

D-AG-341

PROJECT EVALUATION SUMMARY (PES) - PART I

Report Symbol U-447

6450062001501
 attached 6450062015301
 CLASSIFICATION 025301

645-0062

1. PROJECT TITLE SWAZILAND HEALTH MANPOWER DEVELOPMENT PROJECT			2. PROJECT NUMBER 645-0062	3. MISSION/AID/W OFFICE SWAZILAND
5. KEY PROJECT IMPLEMENTATION DATES			4. EVALUATION NUMBER (Enter the number maintained by the reporting unit e.g., Country or AID/W Administrative Code, Fiscal Year, Serial No. beginning with No. 1 each FY) 645-80-3	
A. First PRO-AG or Equivalent FY <u>77</u>	B. Final Obligation Expected FY <u>82</u>	C. Final Input Delivery FY <u>83</u>	6. ESTIMATED PROJECT FUNDING A. Total \$ <u>4,300,000</u> B. U.S. \$ <u>7,748,000</u>	
			7. PERIOD COVERED BY EVALUATION From (month/yr.) <u>September, 1977</u> To (month/yr.) <u>September, 1979</u> Date of Evaluation Review <u>November, December, 1979</u>	

B. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR

A. List decisions and/or unresolved issues; cite those items needing further study. (NOTE: Mission decisions which anticipate AID/W or regional office action should specify type of document, e.g., airgram, SPAR, PIO, which will present detailed request.)	B. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
A. <u>Institute Health Sciences: Training Component</u>		<u>17</u>
1. Appoint an appropriate Institute Health Sciences Principal.	PS-MOH	Aug., 1980
2. Select training sites for clinical/practical experience in rural areas.	PS-MOH	Jan., 1981
3. Develop contingency plans for the provision of two nurse tutors and participant training in mid-wifery and psychiatry.	IHS-Administrator	Sept. 1980
B. <u>Health Administration Component</u>		
1. Develop new plans for organizing the administration of health services.	Chief Planner-MOH	May 1981
2. Make decision on continuation of this component of project, including replacement for Health Administrator based on joint acceptance of the new job description and plans.	PS-MOH USAID/S	July 1980
3. Appoint counterparts for Hospital and Rural Health Administrators.	PS-MOH	Aug. 1980
4. Establish a position and a counterpart within the MOH for a Health Statistician.	PS-MOH	May 1981

9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS			10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT		
<input type="checkbox"/> Project Paper	<input type="checkbox"/> Implementation Plan e.g., CPI Network	<input type="checkbox"/> Other (Specify)	A. <input type="checkbox"/> Continue Project Without Change		
<input type="checkbox"/> Financial Plan	<input type="checkbox"/> PIO/T		B. <input type="checkbox"/> Change Project Design and/or		
<input type="checkbox"/> Logical Framework	<input checked="" type="checkbox"/> PIO/C	<input type="checkbox"/> Other (Specify)	<input type="checkbox"/> Change Implementation Plan		
<input type="checkbox"/> Project Agreement	<input type="checkbox"/> PIO/P		C. <input type="checkbox"/> Discontinue Project		

11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)		12. Mission/AID/W Office Director Approval	
PS, Health DIR, Ned. Services Chief Planning Chief Health Admin. IHS Staff	T.D. Morse, ADIR A. Mackie, Reg. Health/ Econ. C. Collins, Proj. Off.	Signature <i>Julius E. Coles</i>	Typed Name Julius E. Coles, DIR
		Date May 6, 1980	

13. Summary

In the twenty-second month of this project, progress in the nursing component is satisfactory and timely. The IHS opened in January 1980 for the first nursing class and a health inspectors course assisted by WHO. Senior Swazi nursing faculty have been assigned and five faculty members are now in training. Unresolved issues concern the appointment of an appropriate IHS principal, selection of clinical training sites, and the provision of two nurse tutors by ODA.

Progress has been much slower in the administrative component. The hospital administrator and the rural health administrator are both located in a pilot rural district. Their work in improving administrative services in their respective areas has been hampered by lack of definition of the model or system desired and strategy to achieve the same. Since they do not have counterparts they are not able to fulfill the training function envisaged in the PP. The health statistician has arrived, but also lacks a counterpart and needs the MOH to define the position more concisely. Central MOH staff are hampered in their project support by lack of appropriate senior positions/personnel, and lack of time and manpower for planning. Until some of these problems are resolved, it seems premature to assist in smaller aspects of the administration of health services, unless definition of objectives and strategy in the next nine months indicates a real possibility of progress in this area.

Many of the operational problems identified in the September, 1979 "Project Evaluation Report" Appendix A, have been jointly addressed, solved and therefore dropped as recommended actions or decisions in this PES.

14. Evaluation Methodology

This is the first evaluation of the Health Manpower Development Project. Inasmuch as the technical assistance team has only been in country for 22 months, construction is only now nearing completion and the trainees have just departed, the evaluation did not attempt to measure impact; instead it focussed on problems, progress and effectiveness of inputs and outputs, as contained in the logical framework. In addition the evaluation addressed the project Goal and Purpose in terms of their continuing validity and commitment, and to ascertain what data was going to be available later to verify achievement of Goal/Purpose. Several factors indicated that delays in project timing should be evaluated to ascertain implication for project implementation: these factors include the long delay between project conception through design and obligation to actual implementation; delay in team arrival and commodity ordering, and delay in counterparts selection/assignment.

The evaluation was conducted between August 28 and September 21 by in-house AID staff; Assistant Director Ted Morse, Project Officer Constance Collins and Regional Health Economist Anita Mackie. The evaluation started with a review of project documents and proceeded to interviews with host country officials and technical assistance team members. A total of eleven separate interviews were held after two general meetings where pre-drafted questions were discussed.

The evaluation findings were reviewed in draft with Ministry of Health, MSCI and USAID officials in November and December, 1979, and the evaluation finalized in March, 1980. This PES is based on the September 1979 Project Evaluation Report. The PES "action decisions" (block 8) take into account actions taken on recommendations made in the Project Evaluation Report, which is attached as Appendix A to this PES.

15. External Factors

See paragraph 21 - Unplanned Effects.

16. Project Inputs

A. Technical Assistance - Through a contract with Medical Services Consultants, Inc. (MSCI), USAID has provided the following technicians to the MOH:

1. Maternal/Child Health Nurse Technician (Serves as Chief of Party)
2. Nurse Practitioner Technician
3. Nurse Curriculum Consultant (Short term)
4. Hospital Administrator Technician
5. Rural Health or District Administrator Technician

In addition a Health Statistician is provided through a USAID OPEX arrangement under project funding.

The quantity of technical assistance is satisfactory, and with the exception of the District Administrator (DA), team performance has been satisfactory. The DA technician has been terminated (see below).

ODA is scheduled to provide two technicians, a nurse midwife tutor and a psychiatric tutor scheduled to arrive in 1980. WHO has provided a Health Inspector tutor who arrived in September, 1979. Both of these other donor inputs are important to the Institute of Health Sciences and contingency plans should be developed in case they do not materialize.

B. Participant Training

The project provides long term training for six Swazi nurse faculty, one health planner, one health statistician, and a short term training for eight health administrators. Five

of the six nurse participants have departed for training and the health planner departed in January 1980. No position has been established or personnel selected for the health statistician post. Four administrator positions have been created as of April 1980. The quantity of participant training is adequate and quality of trainees satisfactory.

ODA will provide participant training for one nurse midwife tutor and a psychiatric nurse tutor. The training of these two tutors will complete the IHS nurse faculty.

C. Commodities

1. Construction

USAID is funding construction of the IHS and three technician houses. The houses were constructed and turned over to the MOH in October, 1978. The IHS is scheduled for completion in May, 1980. Construction is on schedule and there are no outstanding issues or problems.

2. Vehicles

Two vehicles, a sedan and a pickup truck, were purchased for the project and a used USAID sedan donated.

3. IHS

USAID is funding books, teaching aids and equipment for the IHS. These commodities were underestimated both in quantity and cost in the PP requiring funding revisions and delaying procurement.

The COS is contributing hard furnishings for the IHS, which are now in place.

D. Contractor Support

Contractor support has been weak creating team morale problems. The contractor lacks a clear understanding of AID policies regarding contract employees and has not provided logistical requirements in a timely fashion. Regular written communication on policy matters is not maintained with the team. In addition the team members are operating without written contracts creating confusion and misunderstandings regarding benefits and contractor and employee responsibilities.

