by, their communities. This can happen best when a village health committee – or other similar name – exists in the community. These groups come under different names; for purposes of this document, they are COMMs.

Ask: What do you know about COMMs? Who comprise the COMMs and at what level they are based? Has anyone has had a work-related interaction with COMMs they could describe to the group?

Lead a brainstorming session about the roles of COMMs in supporting ttC-HVs. Write the ideas on a flipchart.

Activity 2: Roles for the COMM

You may do this activity in plenary or by dividing into groups and assigning each group a type of responsibility from the chart below.

For each type of responsibility the participants should indicate which of the following roles fall to the COMMs, which (if any) are up to the supervisor and where Supervisor-COMM interaction will happen.

- sharing the results of ttC supervision and outcomes
- sharing data from the ttC programme with the community
- dealing with an inactive ttC-HV
- dealing with grievances raised by households
- assuring follow up of action plans after supervision
- assuring follow up of action plans after performance appraisals
- informing COMM of the recurrent barriers to health encountered by ttC-HVs in their community so they can address them

Type of responsibility	COMM roles	Supervisor roles	COMM-Supervisor interaction
1. ttC-HV recruitment	• Encourage community participation in the recruitment of ttC-HVs • Engage community when either new or replacement ttC-HV candidates are selected from within the community • Mediate community meeting for final selection	The MoH will choose qualified candidates based on the criteria agreed upon for ttC-HVs based on ttC minimum standards	Supervisor makes sure the COMM knows the MoH criteria for recruitment
2. ttC-HV roles and written agreement	• Understand ttC-HV's activities and what the expectations of the role are • Prepare and store copies of any written agreement if necessary	Ensure agreements are done	Give the signed agreements to the COMM
3. Initial and ongoing training of ttC-HVs	• COMM does not train ttC-HVs but need to be aware of training they receive	Supervisor is sometimes also the trainer of COMM	Informs COMM of any training
4. Equipment/supplies	• Ensure that, if any supplies are distributed via the ttC-HVs to households, COMM can monitor the stocks according to the national stock system	Supervise stock (not standard for ttC)	2-way reporting of any stock problems found
5. ttC-HV support	• 'Buddy' system of support to ttC-HVs can be advantageous		Share results of ttC-HV supervision
6. Performance appraisal	• Contribute to individual performance appraisals • Follow up on performance action plans to ensure they are put into place	Deal with inactive ttC-HV	Share results of ttC-HV supervision Supervisor consults COMM on action re: inactive ttC-HV

7. Incentives	• Ensure ttC-HVs receive recognition and rewards for doing well, and if not, ensure that actions are taken in line with community expectations • Oversees any distributions according to country policy	If there is a performance-based element of incentives, supervisor may feed into that using data/feedback	Communicate about the incentives provided
8. Community involvement	• Ensure the community is aware of and engaged in the ttC-HVs' work and advises on overcoming barriers to community involvement where needed	Seek feedback from the community on the work of the ttC-HV	Give feedback from the community to the COMM if relevant
9. Referrals	• Understand the referral system so that it can support proper functioning • Strengthen weaknesses or advocate for their strengthening if it requires action from outside entities, such as the MoH • Track and investigate adverse events, including deaths or near misses, misconduct at the clinic in terms of health worker behaviour, stock shortages or overcharges, to discover their causes and plan to address them • Establish community support for referrals (e.g. an emergency transport fund or identifying alternative transport)		
10. Opportunities for advancement	• Approve advancement of ttC-HVs through the performance appraisal system	Inform COMM of any opportunities	Together select candidates for advancement
11. Documentation, information	• Store a copy of the EWG register • Review programme data/reports and include analysis in their action plans • Feedback on reports to CVA if needed	Collect and tally data	Provide reports to COMM via DHMT/health authorities or project staff
12. Debriefing meetings	• Help to coordinate meetings • Participate in discussions and action plans	Contribute to and/or facilitate meetings	Participate in joint planning

Activity 3: Disciplinary processes – dealing with inactive ttC-HVs

Ask: Do your ttC-HVs have a written agreement or understanding regarding their activities? What is the purpose of this and what does the agreement include?

Explain, and distribute an example (if available) to the supervisors.

