**REPUBLIC OF KENYA – MINISTRY OF HEALTH**





**SUPPORT SUPERVISION CHECKLIST FOR COMMUNITY HEALTH UNITS**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Community Health Unit** | |  | |
| **MCUL Code** | |  | |
| **Total population of the CHU** | |  | |
| **Total number of CHWs under the CHU** | |  | |
| **Total number of CHWs Undergone basic training** | |  | |
| **County** | |  | |
| **Sub-County** | |  | |
| **Division** | |  | |
| **Location** | |  | |
| **Sub-location** | |  | |
| **Contacts of CHEWs** | **Name** | | **Mobile Phone Contact** |
| 1. | |  |
| 2. | |  |
| 3. | |  |
| 4. | |  |
| 5. | |  |
| **Name of the link facility** | |  | |
| **Link Facility MFL Code** | |  | |
| **Name of the link facility in charge** | |  | |
| **Date of Supportive Supervision** | |  | |
| **Name and Title of Supervisor(s)** | | **1.** | |
| **2.** | |
| **3.** | |
| **4.** | |
| **5.** | |
| **Name of Supervisee Team Lead** | |  | |
| **Title of Supervisee Team Lead** | |  | |

|  |
| --- |
| **SECTION 1: LEADERSHIP&GOVERNANCE** |

**1-1 Do you have the following plans?**

|  |  |  |
| --- | --- | --- |
| **Plans** | **Yes or No** | **Remarks** |
| Annual Community Work Plans |  |  |
| Quarterly implementation plans |  |  |
| Monthly Action Plans |  |  |

**1-2 AWP Targets for Key priority areas**

i) Key achievements in high impact intervention areas in the last quarter

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Performance indicator** | **Target** | **Achieved** | **Achieved (%)** | **Data Source** | **Make remarks** |
| Proportion of pregnant women completing all four ANC visits within the catchment area |  |  |  |  |  |
| Proportion of pregnant women receiving skilled care during delivery within the catchment area |  |  |  |  |  |
| Proportion of children under 6 months who are exclusively breastfed |  |  |  |  |  |
| Number of ART defaulters referred by CHWs |  |  |  |  |  |
| Number of TB defaulters referred by CHWs |  |  |  |  |  |
| Proportion of households with a functional latrine |  |  |  |  |  |
| Proportion of households with hand washing facilities |  |  |  |  |  |
| Proportion of households with access to regular safe water for drinking |  |  |  |  |  |
| Number of child immunization defaulters referred |  |  |  |  |  |
| Number of children 0-59 months with diarrhoea managed with ORS and zinc |  |  |  |  |  |
| No of new-borns visited with 48 hours of birth. |  |  |  |  |  |
| Proportion of children 12 to 59 months receiving 2 doses of Vitamin A annually |  |  |  |  |  |
| Number of women of reproductive age (15-44 years) receiving Family Planning commodities from CHWs |  |  |  |  |  |
| Proportion of CHWs who timely update and submit their Service Log Book to the CHEW |  |  |  | CHEW Supervisory tool |  |
| Proportion of CHWs completely filling the treatment and Tracking Register (all blanks filled and all boxes appropriately filled or ticked) for last full sheet |  |  |  | CHEW Supervisory tool |  |

ii) What is your rating of CHU performance in the specific priority areas (Tick the appropriate scale point).

Rating: 1 - Excellent 2 – Good 3 - Fair 4 - Poor 5 - Very Poor

**1-3 AWP Targets for Key priority areas**

i) Are the CHWs and CHEWs reporting on key priority areas (as per MOH513/514/515/516)? (Tick as appropriate)

|  |  |  |
| --- | --- | --- |
| **Priority Area** | **Yes** | **NO** |
| MOH 513 (HH Register) |  |  |
| MOH 514 (Service Delivery Log) |  |  |
| MOH 515(CHEW Summary) |  |  |
| MOH 516 (The Chalkboard) |  |  |

ii)Meetings and Supervisory visits in the Last Quarter

|  |  |  |  |
| --- | --- | --- | --- |
| **Meetings/ Supervisory Visits** | **Number**  **Reported** | **Date of Last Meeting/supervision** | **Number of reports/ visits Verified** |
| How many supervisory visits have been made in the last quarter |  |  |  |
| How many written feedbacks did the DHMT provide to the CHU? |  |  |  |
| How many CHWs received at least one supervisory contact in the past 3 Months? |  |  |  |
| How many community mobilization forums were held over the past three months? |  |  |  |

**1-4 What follow up have you done on previous Supervision recommendations?**

**1-5** **What were top three challenges encountered in bridging the previous Supervision recommendations?**

|  |
| --- |
| **Challenges:** |

|  |
| --- |
| **SECTION 2: STAFF MOTIVATION AND TRAINING** |

**2-1: CHW Motivation**

What motivation strategies have been put in place for CHWs? (Ask the CHEW and tick either Yes or No as applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| **Incentive** | **Yes** | **No** | **Specify/Comments** |
| Basic Training |  |  |  |
| Continuous training beyond basic (specify) |  |  |  |
| Mentorship |  |  |  |
| Recognition (Certificates) |  |  |  |
| Cash incentive (specify) |  |  |  |
| Non-cash incentive (specify) |  |  |  |