17. Outputs

Progress in outputs are listed separately for the two major areas of the project: Institutional Development of Training for Health Manpower; and Strengthening of Planning and Administration for Health Services.

A. Health Manpower Training and Institutionalization

<u>Outputs</u>	<u>Progress</u>
1. Institute of Health Sciences (IHS) constructed for training of RNs, Health Inspectors, (HI) allied health personnel.	1. Construction IHS on schedule. Administrative actions for recognition of IHS as national institute under way.
2. Four year RN curriculum developed and designed to produce 20 RNs per year by 1984.	2. First year of 4 year curriculum completed and approved, and work on second year started. First class 25 RN students selected for entrance IHS January, 1980. Rural training sites for clinical/practical experience should be selected.
3. HI curriculum developed training 15 HIs per year.	3. WHO advisor developing HI curriculum for class 8 HIs entered IHS January, 1980.
4. Swazi nurse faculty (7) selected and trained for IHS RN program.	4. Swazi nurse faculty selected with 5 participants having departed for training September, 1979.
5. In-service nurse practitioner program developed for MOH FNs.	5. One NP in-service training program conducted for 16 RNs in 1979. The second NP group are currently in training.

B. Health Planning and Administration

<u>Outputs</u>	<u>Progress</u>
1. Decentralization of MOH services into four regional or district administrative units.	5. Four regions identified, with Shiselweni district/region selected as pilot area for regional administration.
2. Establishment of Regional Health Administrative System.	2. Positions for four Health Administrators have been established. Systems analysis of rural health services initiated by TA and local maintenance and supply systems being developed.

Outputs

Progress 9/79

3. Establishment of hospital administrative system within each region.

3. Hospital administrator TA in place but no counterpart assigned. Systems for financial management, food service, drugs and supply procurement initiated on regional basis.

4. Establishment of health statistical unit in the MOH.

4. Health statistician TA arrived in the 12th month of project. No counterpart assigned but unit for health statistics established. A new health information system is being developed and tested.

5.a. 1 Health Planner

5. a. Participant selected, post established; participant departed for training January, 1980.

b. 1 Health Statistician

b. No post established or participant selected.

c. 4 hospital Administrators
4 Rural Health Administrators.

c. Four posts established, but no participants selected nor training planned.

18. Purpose

The project purpose is stated as being to: (1) "train nurses and other health personnel; (2) institutionalize this training; and (3) strengthen planning and administration of MGH health services." The project has two major components: Health Manpower Training and Institutionalization of Training; and Health Administration. The two components are inter-related at the goal level but are considered separately at the purpose level.

Within the Health Manpower Training and Institutionalization component the end of project status (EOPS) is to be measured by:

- A. A functioning Institute of Health Sciences officially recognized as a GOS training institution for health personnel

Good quality construction of the physical plant for the IHS is proceeding on schedule for completion of May, 1980. Major administrative arrangements are in the final stage for recognition as a national institution, with the only major tasks to be accomplished being the selection of the director, (Principal) and the nursing program administrator. Both positions will require some time to fill because of their political importance; however, a temporary nurse administrator has been appointed to avoid delays in administering the program. Adequate IHS furnishings have been ordered by the GOS and teaching equipment and books have been ordered by AID. The furnishings are in place but some of the books and other equipment have been delayed due to the need to reorganize the lists and increase funding.

- B. A four year Registered Nurse curriculum will have been developed and is in use

Project technicians have completed the first year curriculum which has been approved by the MOH and are in process of developing the second year. This activity is on target and no problems are anticipated through the second year. The development of the third and fourth year curriculum requires input from the two ODA nurse tutor technicians and delays could be experienced unless these technicians arrive in 1980.

- C. A Swazi nurse faculty trained and in place

Six qualified tutors and three clinical instructors have been selected as the nurse faculty. Five tutors have departed for U.S. and third country training with the sixth scheduled to leave in 1980. At least five tutors will have returned by the end of the project; this should allow full replacement of AID contractors.

D. Twenty Registered Nurses will graduate from the IHS yearly by 1984

The first class of 25 nursing students has been selected and entered the IHS in January 1980. Each successive year 25 students will be selected to enter the nursing program; allowing for attrition, an average of 20 nurses will graduate beginning in 1984.

E. A Capacity to train Health Inspectors is established in the IHS

The WHO technician is developing the first HI course to be taught in 1980 and 1981. Eight students have been selected. No counterpart has been selected for the WHO technician. The PP planned for 15 HIs to be trained a year by 1984, however, the MOH capacity to absorb a continuing number of HIs is limited and this course may not be continued on a regular basis unless additional students are accepted from the Southern Africa region.

F. Continuing Education Programs are established and conducted on regular basis

An in-service nurse practitioner course for RNs was conducted in 1979. A second course is now under way for 1980 and will be conducted in subsequent years of the project. Teaching in additional regular in-service programs by project technicians will be an activity which needs to be addressed for its impact on the project.

Within the Administrative Component of the project the EOPS is to be measured by:

(a) The establishment of a Regional Health Administrative System

The MOH has divided the country into four administrative regions for health services and has designated Shiselweni District as the region for pilot rural health and hospital administrative systems. A Health Administrator Technician was deployed to the region in July 1978. This technician has attempted systems analyses for the development of administration but has mainly been involved in maintenance and logistical supply systems for rural clinics. Very little measurable progress on "systems development" has been made since the MOH has still not developed a clear concept of a district administration. The technician has not been assigned a counterpart. These factors have contributed to a poor working relationship with the MOH. This technician was terminated in Jan. 1980, and replacement is dependent on the production of a clear concept of district administration by the MOH.

(b) The establishment of a Hospital Administrative system within each region

The Hospital Administrator (HA) technician arrived in the sixth month of the project, due to recruitment problems, and was assigned to Hlatikulu Regional Hospital in January 1979. The HA has been given operational authority by the MOH and enjoys a good relationship with the MOH staff. During the first nine months, the HA put into effect new financial management procedures, established a therapeutic master diet menu, set up a local procurement system for drugs and supplies, increased the local maintenance capacity, and made improvements in the hygienic standards of the hospital.

While the MOH has expressed satisfaction with the progress of the HA, none of these innovations have been incorporated into policy. Most importantly, the HA has not been assigned a counterpart to train.

(c) Establishment of a Health Planning Capacity within the MOH

An ODA funded Health Planner (HP) was assigned to the MOH in 1977, and performs in an operational role. However, while this technician has been able to do some planning he is often used in a general administrative capacity due to an extreme shortage of staff at headquarters. The HP was assigned a counterpart in 1977 but this person resigned in September, 1978, and a replacement was not found until August 1979. The present counterpart is proving to be satisfactory. She departed for participant training in health planning at the MA level in early 1980. The ODA funded Health Planner's assignment terminates in December 1980, and plans for continuation or replacement have not been confirmed between ODA and COS.

(d) Establishment of a Health Statistical System within the MOH

The OPEX health statistician (HS) technician arrived in the twelfth month of project implementation due to problems in recruitment. This HS is operational and has been assigned to develop a Health Statistics Unit within the MOH. While the PP planned for the training of a health statistician, the MOH has been reconsidering the kind of training required to fill this position. No post has been established or counterpart assigned. However, the HS has been assigned two statistical clerks. In the first nine months of his tour, the HS has been developing and field testing a new health information system to be used nation-wide.

(e) Eight Health Administrators will be trained and functioning as District Health and Hospital Administrators

Under the PP plan eight health administrators were to be employed and trained at the Institute of Development Management in Botswana. The administrators were to serve as counterparts to the Health and Hospital Administrators and were to rotate through the four health regions before being assigned to a region.

To date four of these posts have been established and recruitment of personnel is commencing. The MOH expects additional posts to be established in the future. The MOH plans to recruit 1980 university graduates which means that the Project will be in its third year before the first administrators are on board. The lag in the approval of Establishment Posts, recruitment, and training of the administrators negates most of the initial efforts of the technicians and unless these personnel are brought on board not later than June, 1980, it will be difficult to accomplish the training objectives in the administration component of the project.

19. Goal

The Swaziland Health Manpower Development Project assists the Government of Swaziland (GOS) to meet its long term goal of improving the health of the rural population through expanded and improved health services in rural areas. The project contributes to this goal through the establishment and institutionalization of training for health personnel to staff rural facilities and through strengthening of planning and administration for expanded health services.

The project is designed in two components training and administration. The components are inter-related at the goal level but have less inter-action at the implementation level.