THE WRITTEN AGREEMENT INCLUDES:

- who the agreement is between
- dates of validity
- all ttC-HV responsibilities (i.e. the ttC-HV's roles)
- child protection protocols*
- codes of conduct
- an estimate of the time commitment for ttC
- an understanding of the process of replacement in the event of inactivity.

*World Vision Child Protection protocols are provided by NOs, and elements can be included.

Explain that the purpose of the written agreement is that there can be clarity about the time commitment, the activities and the expectations in terms of behaviour.

Ask: What happens when a ttC-HV does not conduct the activities according to the plan? Does this happen a lot? What might be the reasons for this?

Write the answers on the flipchart. Answers might include the following:

- unrealistic time commitment
- burden of other tasks is too great
- ttC work is too difficult
- ttC-HV was not the right candidate.

The attrition of ttC-HVs may be due to workload, time or loss of motivation; therefore a 'disciplinary' approach may not be relevant, and supervisors should take every step to help them overcome their barriers. Many may start with good intentions but over time find they are unable to meet the commitment.

Ask: What steps should be taken before we consider replacing a ttC-HV with a new one?

DISCIPLINARY PROCEDURES/STEPS TO REPLACEMENT

The following are some examples of work agreement violations which would trigger disciplinary action:

- non-participation in trainings or supervision events
- non-availability due to other commitments
- non-treatment of patients
- disputes in the community.

When disciplinary action is required repeatedly by the same ttC-HV, the COMM and/or the ttC-HV supervisor should follow these steps:

- Conduct root-cause analysis to understand why the issue has arisen.
- Give support to overcome the difficulties.

If the problem continues with no effort to improve performance then proceed:

- Step 1: A verbal warning from the supervisor
- Step 2: A verbal warning from the health facility lead
- Step 3: Discussion with the COMM
- Step 4: Suggested replacement of the ttC-HV

Activity 4: ttC-HV support by the COMM

Note: *If the COMM is directly supervising ttC-HVs, the COMM will receive training on ttC so that it can competently supervise the ttC-HVs' activities. It will also become familiar with the forms the ttC-HVs use for ttC so that it will be able to recognise if something is not being done correctly. If the COMM is not supervising ttC-HVs, the COMM will play a supporting role only. In these cases, please use the word 'support' to emphasise this.*

Buddy system – Applies only when COMM is not the supervisor

Explain that when working with COMM, creating a **buddy system** will help build relationships and make support easier and more productive. This means that each CHW can be 'buddied' with a COMM member who can give them support, especially in getting started. When people build a history together it is much easier to grow from there. Supervisors can help the COMM decide how it will match 'buddies' as the COMM begins to work with this system. Ensure that every ttC-HV is linked to one COMM member and that time is made to informally ensure that they build connections. COMM members may choose to pair with ttC-HVs they know well or ttC-HVs they don't know well. It is up to the COMM (and the context) how the buddy system will be set up. Explain that the COMM members will support their 'buddy' ttC-HVs through:

- issue resolution and troubleshooting
- follow up if the ttC-HV's supervisor is not doing her or his job
- noting and attempting to address grievances or problems the ttC-HV has
- providing input on individual performance appraisals
- helping the ttC-HVs to overcome any difficulties they have in reaching their potential.

Point out that COMM members might find it useful to shadow their 'buddy' ttC-HVs sometime during a home visit. If a ttC-HV is not performing to the standards laid out in the written roles and agreement, the COMM needs to address it, even if this only means alerting the supervisor.

Activity 5: Recognition and appreciation (incentives)

Contextualisation: Find out what incentives ttC-HVs are intended to receive in the programme. Remember that World Vision does not recommend that incentives be determined on a project basis, due to the effect of potentially causing competitive practices amongst different non-governmental organisations (NGOs) or MoH. We recommend incentive systems (including non-monetary) that are harmonised under a unified government policy, where one exists, or are agreed amongst all NGO partners operating within a country or district. If you have a financial incentive system in place in your country, then you should adjust this section to make sure supervisors understand their roles in determining the amount or in distributing the incentives.

Ask: What are incentives and what role do they play?

Ask: What type of incentives exist?

