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CLASSIFICATION  
**PROJECT EVALUATION SUMMARY (PES) - PART I**

Report Symbol U-147

<b>1. PROJECT TITLE</b> Swaziland Health Planning and Management Project (OPG)			<b>2. PROJECT NUMBER</b> 645-0215	<b>3. MISSION/AID/W OFFICE</b> USAID/SWAZILAND
<b>5. KEY PROJECT IMPLEMENTATION DATES</b> A. First PRO-AG or Equivalent FY <u>81</u> B. Final Obligation Expected FY <u>85</u> C. Final Input Delivery FY <u>86</u>			<b>6. ESTIMATED PROJECT FUNDING</b> A. Total \$ <u>1,739,780</u> B. U.S. \$ <u>1,126,000</u>	<b>4. EVALUATION NUMBER</b> 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 <input checked="" type="checkbox"/> REGULAR EVALUATION <input type="checkbox"/> SPECIAL EVALUATION <b>7. PERIOD COVERED BY EVALUATION</b> From (month/yr.) <u>July, 1983</u> To (month/yr.) <u>Nov., 1985</u> Date of Evaluation Review <u>NOV, 10 - 26, 1985</u>

8. ACTION DECISIONS APPROVED BY MISSION OR AID/W OFFICE DIRECTOR <small>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.)</small>	9. NAME OF OFFICER RESPONSIBLE FOR ACTION	C. DATE ACTION TO BE COMPLETED
1. Develop/implement training for Regional Health Management Teams and advisory councils in health planning and budget preparation	MOH, IHAP Jun. 1, 1986	
2. Conduct a study of the management information requirements for the decentralization management system	MOH, new PHC contractor team	Sept. 1986
3. Develop/implement a strategy permitting Ministry of Labor/Public Service to cede personnel flexibility to MOH.	MOH, new PHC contractor team	Dec. 1986
4. Develop/implement a uniform regional financial management system for use by MOH and Mission facilities including central monitoring procedures and training in the system's use.	MOH, new PHC contractor team	July 1987
5. Prepare updated manpower plan.	MOH, new PHC contractor team	July 1987

<b>9. INVENTORY OF DOCUMENTS TO BE REVISED PER ABOVE DECISIONS</b> <input type="checkbox"/> Project Paper <input type="checkbox"/> Implementation Plan e.g., CPI Network <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Financial Plan <input type="checkbox"/> PIO/T <input type="checkbox"/> Logical Framework <input type="checkbox"/> PIO/C <input type="checkbox"/> Other (Specify) _____ <input type="checkbox"/> Project Agreement <input type="checkbox"/> PIO/P	<b>10. ALTERNATIVE DECISIONS ON FUTURE OF PROJECT</b> A. <input type="checkbox"/> Continue Project Without Change B. <input type="checkbox"/> Change Project Design and/or <input type="checkbox"/> Change Implementation Plan C. <input type="checkbox"/> Discontinue Project
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**11. PROJECT OFFICER AND HOST COUNTRY OR OTHER RANKING PARTICIPANTS AS APPROPRIATE (Names and Titles)**  
 Linda Bernstein, PDO, REDSO/ESA, Jeanette North, Headquarters, Harry Feirman, Health Systems Consultant, Charles DeBose, RHPDO, USAID/Swaziland, Mary Pat Selvaggio, HPO, USAID/Swaziland, H.B. Malaza, Acting Financial Secretary, GOS.

**12. Mission/AID/W Office Director Approval**  
 Signature: Robert Huesmann  
 Printed Name: Robert Huesmann, Director  
 Date: December 1985

OIAU 1300-1 (7-69)  CONTINUATION SHEET  FORM SYMBOL:	DEPARTMENT OF STATE AGENCY FOR INTERNATIONAL DEVELOPMENT  TITLE OF FORM  <b>PROJECT EVALUATION          SUMMARY</b>	<input type="checkbox"/> Worksheet	<input type="checkbox"/> Issuance	PAGE 2 OF _____ PAGES
		1. Cooperating Country <b>Swaziland</b>		2.a. Code No.
		2.b. Effective Date		2.c. Amendment <input type="checkbox"/> Original OR Net: _____
		3. Project/Activity No. and Title <b>645-0215          Swaziland Health Planning Management Project (OPG)</b>		