The training component is progressing satisfactorily and while some major issues remain unresolved these are not expected to interfere with the implementation schedule. The administration component, however, has only made minor progress.

While the MOH has accepted the fact that the purpose of the training component of the project is to institutionalize training and localize this capability, the concept of institutionalizing an administrative system is not as well understood. The problem of conceptualizing administrative institution building is made more difficult since the administrative component of the PP is the weakest and least defined and is not well integrated into the project purpose.

The problem may also be linked to the fact that administration and planning is weak in all sectors of the GOS and decentralization of administration has not been successfully accomplished in any sector. Also planning and administration

has been traditionally carried out by expatriate technicians and localization of these positions is only now beginning.

The MOH can develop a plan for decentralization but actual implementation is limited since essential areas such as transport, communications, maintenance, and construction fall under other agencies and ministries. Unless adequate facilities for these services are operating regionally, the MOH will not be able to grant full regional administrative authority to health administrators. Therefore perhaps it is premature to develop a totally decentralized health administration system without the parallel development of other functioning regional support systems.

20. Beneficiaries

Of the rural population of Swaziland, 80 percent of the total will be the beneficiaries of the project. Rural women and children will especially benefit from improved and expanded MCH/FP services designed to reduce maternal and infant mortality, promote planned population growth, and reduce the incidence of communicable diseases, which contribute to infant mortality, poor growth and development, and eventually decreased human productivity.

21. Unplanned Effects

The major unplanned effect has been the MOH's high priority attached to in-service training. This has been a tribute to their esteem for the IHS teachers, but has placed a demand on the TA team not planned for in the PP. How to continue to respond to the MOH and still have time to meet the original project objective should be discussed and resolved soon between COS and USAID.

22. Lessons Learned

Several lessons learned in the early stages of this project should be borne in mind during future planning. The Department of Establishments and Training should be consulted in the planning stage to be sure counterpart, trainees, posts will be authorized. A clear perception should be shared by all on the operational versus advisor roles of all TAs. Planners should verify that adequate host country capacity exists to work with the TAs. A clear understanding of the project, before submission approval is essential for later follow through by the host country project manager.

23. Special Comments. None.

APPENDIX A

~~645006-2015301~~
~~645006-2025301~~

PROJECT EVALUATION REPORT

THE SWAZILAND HEALTH MANPOWER DEVELOPMENT

PROJECT 645-0062

USAID/SWAZILAND

SEPTEMBER, 1979

TABLE OF CONTENTS

	<u>Page</u>
I. The Swaziland Health Manpower Development Project.....	1
II. Institute of Health Sciences.....	1
A. Planned Objectives/Activities...	1
B. Progress and Accomplishments....	2
C. Problems and Issues.....	9
III. Health Administration Component....	14
A. Planned Objectives/Activities...	14
B. Progress and Accomplishments....	14
C. Problems and Issues.....	17
IV. Evaluation of Project Inputs.....	25
A. Contractor Support.....	25
B. USAID Support.....	26
C. GOS Support.....	27
D. Future Evaluations.....	29

I. The Swaziland Health Manpower Development Project

The Swaziland Health Manpower Development Project assists the Government of Swaziland (GOS) to meet its long term goal of improving the health of the rural population through expanded and improved health services in rural areas. The project contributes to this goal through the establishment and institutionalization of training for health personnel to staff rural facilities and through strengthening of planning and administration for expanded health services. The project provides a health training facility, technical assistance for the development of a national registered nurse midwife curriculum, teaching aids, participant training for Swazi nurse faculty, technical assistance in rural health and hospital administration, and participant training for Swazi health administrators. A health statistician is also provided through OPEX to assist the Ministry of Health (MOH) to improve data collection for planning purposes. Other donor assistance in the form of technical assistance in training supplements the USAID effort.

While the training and administrative components of the project are inter-related in terms of the project goal, the complexity of each component has made it necessary (for the purposes of this evaluation) to consider them separately. Therefore Part II deals with the training component, Part III the administrative component, and Part IV support for the project by the GOS, USAID, and the contractor.

II. Institute of Health Sciences.

IIA. Planned Objectives/Activities

1. Objectives.

The establishment of the IHS under the Swaziland Health Manpower Development Project is designed to:

1. Provide the GOS with a national training institution for Registered Nurses (RN's), Health Inspectors (HI), and other allied health personnel,
2. Institutionalize the GOS training capacity for preparing nurses and other non physician personnel for Ministry of Health services.
3. Initially reduce and ultimately eliminate dependence on third country institutions for the basic training for non-physician health providers.

2. Activities.

The activities required under the Swazi Health Manpower Development Project to meet the planned objectives of the IHS include:

1. Constructing, furnishing, and equipping a physical facility to house the IHS.
2. Establishing the IHS as a recognized institution for education.
3. Selecting a faculty.
4. Preparing faculty through post-graduate training in the U.S. and third countries.
5. Development of a nursing curricula that meets the health needs of Swaziland and regional criteria for the training, licensing of RN's.
6. Establishment of selection and admission criteria for students entering the RN program.
7. Selection of an initial class of 25 students in 1979, and entry of 25 students each succeeding year.
8. Implementation of the nursing curriculum with regular review, evaluation, and revision throughout project to assure the curriculum is compatible with the health personnel requirements for Swaziland.

IIB. Progress and Accomplishments

1. IHS Construction.

Construction of the USAID funded \$1.2 million IHS facility started in December 1977 with an estimated completion date of January, 1980. The construction is ahead of schedule and the completion date is now October, 1979. The construction has been inspected on a regular basis by the REDSO engineer and the quality of construction is satisfactory.

The MOH has ordered furnishings and equipment for the IHS, expected to be delivered in October, 1979. The USAID project team participated in the selection of these items and is satisfied with the quality.

In addition to construction USAID is providing vehicles (3 sedans and a bus) and approximately \$61,000 for books audio visual aids, and other teaching aids. A PIO/C is being submitted for these items.

2. Concept, Plan, Organization, and Procedures for the IHS.

The IHS was designed in the Project Paper (PP) to provide the GOS with a national health training institution with the capacity for training 20 Registered Nurses (RN) per year and after an initial training course for 14 Health Inspectors (HI), 5 HI's per year.

Other courses such as x-ray and laboratory technology may eventually be in the IHS but they are outside the scope of the project. The HI course will be designed with donor (WHO) assistance and will share basic science and health courses designed in the nursing curriculum.

The basic concept of the IHS as presented in the PP remains valid in terms of the nursing component. The MDH is now re-evaluating the outputs of the HI component as while there is an immediate need for additional HI's the long term requirements may have been over estimated.

The two fulltime project TA's 1 Maternal Child Health/Family Planning (MCH/FP) educator and 1 Nurse Practitioner (NP) educator and a part time curriculum development consultant assigned to the IHS, have in addition to the design and implementation of the nursing curriculum, the responsibility for working with the MDH in establishing administrative, academic, and organization procedures for the IHS.

These have included;

1. Selection of the faculty
2. Development of a student selection and admission criteria for students.
3. Selection of nursing students.
4. Establishment of an academic calendar year.
5. Establishment of rules and regulations for students.
6. Selection of student uniforms and an emblem for the IHS.
7. Development and approval of a constitution for the IHS.
8. Identification of academic, administrative, and ancillary personnel required for the IHS.
9. Establishment of the IHS as a recognized institution of learning.
10. Recommendations for the administrative organization of the IHS.

On the advice of the TA and Swazi faculty, the MDH established an Advisory Board for the IHS which includes GOS (health, education, establishments) representatives, prominent members of the community, the TA COP for the project, and a Swazi nurse IHS faculty member. On the whole the Advisory Board has functioned well and has served to establish the IHS as a Swazi indigenous institution. The administrative leadership of the IHS, however, remains unresolved and this will be discussed under C.I.

Other than this problem, the IHS is now established with the capacity to implement the first year of the nursing course as soon as the physical facility is finished.

IIB.

3. (a) Curriculum Development:

The two USAID technical advisors who arrived in late June, 1978 started work immediately on curriculum design. The first visit of the curriculum design consultant took place from mid-August to mid-November. Working papers have been developed for the three year general nursing program. The curriculum was designed to conform to the requirements of the Nursing Examination Board of Botswana, Lesotho and Swaziland (NEBLS).