- monetary
- non-monetary
- appreciation/community recognition

Community recognition

Explain:

- **Public recognition** and expressions of appreciation by the community are also a form of incentive. COMMs are involved in working with communities to determine forms of recognition.
- Point out that ttC-HVs can receive public recognition and motivation in a **wide variety of ways**. For example, if a particular ttC-HV excels at persuading families to adopt the 7-11 practices, having her share her methods with her peers in a meeting or workshop will recognise her exceptional skill and enable her to share that skill with others.

Ask: What can we do if we notice that one of our ttC-HVs is doing particularly good work and is not yet being recognised for it?

Write their answers on the flipcharts and agree on steps towards encouraging recognition, led by the COMM.

Gifts-in-kind from families

Explain:

- Community members should not be encouraged by WV to give money or gifts as in-kind payment for service. Why might this be?
- Encouraging ttC-HVs to accept **gifts-in-kind** could cause a problem: money and gifts can skew a system that provides free services to all users. Community members who cannot afford to give anything can miss out on care. Emphasise that **the services of ttC-HVs should be free to all users**. Furthermore, ideally the ttC-HVs should prioritise their care towards the households that are poorest, most isolated and most vulnerable (i.e. those least likely to be able to give gifts), but if ttC-HVs become dependent on gifts of cash or food, that might skew their priorities.
- Discuss the cultural norms for gift giving in your context: What do we consider to be acceptable, and when might we consider taking action or speaking to the ttC-HV?
- If supervisors notice this happening, they must talk with people involved and discourage it, explaining why it creates problems and should be avoided. If it becomes a problem, they must report it to the COMM.

Summarise the session

- Community health committees are very important in the management of ttC programmes as they have multiple roles in supporting their work and ensuring good quality.
- Supervisors need to interact with the COMM on multiple issues and regularly debrief COMM on what they observe during supervisions and monitoring.
- When dealing with non-participation or inactivity of ttC-HVs, supervisors, together with COMMs, will take gradual steps through an agreed process defined in a written agreement with the ttC-HVs. COMMs are ultimately responsible for managing grievances.
- Where COMMs are not supervisors, ttC-HV could also have 'buddies' within the COMM who can provide extra support.
- Supervisors who are aware of exceptional efforts of ttC-HVs should inform the COMM and encourage recognition and appreciation of efforts on a regular basis.
- Regular gift giving by families for ttC-HVs is to be discouraged as this has a risk to skew the priorities of the ttC-HVs from the families most in need.

PART 5: SUPERVISING THE SUPERVISORS

Learning objectives	*By the end of this session participants should be able to:* • understand how supervisors will be supervised during the project. • be able to explain when and how they will be supervised, what to expect during supervision and what support they could expect from their supervisors.
Materials and preparation	*Methods:* • Discussion and brainstorming, experience share • Duration – 1 hour

Activity 1: Introduce the session

Ask: what support they would need as supervisors of ttC-HVs to carry out their work effectively. Review responses and ensure that the following are covered:

- Feedback on the completeness and quality of the supervisory work
- Help in improving in areas of weakness
- Sharing lessons and best practices with other supervisors
- Feedback from ttC-HVs on how supervision helps in their work and how it can be further improved.

Activity 2: Discuss the process

Supervision of supervisors needs to be undertaken at least once per quarter, by WV project managers or managerial staff in MoH. This is a minimum set of activities that supervision will involve.

SUPERVISION OF SUPERVISORS

Roles of managers/supervisors of ttC-HV's supervisors

- **Meet with supervisors** at least once a quarter to
  - collect completed supervision forms and review them for completion, quality of feedback provided and continuity in the supervisory support provided to a ttC-HV, etc.
  - review quality and completeness of ttC-related data that supervisors compile
  - compare data across several supervisors
  - share best practices and lessons.
- Carry out a supervisory support visit at least twice a year to:
  - observe a supervision session and provide feedback to the supervisor
  - obtain feedback from ttC-HVs on how supervision is benefitting them and how it can be further improved (as part of the supervision support visit)
- **provide remote supervision support**, reactively (for example, over phone).

They can build this activity into other field-level work that the managers do – such as visiting child health days or outreach campaigns.

Summarise the session

- Supervision of supervisors by WV/MoH managers helps supervisors improve their skills, learn from other supervisors and obtain feedback from the ttC-HVs they supervise. This supervision should ideally combine quarterly review of data and twice-yearly direct observation of supervision.