Indicate block numbers. See Block 8 A, B & C	Use this form to complete the information required in any block of a PIO or PA/PR form.		
	Decentralize further the Personnel Unit's functions.	MOH, IHAP and new PHC contractor team	Dec. 1986
7.	Extended IHAP Personnel Management Advisor for 3 additional months.	USAID, IHAP MOH	Jan. 30, 1986
8.	Coordinate long-term training and counterpart participation to assure that MOH staff are available to work with long-term advisors.	MOH, USAID new PHC contractor team	on-going
9.	Provide short-term TA to planning unit to provide linkage with efforts under new PHC project	USAID, MOH new PHC contractor team	Dec. 31, 1987

**Swaziland Health Planning  
and Management Project Evaluation  
(645-0215)**

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November, 1985

## Acronyms

CMS	Central Medical Stores
DEPS	Department of Economic Planning and Statistics
DET	Department of Establishments and Training
EPI	Expanded Program of Immunizations
FYP	Five Year Plan
GOS	Government of Swaziland
HEU	Health Education Unit
HMA	Health Management Advisor
HTO	Health Training Officer
IDM	Institute of Development Management
IHAP	International Human Assistance Programs, Inc.
IHS	Swaziland Institute of Health Sciences
MEDEX	University of Hawaii Manpower Training Group
MOH	Ministry of Health
NGO	Non-Governmental Organization
ODA	British Overseas Development Agency
OPG	Operational Program Grant
PACD	Project Assistance Completion Date
PHC	Primary Health Care
PHU	Public Health Unit
PMA	Personnel Management Advisor
PO	Personnel Officer
PPO	Principal Personnel Officer
PVO	Private Voluntary Organization
RFM	Raleigh Fitkin Memorial Hospital
RFP	Request for Proposals
RHM	Rural Health Motivator
RHMT	Regional Health Management Team
RMT	Regional Management Team
RN	Registered Nurse

## I. SUMMARY

The Swaziland Health Planning and Management project was implemented via a \$1,126,000 Operational Program Grant to the U.S. private voluntary organization International Human Assistance Programs, Inc., (IHAP) covering the period August 1981 - February 1986. The purpose of the grant was to expand the capability of the Ministry of Health (MOH) in the areas of planning, management and policy development. Most of the large number of objectives specified in the Grant Agreement have been achieved (Annex D).

Through technical assistance provided under the project, the first official national health policy statement--emphasizing primary and preventive health care and maternal and child health services rather than curative services--was formally issued by the Government of Swaziland (GOS), and was incorporated into the 1983/84 - 1987/88 National Development Plan.

The planned reorientation to primary/preventative health care has led to a desire to decentralize health services throughout the country's four regions. The project developed a decentralization plan and has begun to translate the plan into action via new coordinating/management bodies, known as Regional Health Management Teams (RHMT)--the RHMT members being drawn from senior hospital staff, and provincial health administrators, inspectors, and public health officers in each region. The evaluation team found the RHMTs established and enthusiastic. However, mechanisms need to be developed to provide them with the necessary resources (e.g. budget, authority) to carry out their plans.

The project also assisted in reorganizing the Ministry of Health (MOH) to clarify lines of communication among headquarters offices as well as with regional health units. While the proposed new structure has been accepted on an interim basis, the evaluation team found that effective two-way communication with regional staff has not been achieved, and roles remain unclear.

The project purpose of improving management capability was addressed in large part through a focus on the MOH personnel system. Technical assistance was provided to assess existing personnel functions, and to recommend and help implement changes. As a result of project efforts, a Personnel Unit was established, three personnel information systems have been initiated, procedures for determining needs were established and 100 new MOH positions were created for 1985/86 (as opposed to a total of 7 in the two previous years) which reflects MOH's improved capacity to present its case for new posts.

As this was a final evaluation, the recommendations are linked to actions which may be taken under the follow-on project.