During the first year primary emphasis was placed on the following areas:

1. Development of a philosophy of Nursing
2. Development of a conceptual framework to provide a theoretical basis.
3. Definition of terminal behaviour objectives.
4. Formation of an Advisory Board for the Institute (ongoing activity)
5. Formation of a Joint Planning Committee with Matrons and Senior Staff of the Mbabane Government Hospital to plan for the learning experience of the students. (ongoing activity)
6. Establishment of first year's school calendar.
7. Initial presentation and acceptance of curriculum plans by the Director of Medical Services and Chief Nursing Officer (November, 1978).
8. Submission of application for approval to open a program of nursing education to NEBLS (Feb. 1979).
9. Teaching curriculum design workshop, number 1.

During the past few months, the first part of the second year's efforts, emphasis has been placed on the following areas:

1. Development of the syllabuses for six courses (3 completed, 3 now underway).
2. Teaching of curriculum design workshop, number 2 (underway).

3. Completion of papers for approval by NEBBIS (to be considered Sept. 27, 1979).

The nursing curriculum format has been divided into 3 levels:

- Level 1 - Adolescent Problems
- Level 2 - Problems of the Child bearing family
- Level 3 - Health problems of all ages.

At each level of the students will be divided into 3 groups with each group taking a specific course with its corresponding clinical practice. The curriculum was designed with the clinical experiences planned to include both in-hospital and rural outpatient facilities, the balance being approximately 60 and 40 percent respectively.

Further details of the curriculum are contained in the Application for Approval to Open a Programme of Nursing Education dated February 22, 1979.

(b) In-Service Education:

Two programs of didactic training were conducted with the assistance of the IHS staff from December, 1978 to June, 1979. Ten students with an RN background were enrolled in a Family Nurse Practitioner (FNP) which was designed with the assistance of personnel with a Danish funded Community Health Project. Six RN students were enrolled in a Maternal-Child Family Planning (Public Health) Practitioner Program. This was designed with the assistance of the IPPF consultant.

Students from both Programs are currently serving in three-month practicums, during which period they are supervised by cooperating district physicians and Institute faculty. Upon completion of their programs, students will be evaluated and given certificates of completion. These graduates will serve as role models for students in the general nursing program, and will hopefully be employed in sites which can be utilized for clinical practice training. The decision to start this "upgrading" training earlier than originally envisaged was appropriate.

IIB.

4. Training Program for Health Inspectors.

With the recent arrival of the WHO technical advisor for this program, it is too early to assess it. Obviously it will be desirable to train both classes together in so far as possible in the basic sciences. If the rural health team is to become a viable concept, the more nurses and health inspectors are aware of each others'

functions, the more appropriately each can work.

IIB.

5. IHS Professional Staffing.

1. Under the Swazi Health Manpower Development Project, the professional or faculty staffing pattern for the IHS will include USAID TA's, ODA (UK) TA's, a WHO TA, and Swazi nurse faculty. This pattern is as follows:

1	MCH/FP educator	- TA/USAID	4½ years
1	NP educator	- TA/USAID	4 years
1	Curriculum Consultant	- TA/USAID	1½ years
1	Psychiatric Nurse tutor	- TA/ODA (UK)	4 years
1	PH/Midwifery Tutor	- TA/ODA (UK)	4 years
1	Health Inspector tutor	- TA/WHO	4-5 years
2-3	Swazi nurse tutors	- GOS	Indefinite
3	Swazi nurse clinical instructors	- GOS	Indefinite

Status - All USAID TA's have been on board since July, 1978. The Swazi nurse tutors were assigned to the IHS (including 5 now in participant training) soon after the TA's arrival and the clinical instructors have now been assigned. The WHO Health Inspector Tutor arrived September, 1979, after a delay of several months. The ODA tutors although requested by the MDH have not arrived and no ETA is yet available. These tutors need to arrive in the next few months to begin curriculum development for the 4th year midwifery and psychiatric courses.

2. EOPS Staffing Pattern for IHS.

1	Principal	GOS
6	Nurse Educators/tutors	GOS
3	Clinical Instructors	GOS
1	Health Inspector tutor	GOS
20	Ancillary Personnel	GOS

3. Positions approved by Establishments as of July 1979.

1	Principal
6	Nurse Educators/Tutors
3	Clinical Instructors
17	Ancillary Personnel (see IIC.6)

As per these Established positions, the nursing component now has the numbers of faculty requested and since participant training is proceeding on schedule the majority of the 6 nurse educators should be trained and in place by the end of the project.

Three issues which are discussed in section IIC. concern: (1) the role of the principal and leadership of the IHS; (2) ODA TA's; and (3) planning for future IHS faculty training.

IIB.

6. Training Program for Nurse Practitioners.
(a) Curriculum Development.

Every effort has been made by the staff to design the curriculum to meet the needs as seen in Swaziland. There has been extensive involvement of Swazi staff on the Advisory Committee, the Joint Planning Committee, and two Swazi nurse tutors serve on the Curriculum Design Team. The curriculum has to also satisfy the NEBBIS requirements.

The curriculum as being designed will prepare nurses to function as practitioners in rural areas where there are no physicians and focuses more on diagnostic and treatment skills than do traditional nursing programs which mainly prepare nurses to work in hospitals. The focus on diagnosis and treatment requires more academic training and a large proportion of well supervised experience outside the hospital.

The academic focus and field supervision aspects of the curriculum have been criticized by senior MOH staff concerned that the program will not produce a nurse relevant to the needs of Swaziland. These issues need to be discussed by the faculty and MOH staff. In addition, the MOH should define manpower requirements and levels of personnel needed to operate an expanded health service as training will be determined by the roles each level is expected to fill.

Clearly, nurses in charge of rural health clinics will require diagnostic skills which are quite different from those of an assistant nurse in a surgical ward. Both types are required and money and skills would be wasted if all nurses were trained to be highest level required. Though the NEBBIS requirements will produce a nurse with a solid base of skills which can be used in both in and out patient facilities, it would be helpful in curriculum design to receive Ministry guidance on priorities for graduate placement prior to completion of the curriculum design.

The requirements for six months Midwifery training upon completion of the 3 year course will result in a double qualified nurse.

Again this may be very valuable for specific situations but may be an expensive luxury when other speciality skills have to be added rather than substituted.

Further discussions are needed on the selection of sites for clinical training. The following sites have been suggested by the team, and another list proposed by the MOH. Further clarification of the expected placement decisions for IHS graduates would assist in appropriate site selection:

Sites Requested

Siteki Hospital & clinic
Raleigh Fitkin Hospital
(for O.R. experience)
Enkhusweni, Siphofaneni,
& Sitobela Health Centers
Red Cross Mobile Clinics

Sites Approved

Sitobela Health Center
Mbabane Hospital
Hluswana Health Center
(not yet constructed)

There are two further aspects of the curriculum development which require further discussion:

Teaching for Basic Sciences is presenting a problem since none of the current TA and Swazi Nurse staff have appropriate qualifications. The suggestion was made that existing voluntary assistance personnel such as Peace Corps be used. This was not acceptable to the MOH. If this course is not desired, then suggestions should be made for alternatives such as the MOH hiring a recent Swazi science graduate or making arrangements to utilize existing University staff.

Supervision during Practicums has to be well planned prior to placement if it is to be successful. Nurse clinicians require high quality supervision during their training if they are to receive guidance on how to function in their diagnostic and referred roles after graduation. This supervision should be provided by physicians as available and well qualified IHS nursing, faculty on a regular basis.

IIB.

7. Recurrent Budget for IHS

A copy of the MOH recurrent budget for the years 1979/80 to 1983/84 is attached as an Appendix. The assumptions underlying the estimates were reviewed with the TA who assisted in its development. All items seem reasonable except the following adjustments need to be considered:

1. 064 Drugs. This line item did not include laboratory supplies as prepared and needs to be adjusted upwards.
2. 041 Professional. This item has to include per diems for student trainee placements, and this category should be placed as a separate line item and additional funding provided.
3. 01 Personal Emoluments. This item now includes 27 posts approved by Establishments ranging from the Principal at Grade 20 on down. If there are changes such as the upgrading of the accounts office to a burser, or the addition of a warder for the men's hostel, or the addition of a second driver, all of which have been requested, some adjustments will have to be made to this figure.

IIC. Problems/Issues

1. Leadership of IHS

An unresolved and now critical issue is that of the administrative and technical leadership of the IHS. The position of principal has been approved by Establishments, however, this position will probably be filled by either a general administrator or an education administrator. The position is a very high grade and the MOH has been informed that the selection of the principal will be a high level government decision which could delay this appointment beyond the opening of the IHS.