 Insert MOH logo here	TTC Supervision Forms	Date of Supervision	
		Supervision period	From:_______ To:______
		ttC-HV / ttCHV name	
		Community	
		Signature /mark of ttC-HV	
		Supervisor name	

FORM 1 PERFORMANCE AUDIT

This form can be modified to include all the relevant data fields that need to be collected during supervision.

Basic Performance Data						
Case Load	**Eligible women and girls**	**Current registered pregnancies**	**Births**	**Registered infants (1-6m)**	**Registered children (6-23m)**	**Total case load**
Total number # (case load)						
# of cases referred			*Facility births*			
# referrals completed / followed up						
# planned visits for this period						
# completed visits for this period						
# of visits in which male / birth partner present						
		# visited in early pregnancy (16th week)	# visited 3 times in first week			

Reason for low activity	Activity level of ttC-HV during supervision period		
☐Temporary absence ☐ Permanent absence / drop out ☐ Illness or travel ☐ Difficulties with ttC schedule ☐ other (indicate what)	0-50% = poor 50-75 % = needs improvement 75-100% =good >90% excellent OR (delete as applicable) Less than half = poor About half= needs improvement More than half = good Nearly all = excellent		**% completed TTC visits**
			% male / partner participation
			% referral / follow up completion
			% early registration in pregnancy
Overall Performance Level (Excellent, Good, Needs improvement, Poor)			

FORM 2 CASE EVALUATION (Spot Checks)

Home Visit Interview of Mother Randomly select up to five recently visited **families** from the ttC register (one from each of the categories listed under 'client type' if possible) then conduct the home visit and interview the mother, about the ttC-HV's most recent visit to the household. Always ask for consent. If the family is not home or does not agree to an interview, select other cases for assessment.

Client type:	Pregnant woman = 1 Newborn= 2 Infant = 3 Child under 2 years = 3 *High risk / referral case = 4*					
Client No. or ID						
Mother or carer's name						
Age at time of visit (gestational age or age of child)						
Number of home visits completed to date						

1	**Timeliness of visits** **Q:** Did the ttC-HV visit according to the schedule planned and when you expected them?	Visit not done =X Visit too early or too late = 0 Visit less than 2 weeks late =1 Visit done on time = 2					
2	**Data validation** **Q:** For each recorded data points on the register ask the woman to confirm this is correct	Data mostly wrong=X Data partially correct= 0 Data mostly correct =1 Data all correct = 2					
3.	**Topics covered during visits** **Q:** What stories were used during the visit? What topics discussed?	Inadequate /wrong topics = 0 Partially correct topics = 1 Correct topics for visit= 2					
4.	**Rapport with family** **Q:** Did the ttC-HV establish good communication, did they listen well, and engage well during the visit?	Poor = 0 Reasonable = 1 Good = 2					
5.	**Barriers identified** **Q:** Did the ttC-HV discuss any difficulties you were having in doing the recommended practices?	None identified = 0 Partial =1 Good =2					
6.	**Problem solving** **Q:** Did the ttC-HV try to help you finding solutions to the problems you have identified?	None attempted = 0 Partial =1 Good = 2					
7.	**Family participation:** **Q:** Did the ttC-HV encourage influential family members to participate in discussions?	Key members not invited = 0 Key members invited = 2					
8.	**Use of visual aids** **Q:** What materials were shown during the visit? Did s/he talk you through the stories?	Visual aids not used = 0 Partially used =1 Correct usage = 2					
9.	**Complications & Referral** **Q:** Did you report any health problems to the ttC-HV during the visit, and if so, did they help you to access treatment you needed?	ttC-HV did not enquire = 0 Yes, and they referred me= 2 They enquired, but I had no health problems = 2					
10.	**Referral Follow up** **Q:** If you were referred by the ttC-HV did they return to visit you after you returned from the facility?	Not referred by ttC-HV= 2 Referred but no follow up = 0 Referred with follow up = 2					
11.	**Service Satisfaction:** **Q:** Did the ttC-HV treat you well, act supportively and were you satisfied with the service?	Unsatisfied =0 Partial = 1 Satisfied= 2					
Evaluation	**Performance total of treatment / follow up of ttC-HV (Count scores from questions 1-11 – grey areas)**		**/ 22**	**/ 22**	**/ 22**	**/ 22**	**/ 22**
	If less than 16, or if response to Q #1 is X, then the score = poor (ttC-HV did not go but reported going) *<10 or X response for Q1 Poor* *11-15 Needs improvement* *16-18 Good* *> 18 Excellent*						
	Average performance across the five clients			**Comments**			