**2 -2 CHC Motivation**

This refers to whether there are any motivation strategies/mechanisms for the CHC (Tick either Yes or No as applicable)

|  |  |  |  |
| --- | --- | --- | --- |
| **Incentive** | **Yes** | **No** | **Specify/Comments** |
| CHC Training |  |  |  |
| Certificates |  |  |  |
| Meeting Allowance |  |  |  |
| Other incentives (Specify) |  |  |  |

|  |
| --- |
| **SECTION 3: HEALTH INFORMATION** |

3-1. Is the CHU reporting monthly (Tick one)? Yes/No

3-2. Did the CHU submit the last quarter report?

3-3. Check for Accuracy, completeness and timeliness of the last available reports

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Reporting parameter** | **A**  **(80-100%)** | **B**  **(60-79%)** | **C**  **(50-59%)** | **D**  **(Below 50%)** | **Remarks** |
| 1 | Accuracy |  |  |  |  |  |
| 2 | Completeness |  |  |  |  |  |
| 3 | Timeliness |  |  |  |  |  |

**3-4 Utilization of Information**

3-4-1: (Tick) whether last month’s data was updated in the MOH516 Yes\_\_\_\_ No\_\_\_\_\_

3-4-2 (Tick) whether MOH516 is complete and up to date? Yes \_\_\_\_ No\_\_\_\_\_

3-4-3 (Tick) Ask whether the data displayed was discussed together with the CHC at least once in the last 3 months? Yes\_\_\_\_\_\_ No\_\_\_\_\_

3-4-4: If the answer in item 3.4.3 is no, explain why

|  |
| --- |
|  |

**3-5 Information Resource Corner**

3-5-1: Has the CHU established information Corner? Yes\_\_\_\_No\_\_\_\_

|  |
| --- |
| **SECTION 4: SERVICE DELIVERY** |

4-1 Do all the CHW have the Comprehensive CHS Job Aid? Yes\_\_\_\_\_\_No\_\_\_\_\_\_

4-2. How many CHWs are demonstrating correct case management of childhood illnesses?\_\_\_\_\_\_\_

4-3 What percentage of children are followed up after treatment?\_\_\_\_\_\_

|  |
| --- |
| **SECTION 5: FINANCING** |

5-1 Ask and complete the following table on CHU finances. The amount should be entered in Kenya shillings.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Source of Funds | Budgeted (Kshs) | Received  (Kshs) | Utilised  (Kshs) | Accounted for (Kshs) |
| County Government |  |  |  |  |
| Constituency Development Fund |  |  |  |  |
| NSSF |  |  |  |  |
| HSSF |  |  |  |  |
| IGA |  |  |  |  |
| Other (specify) |  |  |  |  |
|  |  |  |  |

|  |
| --- |
| **SECTION 6: TRANSPORT AND REFERRAL SYSTEM** |

6-1. Provide information for completing the following table on CHU means of Transport and Referral

|  |  |  |  |
| --- | --- | --- | --- |
| **S/N** | **Available Means of Transport** | **Number** | **Remarks** |
| 1 | Motor bikes |  |  |
| 2 | Bicycles |  |  |
| 3 | Others (donkey carts, etc.) |  |  |

6-2. Do you use any standard referral form for referring Patients in the community? (Tick the appropriate answer) Yes\_\_\_\_ No\_\_\_\_\_

6-3. Are the referral forms available presently? (Tick as appropriate) Yes\_\_\_\_ No\_\_\_\_

6-4.What is the available communication system for referrals available presently? 🞎 Phone 🞎 Other (specify) ……………………………………

|  |
| --- |
| **SECTION 7: SUPPLIES AND COMMODITIES** |

7-1. Is there an updated inventory of CHV Kit? (Tick as appropriate): Yes\_\_\_\_No\_\_\_\_

7-2. Proportion of CHWs with no stock outs of key CHS kit commodities \_\_\_\_\_\_\_\_\_\_\_\_\_

7-3. Proportion of CHW with all the Basic Equipment (Thermometer, MUAC Tape, Respiratory Timer and First Aid Kit) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Comments:** |

|  |
| --- |
| **SECTION 8: FUNCTIONALITY OF COMMUNITY HEALTH UNITS** |

8.1 Fill in the following table with parameters to assess CHU functionality

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Expected Value** | **Actual Value** | **% Achievement** | **Remarks** |
| Active CHWs Reported |  |  |  |  |
| Active CHC Members |  |  |  |  |
| Number of Dialogue days held in the last 3 months |  |  |  |  |
| Number of Health action days held last 3 months |  |  |  |  |
| CHC meeting held in the last 3 months |  |  |  |  |
| CHIS tools available  MOH 513  MOH 514  MOH 515  MOH 516  MOH 100 |  |  |  |  |

|  |
| --- |
| **Action Points as per the supervision** |

Signature of Supervisee Team Lead \_\_\_\_\_\_\_\_\_\_\_\_

Date of Supervision\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_