In addition there is no provision for administration of the nursing program. The MOH had planned to appoint a nurse administrator from the Swazi nurse tutor staff however, they have been informed that Establishments will make the appointment and again this could delay the appointment.

The MOH suggested that the MCH/TP project technician assume this role until a Swazi is appointed. The MOH has been advised that AID does not concur in this because AID believes the positions is too culturally sensitive for an expatriate. The MOH will now attempt to have the senior nurse tutor appointed temporarily as "team leader" of the nursing program.

Another issue which needs to be addressed early in this project is the training of additional faculty. USAID had planned to train 7 faculty (6 to the BSc. and 1 to MA level). Five tutors have now departed and a sixth will depart for an MA in the next few months. Training of a seventh tutor is still to be decided as one of the Swazi faculty has a BSc. degree. In addition ODA is scheduled to

provide training for a psychiatric nurse tutor and a midwifery tutor. However, this training depends on ODA's funding and priorities and the nurses have not yet departed for training.

While it appears that the EOPS for training of required faculty will be satisfactory there is no allowance for attrition. To maintain this minimum faculty, the MOH should consider sending 1-2 participants per year abroad or to other African countries for BSc. or higher level education. Since the selection of the nine tutors has decimated the number of qualified nurses available for advanced training, Establishments should consider offering scholarships to students eligible for university for basic BSc. nurse training. Once the IHS is established and producing graduates, participants can be selected from this group for tutor training.

The faculty for the Health Inspector's program is also unresolved. Establishments did not include a Health Inspector Tutor position among those approved in 1979. Since the WHO tutor will have a limited assignment (2-3 years is usual) the MOH needs to consider sending a participant for training immediately, as an eventual replacement for the WHO tutor. At present there appears to be no participant identified or advance planning for localization of this training.

2. Future Manpower Requirements.

The Ten Year Development Plan lists the following needs for para medical personnel:

<u>CATEGORY</u>	<u>NUMBER REQUIRED</u>	<u>AV. ANNUAL OUT- PUT REQUIRED</u>
State Registered Nurse (SRN)	195	19-20
Auxiliary Nurse	156	16
Health Assistants	103	11
Health Inspectors	19	2

At the moment about 10 SRN's are graduated per annum from the Raleigh Fitkin Memorial Nursing School. Many continue for a year training course in midwifery and are double registered. Training is traditional and hospital oriented.

A MOH Manpower Survey conducted in 1977 found that of the 313 nurses and midwives employed in the Government sector, the majority had completed Form III. Only 4 had degree training, and none post-graduate. By 1982/83, the Manpower Survey Projected the demand from the government sector to reach 496, or an increase of 183 in 5 years, 35 per year. This study showed 95 nurses and midwives to be employed in the private sector and projected a need for 198 in 1982/83, or increase of about 100 or an annual requirement of about 20.

The MOH developed some projected enoluments for the SRN Programs for this report. They show an intake of 15 students in year I of study at RFM through 1978 and an annual output of 10 from year 4. Starting in 1979 they show a total of 40, or 25 at IHS and eventual maximum output of 30 reached in 1982.

While manpower requirements are always difficult to project, there are clearly areas to which the MOH is going to have to give further consideration. These include the following.

1. Will the RFM Nursing School continue at its present level, and if so will these nurses be placed primarily in hospital positions (private or governmental)?
2. Will the IHS nursing graduates be preferred for outpatient positions?
3. What are the details of future MOH Nursing needs by hospitals and by clinics?
4. What staffing patterns are desired for health centers and health clinics in the future? How many of each will be operated in the next 5 years?
5. Who will supervise the rural health visitor? If it is the SRN will this require additional manpower?
6. What are future senior SRN needs for educational and administrative needs?
7. What is the future role of the PHN versus the clinic nurse? How is the nurse clinician graduating from IHS seen with aspect to PHN's?

A similar set of questions could be developed for health inspectors. The Ten Year Plan showed a need for 19, or two per year. The Manpower survey showed the training program starting with an intake of 8 in 1979 and an annual output of 6 starting from the three year program in 1981. (The project paper estimated an output of 14 for the first class and 5 per year thereafter.)

A further aspect of manpower planning relates to the placement of the SRN's who have participated in the upgrading (inservice NP training) program. They should be placed in positions which can then be utilized as training sites for the student nurses in the IHS curriculum.

New attention should be given to the Policy decisions underlying the development of comprehensive planning for nursing at the teaching,

supervisory, and placement levels. Only after these decisions are made can Establishments be presented with soundly based forward planning for positions.

3. IHS Clinical Training Sites.

The selection of clinical training sites for IHS nursing students is another issue which needs to be addressed. The major problems are: (1) the ratio of urban hospital to rural clinic training; and (2) the use of Mbabane Hospital as the principal training site.

Since the majority of the Swazi population is rural and the bulk of health services will be delivered through rural clinics and health centers, the PP planned that most of the IHS clinical training would be done in rural areas and peri-urban hospitals to produce a nurse who could function effectively in these settings.

However, the MOH has now decided that the prime hospital training site will be Mbabane Hospital since it is located next to the IHS. Aside from the fact this is an urban facility it is in poor condition and may not be approved by NEBBLS. This decision will be made before the end of September by NEBBLS. Approximately 60% of the clinical training will be provided in Mbabane Hospital if it is approved while 40% will take place in 2 rural health centers. However, one of the health centers is not constructed as yet.

Issues which remain to be addressed:

1. Improvement or upgrading of Mbabane Hospital to serve as a more suitable training site since NEBBLS almost certainly won't approve this facility without conditions for improvement.
2. Selection of another hospital site for training if NEBBLS disapproves Mbabane Hospital.
3. Provision of adequate numbers of rural training sites.

IIC.

4. Commodities and Equipment.

The USAID PIO/C for books, equipment and various audiovisual items is almost completed and should be submitted for procurement in the next two weeks. Several factors have contributed towards the delay: a change in the responsible person, a decision to delay ordering until all items were completely specified, and poor performance by the prime contractor's headquarters who could have supplied the team with appropriate lists and prices. The estimated time of delivery for these items is now January, 1980.

During PP discussions the funding for these items was severely cut. At the moment the PIO/C will account for almost all the available funds. It is clearly both impossible to foresee or even order all items for a 4 year curriculum ahead of time. This category should receive consideration for additional funding.

IIC.

5. IHS Ancillary Staff

The MOH has received Establishment approval for 17 Ancillary Positions. These include a secretary, clerk typist, librarian, house mother, housekeeper, driver, accounts officer, 4 cooks, 3 cleaners 2 grounds-men, and an orderly. These are less personnel than required; a male warder is needed since there are both male and female hostels, and an additional driver. A business manager is also needed but not approved. The IHS Advisory Board recommends that the accounts officer position be upgraded to permit recruitment of a more qualified individual who could serve as business manager.

The MOH has not begun recruiting for these positions as yet and the TA project staff is concerned that the staff will not be on board when the IHS opens. This problem is difficult to resolve since the recruitment procedures of the GOS are time consuming. The MOH will begin advertising the positions in late September, 1979.

IIC. Problems/Issues

6. Nursing Administration

The TA project staff in both the nursing and administration components have identified poor nursing administration as a major obstacle to the improvement and expansion of health services. Very few Swazi Nurse matrons have had any formal training in administration and nursing services are poorly managed and supervised. This situation will become more critical with decentralization because the new organizational pattern requires regional nurse supervisors who will carry heavy responsibilities.

The TA nursing personnel state that the project should have included a TA nurse administrator to work with the Chief Nursing Officer (CNO) to improve nursing administration so that expanded training programs will have better support. The CNO agreed with this suggestion and stated she would welcome this assistance.

The role of this TA would include in service training for matrons and assistance to the CNO in developing and implementing nursing administrative procedures. Since the TA would be involved in both teaching and the development of nursing administration systems and would not fit in the IHS staffing pattern it is recommended that recruitment be considered under USAID OPEX, WHO, or ODA.

III. Evaluation of Health Administration Component

A. Planned Objectives/Activities

1. The objective of the Health Administration component of the project is to strengthen the planning and administration of the MOH health services.
2. The activities planned under this component include:
 - a. Training of a Health Planner
 - b. Training of a Health Statistician
 - c. Training of 8 Health Administrators
 - d. Decentralization of MOH services into four regional or district administrative units.
 - e. Establishment of a regional health administrative system.
 - f. Establishment of a hospital administrative system within each region.
 - g. Establishment of a health statistical system within the MOH.
 - h. Development of a Health Planning system within the MOH.