FORM 3 HOME VISIT OBSERVATION ASSESSMENT

Scoring Guide: *0 = action contained in the item is not carried out; 1= action contained in the item is carried out to some degree; 2 = action contained in the item is carried out fully in accordance to guidelines; NA = not applicable*

#	Item	Scoring Guide	Score			
			Case 1	Case 2	Case 3	Average
1	Greets family and builds rapport.	Does not greet = 0 Greets hurriedly/insufficiently = 1 Greets sufficiently = 2				
2	Give opportunity for mother & family to raise any immediate concerns they have.	Does not give this time at all = 0 Gives time but hurries = 1 Gives sufficient time = 2				
3	Reviews previous meeting (Step 1 of Home Visit Sequence), and assists the family to update household handbook	Does not review = 0 Reviews but not all actions = 1 Reviews all agreed actions of previous visit = 2				
4	Tells Problem Story and asks Guiding Questions (Step 2), if applicable. *(If no Problem Story for the Visit, indicate "N/A").*	Does not do this step = 0 Insufficiently covers story = 1 Tells story in sufficient detail = 2 No problem story for this visit = NA				
5	Tells Positive Story and asks Guiding Questions (Step 3a).	Does not do this step = 0 Insufficiently covers story = 1 Tells story in sufficient detail = 2				
6	Carries out Technical Session (Step 3b), if applicable. *(If no technical session for visit, indicate "N/A").*	Does not do this step = 0 Does incompletely = 1 Covers sufficiently = 2 No technical session this visit = NA				
7	Reviews illustrations in the Household Handbook corresponding to the Visit and conducts negotiation process referring to the correct negotiation illustrations (Step 4).	Does not do this step = 0 Does insufficiently= 1 Carries out sufficiently = 2				
8	For behaviors already practiced, circles the tick mark and praises the family *(If the family is not currently practicing any of the behaviors, indicate N/A)*	Does not do this step = 0 Completes this step = 2 Family does not practice any behavior = NA				
9	If the family says they <u>*do not practice*</u> a behavior, puts down the household handbook and discusses with the family, tries to identify the barriers that the family is experiencing *(If the family is already practicing all behaviors, indicate N/A)*	Does not identify barriers = 0 Does the step insufficiently = 1 Sufficiently identifies barriers = 2 Family practicing all behaviors = NA				
10	Circles the correct symbol beneath each negotiation Illustration in the Household Handbook (Step 4).	Does not do this step = 0 Circles correctly = 2				
11	After a complete discussion, asks family if they will agree to try the behavior (or negotiated practice) and encourages the family member to write his/her initials *(If the family does not agree to try any of the behaviors, indicate N/A)*	Does not ask for initials = 0 Asks for wrting initials = 2 Family did not agree to any behavior = NA				
12	Demonstrates active listening & good communication skills	Ignores family's statements = 0 Listens insufficiently = 1 Listens actively = 2				
13	Asks open ended questions	Does not ask questions = 0 Asks close ended questions = 0 Asks open ended questions = 2				
14	Shows good understanding of all of the health and nutrition information related to the visit	Very little understanding = 0 Insufficient understanding = 1 Good understanding = 2				
15	Carries out all other actions required for the visit (context)	Does not carry out any action = 0 Carries out some = 1 Carries out all actions = 2				
16	Plans date for next visit	Does not plan = 0 Plans = 2				
17	Accurately fills out the TTC register for this visit	Does not fill register at all = 0 Fills incompletely or with errors =1 Fills accurately = 2				
Score	Ignoring NAs, please review the scores of each case: Score of 2 in most or all items and 0 in none: Excellent Score of 1 or 2 in all items, no score 0: Good Score of 0 in some items: Needs Improvement Score of 0 or 1 in most items: Poor					
	Feedback to the ttC-HV					

FORM 4 HEALTH KNOWLEDGE & REVISION NEEDS ASSESSMENT

Knowledge test (select at least 8 questions each time and circle the question numbers. Place a check mark to the left of the answers that the ttC-HV provides. . DO NOT provoke the response Rotate the questions every time you use this form.

