all health areas. The supervision visits worked to bridge the gap in the quality of service delivery using a team approach by offering solutions that are discussed and agreed upon by a whole team.

This initiative was wholly implemented by the Ministry of Health Provincial Health Management Team (PHMT) and DHMTs and aimed to carry out quarterly supervision visits to all 374 government health facilities operating in Western Province. Supervision of smaller facilities is generally completed in half a day whilst larger facilities will require a full day to complete the process. A total of 207 health workers were trained in management supervision skills in the project lifespan.

The DHMT supervisory team comprises the Medical Officer in Charge, the Clinical Officer and other heads of department including nursing, laboratory, nutrition, M&E and the DASCO. These teams prepare a supervision timetable for the district and then consult with the health facilities. This process of consultation is crucial for engaging the facilities in the supervision process and enabling them to identify the low-volume patient days when supervision visits would be best carried out.

Supervisors use a Supervision Checklist and a Supervision Support Manual to guide them in their work. A supervision visit starts with a pre-supervision meeting with the entire team of facility staff. Topics for supervision are selected based on problems and issues that are identified through monitoring and evaluation information. The supervision team then splits up to allow each member to offer individual and departmental supervision and support to the facility staff. Once the individual supervision is complete, a post-supervision meeting is convened during which observations are shared and a joint action plan is developed for completion by the time of the next supervision visit. Two copies of the plan are produced and one kept by the supervision team and the other kept by the facility. A key element in this process is linking up staff with personnel and resources to provide them with support in dealing with issues as they arise.

The joint planning and team approach to supervision has resulted in a stronger sense of teamwork amongst facility staff and has improved relationships between them and the managers. The use of supervision checklists and development of written action plans have helped to improve levels of accountability for both health workers and managers. The time required to carry out supervision in smaller facilities has been effective, whilst the time taken in the larger health facilities has proved to be more of a challenge.

This integrated support and supervision approach has proven to be an efficient, cost-effective and easily replicable means of monitoring and ensuring the improved quality of health services on offer in facilities. Communication barriers between staff and their supervisors have been broken and health workers report higher levels of motivation and claim that teamwork and quality of work have improved in the facilities as a result of the practice. A critical element in the successful implementation of this practice is ensuring that there is management buy-in and ownership of the process.

3.7 TB Management

MDR Ambulatory Support Model Promising - Intervention

Kenya ranks 13th on the list of 22 high-burden tuberculosis (TB) countries in the world and has the fifth highest burden in Africa. Kenya introduced the WHO-recommended DOTS strategy in 1993 and achieved 100% DOTS coverage by 1996. By 2005, Kenya had reached WHO's 70% case detection rate target. Kenya's TB notification rates have increased six-fold since 1993, largely as a result of the impact of the HIV epidemic. There is widespread co-infection, estimated at close to 48%. Western Province had an annual co-infection rate of 45% in 2009. Multi-drug resistant TB (MDR-TB) has become an additional challenge in this picture. WHO estimates there were around 2,000 cases of MDR in Kenya in 2007, although only 4.1% of these cases were diagnosed and notified .

One of the most effective ways of minimizing the spread of MDR-TB is to improve MDR-TB surveillance and reporting to ensure treatment compliance and to prevent it from spreading further. There are five notified cases of MDR-TB in Western Province, four of whom are HIV+. Of these, three have died and two are on treatment. One of the surviving MDR-TB patients is a fifteen-year old girl who is being given close support to maintain and complete her treatment using the Ambulatory Model of Support.

The patient is on a 24-month course of treatment and was struggling to adhere to her treatment regime and take her doses on time. She now visits Kakamega Provincial Hospital (KPGH) every morning for daily treatment observation and is visited by a community health worker for her evening dose. The project supports the cost of the daily transport to and from the facility as well as the transport and incentive costs for the CHW who visits her. In addition to her treatment costs, the patient receives a small stipend to help her meet her nutritional requirements to successfully complete the drug therapy regime. Health education activities have been undertaken with the patient, her guardian, all household members and the boda- boda driver who transports her to and from the hospital every day. The support process is clearly bearing dividends; the patient is showing great improvements and no reactions to the drugs at her monthly clinical reviews and tested sputum negative at two months.