IIIB Progress and Accomplishments

To implement these activities, the project provides for a Rural Health Administrator (RHA) technician and a Hospital Administrator (HA) technician. A Health Statistician (HS) is provided under a USAID/OPEX arrangement and a Health Planner (HP) through ODA (UK).

The HP arrived in late 1976, the RHA in June, 1978, and the HA in December, 1978. Due to long recruitment delays the HS did not arrive until June, 1979.

This component of the project has made only minimal progress for a number of reasons which will be discussed in this section and in the issues section.

A major problem has been an inadequate staff at the central MOH level to plan and direct this component. The HP has had to take on additional duties and cannot devote full time to planning. The first counterpart assigned to the HP resigned from the MOH and a second one has just been appointed after several months delay. However, the counterpart will be sent for formal training in 1980, and no additional personnel are available during her absence.

As a result the MOH has not developed a strategy for a decentralized administrative system and this leaves the administrative

TA's without a policy and procedural framework within which to develop district systems. The TA's also have little input into the central planning activities and feed back on their efforts is not provided on a regular basis.

Counterparts planned for the RHA, HA, and HS have also not materialized so that the TA's are not fulfilling their training roles and no participant training in this area can be planned.

IIIB.

1. Progress/Accomplishments in Hospital Administration.

The Hospital Administrator (HA) arrived in Swaziland in December 1978 (against a planned arrival of June 1978). After an initial orientation in Mbabane, he took up residence in Hlatikhulu in January 1979. (Initial problems with transport, housing and counterparts are discussed in section IV.C and II.C.4 of this report.) After an initial period of a month, a meeting was held in February 1979 to discuss the HA's assignment. In the absence of a counterpart, the HA was faced with the problem of: (a) designing an improved system of hospital operations and either implementing them himself or waiting for a Swazi counterpart to be appointed to implement the new systems/operating; (b) assuming operational authority and begin to "make" improvements vs "advise" on improvements. The Ministry of Health (PS, Planning, and Administration) wanted urgent improvement in the maintenance administration and operation of the hospital and by March 1979, operational authority was delegated to the HA in areas related to budget, finance, maintenance, and non medical administration. (See Section IIIC.3 on Institution Building vs operation for a discussion of the implications of this switch from advisory to operational assistance.)

In the intervening 7 months, many changes have been made at the hospital and the MOH officials have been very pleased with these improvements. Without dwelling at length on these the HA has introduced a new economic/dietary specific menu, routine maintenance procedures, local procurement of pharmaceuticals, and budget-planning procedures which led to the discovery of unused funds that were used for construction and renovation of badly needed facilities.

The only reported negative affect in this aspect of the project was a conflict of role perceptions with some of the medical staff at the hospital who traditionally had been assigned administrative responsibility. The evaluation team understands that the P.S. chaired a meeting to resolve these differences on August 8, 1979. The reported solution was to assign total operation of the hospital to a committee of three - the District Medical Officer, the Matron, and Administrative Officer (HA) with the latter charged with carrying out the committee recommendations in the administration area.

The evaluation team believes that the MOH will need to make a clearer distinction of roles once Swazi Health Administrators have been approved, positioned, recruited, trained and assigned. The clearer distinctions will need to account for difference in academic standing, age, experience, and traditional power position of the District Medical Officer. (See IIIC. below).

While the immediate improvements in Hlatikhulu hospital are "good" in and of themselves, there is real concern about the long term, self-sustaining viability of these changes. In the absence of counterparts, and the generally fuzzy understanding about what permanent systematic changes in health administration are being made, the institution building purpose of the project is not being met and there is the question as to whether continuation of this component of the project is appropriate at this time.

IIIB. Progress/Accomplishments

2. Rural Health Administration.

The Rural Health Services Administrator (TA) or District Health Administrator, as preferred by the MOH, has now been working in the catchment area of the Hlatikhulu Hospital for over one year. He has visited all the health facilities in the area and provided MOH with reports dealing with state of physical buildings and equipment, needed maintenance, availability and state of services, such as electricity and water and staffing patterns.

The RHSA defined his role as the provision of effective logistical management support to a regionalized health care delivery system. He has been effective in the planning, supervision, and sometimes execution of maintenance services to the clinics. In general this work is supposed to be conducted by FWD. However, the situation is complicated by lack of a firm budget figure having any relationship to the work required, and no accountability for financial outlay expanded on MOH buildings. This in turn means that it is impossible for the MOH to have a priority listing for a fixed amount of total expenditures to be undertaken by FWD.

Efforts have been made to rationalize the transport system with respect to movements of personnel, supplies and communications. It is not clear how much authority the RHSA has over transport disposition, maintenance or accountability as he has not requested operational authority from the MOH, and his present status in terms of authority is not defined.

The RHSA has also reported on manpower working in his district. These reports have included numbers of each speciality area working at each clinic. Some suggestions have been given for making optimum use of

of personnel. Again when requirements are by MOH headquarters through Establishments it is unclear how much authority is vested at the Regional Level. Since housing is often a critical local variable, it would seem logical to delegate the housing of local employees for the unskilled positions such as orderly and grounds keeper. No policy on provision of housing by level of staff was reviewed.

The RISA has dealt with the issue of supplying clinics with consumable items (paraffin, soap, etc) and also of drugs and medical supplies. This system has achieved considerable progress during the past year. The change of purchasing these items by district through the hospital has yet to be made.

The RISA has reviewed the financial outlays for the district and drawn attention to some unexperienced funds. Financial and management plans for district administration were lacking.

IIIC. Problems and Issues Relating to the Administrative Component

1. The evaluation team believes the Health Administration part of this project was "added on" to the manpower part of the project; relatively weak analysis and lack of detailed planning and generally fuzzy understanding about the Health Administration component give rise to this belief. These in turn have lead to misunderstanding between the TA's USAID and the MOH regarding the desired strategy or approach to improved health administration as well as the basic objectives of such improvements. The non-availability of counterparts has been a major factor contributing to the inability to pursue the originally planned objectives/strategy.

Various parties at various times have stated that the objectives of this part of the project are to:

- (a) maintain the hospital and clinics in Sheselweni district;
- (b) improve the maintenance and operations of the hospital and clinics, to show the rest of the GOS the need for Health Administrative personnel;
- (c) design improved systems for decentralized health administration which can be used in all four districts in Swaziland.

Various parties at various times have stated that the strategy to be followed in this part of the project is to:

- (a) operate, exercising the full authorities of a GOS civil servant to implement changes as perceived;
- (b) conduct systems analysis and design improvements which were to be proposed to the MOH for approval and promulgation;

- (c) train a Swazi counterpart to maintain the district health facilities;
- (d) advise (who?) on improvements in district health administration.

On the whole the evaluation team believes that this part of the project has not made sufficient progress to date to believe that it will achieve the project purpose by the stated completion date. The reason for this seems to be that the TA team is working in a vacuum - the other components of policy, procedures, staff, positions, leadership, budget and other resources needed to make meaningful self-sustaining, long-term improvements in health administration are not in place.

Because the MOH reaffirmed its interest in this part of the project to the evaluation team, the team recommends the following;

- (a) The Health Planner/Administrator and two TA members meet ASAP, (with the COP and AID Project manager as observers) to define immediate achievable changes desired in district health administration.
- (b) The MOH produce a strategy which authorizes a concept for this aspect of the project which takes into account MOH objectives, USAID desires for institution building, and the constraints of the present situation. This paper should be available for discussion by all parties by December, 1979.

There appears to be a fundamental difference in approach to the health administration part of this project between the USAID and MOH; this could be only simplified by stating, on balance the MOH leans more toward operational accomplishments, and USAID leans more towards institution building accomplishments. The MOH has stated it does not want "advisors" but "doers". USAID states it does not believe it is helping Swaziland develop its own capacity to manage its own affairs by "doing" a job, which will not be done when U.S. TA. is pulled out. The MOH states it wants AID TA which can operate the health administration in one district, and from such operations learn what improvements can be realistically made. Some excellent attempts in meetings, in papers, in day-to-day implementation, and at social occasions, have been made to bring about a closer meeting of the minds - and there appears to be some success in this regard. Further attempts should be made before it is agreed to commit additional resources to achieving an agreed objective for this sub-project.

The evaluation team recommends that both parties consider a two day Institution Building workshop after the MOH has produced its strategy paper. The objective would be to fit the substance of this concept paper into an Institution Building model as a way of bringing the thinking of AID/MOH closer together and assuming that they both have a common objective and strategy in mind. In addition it is recommended that AID pass appropriate institution building materials to the MOH

to take into consideration before/while drafting the strategy paper.