	Question	Points		Answer		Answer
Healthy pregnancy (following Training Module 1)						
P1	What should a pregnant woman do to ensure an adequate diet in pregnancy?	**5**		Eat more than usual, additional meal/ snack		Use iodized salt
				Dietary diversity		Eat vitamin C and vitamin A rich foods
				Eat iron rich foods		
P2	What is anaemia and why is it dangerous? How can it be prevented?	**4**		Weak blood or lack of iron; causing breathlessness fainting.		Take IFA tablets during pregnancy & postpartum
				Risk of miscarriage & labour complications		Eat iron rich foods
P3	What is tetanus and why is it dangerous? How can it be prevented?	**2**		Life threatening infection acquired during delivery if unclean place of birth or cutting of cord		Have two tetanus vaccines in pregnancy
P4	Why is malaria dangerous for a pregnant woman? How can it be prevented?	**4**		Risk of miscarriage, premature and stillbirth		Sleeping under a mosquito net every night
				Seek immediate help for symptoms of fever, chills, headache and muscle aches		Taking 2 or more doses of IPT during ANC
P5	What measures does she need to take for her birth plan and birth preparation	**6**		Identify preferred PHU, hospital or clinic		Identify transport means to facility
				Know due date, plan travel before labour		Material -birth kit, cloths, blade, soap
				Savings to cover costs		Skilled birth attendance
P6	What health services are essential for every pregnant and post partum woman?	**4**		Have four antenatal consultations during pregnancy		2 postpartum consultations
				STI/ HIV testing & treatment for HIV+ mothers		Timely diagnosis and treatment of TB
						Access to post partum family planning
P7	What are the danger signs during pregnancy?	**10**		Fever/high temperature		Severe headache
				Abdominal pain		Vaginal bleeding
				Swelling/oedema of face, hands or feet		Vaginal irritation or discharge
				Convulsions/fainting		Breathlessness, dizziness
				No baby movement for 24 hours (3rd trimester)		Premature rupture of waters or, if full term, no labour within 24 hours of rupture
P8	What additional care and hygiene should a pregnant woman take? What should be avoided?	**6**		Rest more than usual		Avoid heavy exercise, lifting and carrying
				Wash hands with soap or ash after latrine use, before preparing food or feeding		Avoid alcohol and smoking
				Deworming, wearing sandals to avoid catching worms		Avoid medicines from unofficial sources
P9	What are the danger signs during labour?	**4**		Excessive bleeding		Prolonged labour/birth delay (>12 hours)
				Fever and chills		Fits or loss of consciousness
P10	What are the guidelines for birth timing & spacing?	**2**		Best child bearing years are ebtween18 and 35 years of age		Two years between birth of one child and the start of the next pregnancy
Child birth and essential newborn care (following training module 2)						
N1	What are the major guidelines for breastfeeding?	**4**		Initiate in first hour of life		Exclusively breastfeed for six months
				Feed on demand as much as baby wants		Continued breastfeeding until 2 years
				Avoid bottles & formula		Increase feeding during illness
N2	What are the care procedures for the newborn in the first hour of life?	**6**		Clean cord cutting and care		Dry & wrap baby, covering head
				Initiate breastfeeding		Monitor breathing
				Eye care		Skin to skin contact with mother
N3	What are the danger signs for the newborn?	**10**		Lethargic unconscious/reduced activity		Unable / reduced breastfeeding
				Seizures, muscle tension		Vomits everything
				Rapid breathing		chest indrawing
				Wheezing/ grunt/ stridor		Jaundice
				Fever		Cold body
N4	How to care for the umbilical stump? What signs indicate umbilical cord infection?	**6**		Swelling		Puss/bad smell/wet cord stump
				Redness extending to the skin		Skin pustules
				Do not bandage		Clean with chlorhexidine or soap & water
N5	What is low birth weight? How to care for LBW babies?	**4**		Babies under 2.5 kilos birth weight		Refer to health facility as soon as possible
				'Kangaroo care' during first weeks of life.		Breastfeed or feed expressed milk as frequently as possible.
N6	Appropriate hygiene & health services for the newborn	**4**		Wash hands before handling or feeding		Take for vaccination as soon as possible
				Bathe baby daily after first day		Change & clean soiled cloths regularly
N7	Danger signs in post-partum woman	**5**		Fever		Bleeding
				Abdominal pain		Severe anaemia
						Convulsions
N8	Which are the most highly vulnerable mothers and newborns?	**6**		Teenage pregnancies		Preterm or LBW babies
				Women of high obstetric risk		Disabled mothers and children
				HIV positive women and their infants		Orphans