IIIC. Problems/Issues

2. Personnel

(a) Hospital Administrator

A major issue involving both the IHS and the administration component is the future assignment of the HA. The MOH has made the decision to use Mbabane Hospital as the primary clinical training site for the IHS nursing program however, the hospital is poorly managed and at present unacceptable for training. Based on the accomplishments of the HA in Hlatikhulu Hospital, the COP has requested that the HA be re-assigned ASAP to Mbabane Hospital to improve conditions and make it more acceptable for training.

The MOH is not adverse to this recommendation but is concerned that the efforts of the HA at Hlatikhulu will be lost if the HA is transferred. The MOH has requested a HA from ODA to replace the USAID/HA; however, it is improbable that this technician will arrive in time to relieve the HA to accomplish any improvements to Mbabane Hospital before the first nursing class begins clinical experience.

The issue to be resolved is which area takes priority, training or hospital operations - within limited resources.

(b) District Health Administrator (Rural Health Services Administrator).

The DHA position and the technician serving in this position present the most serious issues in project implementation. The issues involve the DHA's personality, his experience, and the MOH's concept of this position, which differ from his and AID's.

The DHA's personality has created conflicts with MOH central and district staff and as a result he has limited access to MOH personnel especially the HP/Project Manager. Secondly, it appears that while his academic background is in administration, he lacks relevant basic health administration experience for this position. Thirdly, it is apparent that the MOH lacks a clear concept or definition of the DHA's role and cannot communicate to the DHA what is expected of him.

This situation led to the DHA being put on 60 days probation after the visit of George Contis, President of MSCJ, in April, 1979. During the probationary period the DHA improved his performance. He also stayed in the district during the work week (frequent trips to Mbabane had raised doubt as to whether the DHA was working full time). These improvements lead USAID to recommend (June, 1979) that

he be retained, based in part on interviews with the MOH.

However, during this evaluation, the MOH indicated that they will request the DHA to be replaced at the end of his two year tour (June, 1980).

This raises the issue of a replacement for the DHA. Aside from the fact the RIA position remains undefined, the allotment of resources appears insufficient to effect the major changes desired by the MOH. Recruitment of a replacement then is contingent on the development of a job description and support plans by the MOH no later than December, 1979.

The following alternatives in relation to the administrative component are suggested:

1. Recruit a new DHA technician based on a revised MOH job description and support plans for rural services.
2. Eliminate the DHA technician and have the IIA assume responsibility for both the hospital and district (this was a MOH suggestion and generally involves logistic and non-technical health administrative procedures).
3. Eliminate the entire administrative components (including the statistician) since the MOH cannot provide counterparts and adequate support.
4. Eliminate the district component and move the HA to Mbabane Hospital to support the nurse training component.

To facilitate a decision on these options USAID has suggested that:

1. The HP and Health Administrative Liaison Officer (HALO) visit the district to observe the activities of the DHA and IIA and develop a work plan for the DHA for the last nine months of his assignment.
2. That the HP and HALO meet with the DHA and IIA twice a month to discuss problems and progress, to develop a more practical strategy for the DHA's role, and to further define the relationship of the DHA and IIA to district administration.

The MOH has been informed that the USAID contractor and the DHA must be given 6 months notice if the DHA is not to be retained after June, 1980. Therefore by December, 1979, the MOH must select one of the four options and if they choose to replace the DHA, be prepared to provide direction and support for this position. This would be

initially confirmed by a clear job description for the DHA defining responsibilities and administrative relationships as part of an overall strategy for decentralizing health administration to the districts.

IIIC.

3. Institution Building vs Operations

AID's policy in development projects is to assist host countries to build viable systems or institutions that can be operational within local manpower resources once the project is finished. This policy is reflected in the Swazi Health Manpower Development Project through the technical assistance and counterpart training components.

While recognizing that the administrative component of the project is the weakest and least defined area, it was added to the project because it was recognized that better trained personnel still cannot function effectively unless an adequate support system exists. USAID continues to support the need for more adequate administrative systems but questions whether these systems are being developed as the project is presently operating.

At present neither the district TA's (DHA and HA) or the statistician have counterparts. Since the project involves limited time periods for these TA's it appears that even if counterparts were to be selected in the near future the timing will not permit formal and on the job training as envisioned in the PP. Furthermore the MOH has not developed a clear strategy of decentralized administration or the roles of personnel in this system.

It also appears that for the present the MOH is more interested in the operational capacities of the TA's rather than in longer term institutional development. This is understandable in light of the totally inadequate staffing of the MOH but it is in conflict with AID policies and leaves the TA's without a clear concept of their roles in terms of their USAID job descriptions and the expectations of the MOH.

As the administrative component of the project is progressing, it will alleviate some of the logistical and administrative problems in one district for the next 2 years but it will not leave an adequate support system in place when they depart. Therefore unless the issue of institutional development can be resolved through the provision of counterparts and a strong strategy for decentralization, which includes more specific tasks for the TA's, by the MOH no later than December, 1979, it is recommended that USAID phase out the

administrative component of this project.

IIIC.

4. Counterparts.

Under the administrative component, it was planned that positions for eight health administrators would be established to serve as counterparts to the two TA's in the four health administrative districts of Swaziland. Four administrators would serve as hospital administrators and four as district health administrators. The eight administrators were to receive a one year training course in health administration conducted by IDM in Botswana then return to work in the four districts as counterparts to the DHA and HA.

To date no Establishment positions for the health administrators have been established nor has recruitment been initiated. The next IDM course begins in January 1980, and it appears highly unlikely that the counterparts can be recruited and selected by that time even if Establishment posts are created in the next few weeks (as the MOH has been informed).

The MOH plans to recruit university graduates for these posts and the next class graduates will not be available until April 1980. The level of the HA's and their job positions could create potential problems. University graduates are in demand and additional administrative training could increase their potential for obtaining higher paid non government positions. Also as planned by the MOH, the HA position will be lower position than the DHA, however, both the DHA's and HA's will have equal academic qualifications and the same administrative training.

IIIC.

5. Relationships/Links.

Another issue in the administrative component is the relationship of the DHA and HA to each other, other district personnel, and the MOH.

Under the MOH plan the DHA will serve as the overall district administrator for health services and the HA, while responsible for the hospital, will report to the DHA. Due to personality problems with the DHA this position has been reversed by the MOH for the TA staff and the DHA reports to the HA. This situation does not permit the MOH to implement district administration as planned. Furthermore as noted under the counterpart section the administration as planned with the DHA above the HA is going to

create problems if both have equal qualifications.

The relationship of the DHA and HA to other personnel on the district level is not defined very well because a district administration is not yet in existence. The MOH did determine that the HA, district medical officer, and matron will share administrative responsibility for the hospital but this only occurred after friction at the hospital level was threatening delivery of services.

The relationship of the DHA and HA to the central MOH is also not clearly defined. No regular meetings are held to discuss progress and problems and the TA's do not participate in central level planning. Also complicating the situation, all funds for repairs and construction are under the Ministry of Public Works, Power, and Communications and PWD is responsible for maintenance of district health facilities. Therefore while the DHA and HA can do minor repairs themselves they are dependent on the inadequately staffed PWD teams to do major repairs and construction and this creates delays.

Because of the multiple problems involved in setting up a district administrative system there is a need for the MOH to provide regularized contacts for the TA's to share problems and find solutions. Without this feedback the TA's are working in a vacuum and have no idea as to whether their innovations are acceptable or practical in the system.

IIIC.

6. The Role of the Health Statistician.

Since the Health Statistician has only been working since June, 1979 his accomplishments to date will not be evaluated. There are significant problems connected with his role and function within the Ministry. These will be enumerated.

- (a) Lack of a job description including duties, functions, supervising officer, etc.
- (b) Physical presence in the Department of Statistics with no provision for regular attendance of MOH senior staff meetings, or encouragement to work in a team approach to solve management problems caused by inadequate data. Support staff (2 clerks) are responsible to Dept. of Statistics.
- (c) Lack of transport provided by MOH. Statistics has stated that they are responsible for provision of office space only. MOH is the employer of record on the contract. Reimbursement has not been made for use of a personal vehicle. The recommendation to accompany other health officials on a trip would

- not be feasible if his role is to function as the Chief Health Information Officer.
- (d) Lack of a counterpart or plans to indicate that a Swazi will be found who can be placed for an initial period with the HS and then sent for advanced training. The suggestion that 4 or 5 low grade clerks be sent for short overseas training is not acceptable. Upgraded clerks are not required but a senior staff member capable of being a valued participant in policy and management decision making levels in the MDH is essential.
 - (e) Provision of a budget for support of the HS role and staff. There is no specific budget item for printing of forms, books, hand calculators, attendance at meetings, etc.