Maximum possible points in the questions asked	**Points achieved in questions asked**	**% or** Nearly all answers: excellent About half the answers: good Less than half the answers: needs improvement Very few answers: poor

CHILD HEALTH AND NUTRITION						
C1	At what ages (in weeks) should a child receive vaccinations after delivery, and which vaccines are given	6		As soon as possible after delivery, or before 15 days		6 weeks
				10 weeks		14 weeks
				9 months		OPV
				DTP or Penta		Measles
				BCG		Other (e.g. Yellow fever, RV)
C2	How often should an infant eat complimentary foods from 6-24m of age?	3		2-3 times daily between 6-8 months		3-4 times daily between 9-11 months
				3-4 times daily between 12-24 months plus nutritious snacks 1-2 times a day		
C3	Name the four food groups need for a balanced complimentary feeding diet	4		Body-building foods (fish meal, egg, beans, pounded meat or lentil);		Protective foods (fruit and vegetables)
				Energy-giving foods (rice meal, maize, sorghum, bread)		Super-energy-giving foods in small amounts (for example peanut, oils, fats)#
C4	What are the (general) danger signs with a child with fever that indicate urgent referral?	4		Unable to drink/ breastfeed		Vomiting everything ingested
				Unconscious / lethargic		Convulsion
C5	Signs of danger for fever which might indicate a serious infection (such as measles or meningitis)?	4		Skin rash		Stiff neck
				Swollen fontanel		Mouth ulcers / cloudy eyes
C6	To care for a child with fever in the community what advice should you give the family?	4		Coartem / antimalarial treatment for children with a positive test for malaria		Give more to drink than usual and increase breastfeeding during and after illness
				If malaria, don't wrap the child, keep them cool		Increase feeding during & after illness with additional meal including nutritious foods
C7	What is diarrhoea and what can be done to prevent a child getting a diarrhoeal disease?	6		Three or more watery stools per day		Breastfeed exclusively to six months and continue to two years.
				Wash hands with soap before preparing food, feeding and after changing nappies		Prepare and store food safely, only feed fresh cooked foods.
				Never give unsafe water to drink		Dispose stools in latrine and clean baby carefully.
C8	What are the danger signs for a child with diarrhoea?	7		Sunken eyes, loose skin.		Unable to breastfeed or feed
				Vomiting everything ingested		Lethargic or unconscious
				Convulsions		Blood in the stools
				Diarrhoea has rice-water / cholera appearance		
C9	What care guidance would you give a mother of a child with diarrhoea to treat and prevent dehydration and death	4		Breastfeed frequently and more than usual		Give more fluids than usual
				Give an extra meal a day during and after illness		Give ORS and zinc from a reliable source
C10	What danger signs in a child with cough indicate that they may have pneumonia and what should you do?	4		Fast or difficult breathing		Noisy breathing or grunting
				Chest draws inwards when infant breathes in.		Take the child immediately to a health centre
C11	What care guidelines should you give a mother of a child with a cough / cold to prevent the child from developing pneumonia?	4		Wrap the baby warmly		Clean mucus from the nose frequently and wash hands with soap after handling.
				Give more to eat - an additional meal of nutritious foods per day during and after illness		Give more to drink and breastfeed more frequently than usual
C12	What signs in the curve of growth indicate that a child can have malnutrition?	2		A reading in the yellow zone, red or below red zone		A flat line or downward curve
C13	What colours in the range of MUAC that indicate severe and moderate malnutrition	2		Yellow = moderate		Red = severe
C14	What are the signs of complicated malnutrition?	2		Marasmus = wasted, baggy pants		Kwashiorkor = Oedema, of extremities or in both legs & feet
C15	Why do children need vitamin and when should it be given	2		Vitamin A deficiency causes blindness and reduces immunity to disease		Give vitamin A every six months from six months of age
C16	Why and when do children need deworming medication - Mebendazole?	2		Worms can cause anaemia, poor growth and disease.		From one year old, children need a de-worming tablet every six months.
C17	Why do children need iron-rich foods and give examples	2		Children need iron-rich foods to prevent iron deficiency anaemia, 'weakness' of blood		Iron rich foods include eggs, red meat, green leafy vegetables, iron-fortified grains.
C18	What kind of children might you consider to be high risk?	4		Malnourished or low weight children		Children with chronic / recurrent illness such as HIV
				Orphans		Twins