The HS has the added disadvantage of being under a IIE contract. They are not providing adequate support. He has not received his June salary, though July and August have been paid. No reimbursement has been made for his Malawi trip to consult with the WHO statistician. There is an outstanding allowance amount of over \$800 to be paid in lieu of organizational benefits. USAID/S has authorized payment for the Malawi trip. The HS will prepare a draft letter enumerating the unpaid salary, allowance, and reimbursements to which he is entitled to be transmitted by USAID/S to IIE.

IV. Evaluation of Project Inputs.

A. Contractor Support.

1. MCSI has provided less than optimum support in several areas which will be itemized:

- (a) Lack of timely and appropriate responses from MCSI management on policy change suggested by the team and implemented without approval. The files reveal a lack of correspondence on professional matters, reports are sent but not commented upon. It should be noted that the person providing support when the President is away is lacking in both the experience and credentials to make independent judgements.
- (b) Lack of anticipatory guidance on logistic support; when the IHS staff had to order books and equipment no lists were sent from U.S. suppliers by MCSI, and the staff were not sufficiently experienced to request same. MCSI was requested to provide materials on development of nursing programs overseas but stated they did not know of any. Some were suggested by a member of the evaluation team. No books were budgeted or provided when the TA team left the US when they clearly required material for curriculum development. No funding was budgeted for transport of the curriculum specialist on her short-term assignments.
- (c) Infrequent attention to staff morale. Discussions should be underway on extensions or terminations of contracts in order to give both employer and employees time to make the alternative arrangements. Salary levels did not seem satisfactory to all member.

IVA.

2. Contract Technical Assistance Team.

The MOH, USAID, and the external evaluator are in agreement that the nursing technicians and the hospital administrator have performed in a highly satisfactory manner.

The COP (MCH/FP educator) is not only technically qualified but has proved to be a mature capable administrator and manager. The MOH expressed appreciation for the NP educator's skills and leadership in working with NEBBLIS to promote understanding and approval of the new curriculum as well as her technical capabilities. The curriculum consultant now in her second short term assignment has provided the

team and the MOH with an excellent external objective review of the curriculum and assisted in the necessary revisions. The hospital administrator, while not performing as envisioned in the project, has made an excellent adjustment and is working to achieve as much as possible within the limits of his situation.

The major problems which have been brought to USAID's attention have centered around the DHA technician, who has had the most difficulty adjusting personally and work wise to the situation. The personal problems have involved the need for the DHA to be separated from his family due to the fact that his spouse (also on the team) is located in Mbabane. This had led to the DHA spending more time in Mbabane than is necessary and has evoked observations from the MOH central and district personnel that the DHA is not working full time. Both USAID and the COP have informed the DHA that he is to spend his forty hour work week in the district unless there is a meeting or official business in Mbabane and in those cases he should not stay longer than necessary. The MOH while concerned has declined to confront the DHA about this matter. There are indications that this situation has improved over the past few months after the matter was discussed with the DHA. The DHA has had many problems in the work area. As has been discussed, the MOH has not provided specific guidance on what is expected from the DHA or given adequate feedback to assist him in his performance. In addition the DHA appears to lack experience in general health administration and in particular the experience to develop a system within the limited resources available. These problems plus the DHA's sometimes abrasive personality, which has created conflicts with central MOH and district staff, has led the MOH to request that he not return after the end of his two year tour. USAID concurs with this decision but it should be noted that the MOH's performance in this area has also been less than satisfactory.

IVB. USAID Support.

1. AID/W.

There are several problems which have impeded smooth progress of the project:

- (a) Late approval of the PP in May 1977 with changes occurring in both the general environment and the MOH in the interim period. The Project Agreement was not signed until September 1977.
- (b) Poor communication between AID/W and USAID/S concerning orientation and team arrival resulted in problems. The TA team was given some erroneous information about support services from the GOS and USAID/S which caused difficulties and some initial ill feelings when this support was not available. In addition USAID/S was informed the team was ready to depart three months earlier than expected with no advance warning. As a result the team arrived before the GOS had housing and much effort and time was spent arranging temporary living quarters.

- (c) Late recruitment of the statistician who initially was to be part of the MCSI team, but ultimately was hired under an OPEX IIE.
- (d) With the late starting date, the PACD will need to be amended.
- (e) The files indicate a lack of concern by AID/W and lack of awareness of either the MCSI back-stopping problems or other problems affecting team member's performance.

2. USAID/S

Backstopping by the Mission was judged superior by the outside evaluator. TA's cited Mission support as being beyond the call of duty in matters such as housing. Professional judgements were appropriately given and did not extend to areas which should fall under team control.

The single problem area noted was with the lack of timely submission of the PIO/C for books, audio-visual aides and other technical equipment which should be submitted as soon as possible.

IVC. GOS Support.

The Ministry of Health of the GOS lacks an adequate central staff to administer and manage a national health program. Therefore, while the MOH reaffirms the validity of the project and its importance to the national health program, the capacity to effectively plan and manage the project is weak.

The advisory team concept of technical assistance has also created confusion and the MOH has had difficulty understanding the relationship of the team to each other, USAID, and the MOH. The MOH has been informed that in technical matters the team is responsible to the MOH, that USAID provides administrative contractual back-stopping, and that the COP is responsible for coordinating technical assistance with the MOH and contractual backstopping with USAID. Nevertheless, there continues to be some confusion about the team's responsibilities and relationship to the MOH.

Logistical support for housing has been resolved with the provision of three USAID constructed houses in Mbabane and two GOS houses in Shiselweni District for the DHA and HA. However, the DHA had to live in a hotel in the district for five months and HA for 4 months before obtaining housing. Initially much of the COP's time was absorbed in getting various Government orders and requisitions for furniture, utilities, and office equipment. The MOH did assist the COP but much time was wasted because the MOH did not have a clear understanding of their technician support responsibilities or the

personnel to adequately manage these routine procedures.

Transport has not been a problem for the contract team. USAID provided a new sedan and a used GCV (donation of USAID) sedan for the IHS team and a pick-up truck for the rural health component. These vehicles have been assigned to the Central Transport Administration (COS) and the team has had no difficulty with access or maintenance.

The health statistician (OPEX) however, has not been provided with transport for work by the MOH or reimbursement for the use of his private vehicle.

Communications (and relationships) between the MOH and the team are generally good with the exception of the district health administrator technician. However, the COP reports that the team generally has to initiate requests for meetings with the MOH and there are no regular MOH/Team meetings.

The MOH has clarified the chain of command for written communication to USAID and the team. All communication is now to be addressed to the PS where it will be logged in as official MOH mail and distributed to the appropriate officer. However, a description of the HP's duties as project manager has not been provided nor is it clear what role the health administrator liaison officer (HALO) plays in project administration.

Participant training to replace TA project personnel is an essential component of this project. The lack of Establishment Posts has completely blocked the selection and training of health administrators and unless counterparts are selected in the next few months, the DHA and HA will complete their assignments leaving no trained Swazis in place. The lack of counterparts in the administrative component does not permit the institutionalization of the health administrator positions and makes it difficult to establish an effective rural health administration system.

The selection of nursing participants has proceeded with less difficulty since the participants had posts. Five nurse participants departed in September, 1979 for degree training (4 to the U.S., 1 to Botswana) and a sixth is due to depart in 1980. A seventh tutor has a BSc. degree and probably will not receive additional training. Another candidate may be selected for training in this participant slot.

In preparing the participants for departure several COS policies were encountered that could have a negative impact:

1. GOS does not bond participants after training.
2. GOS pays full salary and family allowances only for one year.
3. GOS does not pay family support allowances for women participants.

USAID will explore these regulations with Establishments. The failure to pay women allowances is not only discriminatory but also may eliminate well qualified women who are heads of households.

IVD. Miscellaneous

1. Future Evaluations

In addition to the routine yearly USAID/S evaluations, 2 major external evaluations are planned. The first external evaluation is scheduled for September, 1980, and the second at the end of the project in June, 1984.

The first external evaluation will provide a more in depth critical assessment of the administrative functioning of the IHS and the quality and relevance of the curriculum plus the progress made in institutionalizing the administrative component.