Maximum possible points in the questions asked	**Points achieved in questions asked**	**% or** Nearly all answers: excellent About half the answers: good Less than half the answers: needs improvement Very few answers: poor

FORM 5 INDIVIDUAL PERFORMANCE APPRAISAL: COMPETENCY ASSESSMENT

Core competencies for ttC 0= poor; 1= Needs improvement; 2 = Good ; 3= excellent		**ttC-HV self assessment 0-3**	**Observed in Supervision ✓✗**	**Supervisors assessment 0-3**	**Overall Performance Assessment**
1. Effective communication & counselling skills	Building rapport with families				
	Active listening				
	Negotiation and dialogue				
	Use of job aids and materials during process				
	Barriers analysis				
2. Handling of referral cases	Recognition of symptoms and danger signs				
	Referral & Follow up				
	Interpretation of counter referral				
3. Record keeping	Referral forms				
	Record keeping and reporting				
	Use of the household handbooks				
4. Health knowledge	Healthy pregnancy				
	Essential newborn care, post partum care and danger signs				
	Breastfeeding counselling and support				
	IDS and growth curve interpretation				
	Childhood illness				
	Complementary feeding and child nutrition				
	High risk children & households (HIV, TB, OVC)				
5. Other	Timeliness of visiting, punctuality				
	Supportive care for vulnerable families				
	Use of initiative and problem solving skills				
6. Community involvement	Engagement with other Community health actors, COMM CHCs and others				
	Community trust and value perception (feedback)				
	Community sensitisation and health promotion activities (group based)				
COMM or community representative comment and feedback	**Complaints, community feedback** **Recommendations, recognition, awards**				
Specific areas of strengths, weakness or current challenges in delivery of tasks					
Final result **Reviewed by supervisor and COMM representative**	**Name Supervisor:** **Role:** **Signature:** **Date:**				

FOR FURTHER INFORMATION

PLEASE CONTACT:

WVI Offices

World Vision International Executive Office
1 Roundwood Avenue,
Stockley Park
Uxbridge, Middlesex UB11 1FG
United Kingdom
+44.20.7758.2900

World Vision Brussels & EU Representation
18, Square de Meeûs
1st floor, Box 2
B-1050 Brussels
Belgium
+32.2.230.1621

World Vision International Geneva and United Nations Liaison Office
7-9 Chemin de Balexert
Case Postale 545
CH-1219 Châtelaine
Switzerland
+41.22.798.4183

World Vision International New York and United Nations Liaison Office
919 2nd Avenue, 2nd Floor
New York, NY 10017
USA
+1.212.355.1779

WVI Regional Offices

East Africa Office
Karen Road, Off Ngong Road
P.O. Box 133 - 00502 Karen
Nairobi
Kenya

Southern Africa Office
P.O. Box 5903
Weltevredenpark, 1715
South Africa

West Africa Office
Hann Maristes
Scat Urbam n° R21
BP: 25857 - Dakar Fann
Dakar
Senegal

East Asia Office
Bangkok Business Centre
13th Floor, 29 Sukhumvit 63 (Soi Ekamai)
Klongton Nua, Wattana, Bangkok 10110
Thailand

South Asia & Pacific Office
750B Chai Chee Road #03-02
Technopark @ Chai Chee
Singapore 469002

Latin America and Caribbean Regional Office
P.O. Box:133-2300
Edificio Torres Del Campo, Torre 1, piso 1
Frente al Centro Comercial El Pueblo
Barrio Tournón
San José
Costa Rica

Middle East and Eastern Europe Regional Office
P.O Box 28979
2084 Nicosia
CypruS

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