The main problem identified by the evaluation team was inadequate counterpart participation. Counterparts either were not brought on board in a timely fashion, were away on long-term training, or were detailed to tasks that did not permit them to work with advisors. For example, while technical assistance was provided to the MOH Planning Unit, and staff sent for Masters degrees in the U.S., the Planning Unit has been plagued by absences and vacancies, and therefore was not significantly upgraded from its pre-project condition. This should be corrected in the

follow-on project if the improved personnel and management procedures recommended under the current OPG are to be addressed. Other recommendations center on how the decentralization process can be enhanced and institutionalized.

Approximately 84 percent of the OPG funds have been disbursed to date, and about 95 percent will have been disbursed by the current PACD of February 14, 1986. More than adequate funds will remain to cover a three month extension which is being contemplated to provide technical assistance overlap with the follow-on project.

## II. RECOMMENDATIONS

Building upon the accomplishments and activities initiated by the IHAP project, a follow-on project—the "Swaziland Primary Health Care Project" (645-0220)—will be implemented in the early part of 1986. As part of its strategy for improving the health status of children under 5 years of age and women of childbearing age, the Primary Health Care project will focus attention on improving the management of health services within the Ministry of Health continuing the IHAP-supported decentralization process. The following recommendations for the new project have arisen from the evaluation of the IHAP grant:

1. Develop and implement a program of basic training (workshops) in health planning and budget preparation for members of the regional management teams and advisory councils and committees;
2. Carry out a study of the management information requirements of the decentralized management system noting possible structural changes in the MOH statistical unit.
3. Develop and implement a strategy for convincing the Ministry of Labor and Public Service to cede personnel flexibility to MOH.
4. Develop and implement a program for developing a uniform regional financial management system for use by MOH and Mission facilities, preparation of central monitoring procedures, and training in the system's use.
5. Prepare an updated manpower plan which covers all categories of posts in the Ministry of Health and which specifies where and how the proposed manpower will be used.
6. Undertake a review of the personnel management functions under decentralization, recommend and help to implement the necessary structural and operational changes.
7. Extend the IHAP Personnel Management Advisor for an additional 3 months in order to assure a smooth transition to the follow-on Primary Health Care project.
8. Coordinate long-term training and counterpart participation so that MOH staff are available to work with technical assistance.

9. Under the follow-on project, short-term technical assistance should be provided to the MOH Planning Unit to provide linkage with efforts under the current project.

### III. LESSONS LEARNED

- ° In designing institution-building projects and establishing appropriate implementation schedules, the target institution's capacity to effectively absorb technical assistance must be considered. It can be argued the difficulties which the IHAP project encountered in attempting to implement the broad range of project objectives was not due to the disparate nature of the objectives, but rather, the lack of personnel depth within the Ministry of Health.
- ° Long term training and availability of counterparts to work with expatriate advisors must be coordinated, especially when the pool of host country individuals suitable as trainees/counterparts is quite small.

### IV. PURPOSE OF THE EVALUATION, SCOPE

The purpose of the evaluation was to:

- A. Assess progress in achieving objectives (as stated in the AID/IHAP grant agreement and Amendments I and II) within the context of the project setting and constraints.
- B. Assess the process used in implementing the project.
- C. Assess the capacity-building and sustainability of those project activities, where there has been enough time for impact to be observed and measured.
- D. Make recommendations on health policy, planning, and management, based on experience and findings of final evaluation, that would benefit Swaziland/MOH, USAID/Swaziland, and others in future health planning and management efforts in Swaziland.

The scope of the evaluation covered the period since the mid-term evaluation to the present, July 1983 - November 1985.

### V. TEAM MEMBERS, TIMING

The evaluation was conducted during November 10 - 26, 1985, based in Mbabane, with field trips to the three of the country's four regional health management teams. Evaluation team members were: Linda Bernstein, PDO, REDSO/ESA (team leader); Jeanette North, IHAP Program Officer, IHAP HQ/New York; Dr. Harry Feirman, Consultant in health systems based in Omaha, Nebraska; Dr. Charles DeBose, RHPDO and Mary Pat Selvaggio, HPO, both of USAID/Swaziland.

## **VI. METHODOLOGY**

The evaluation team interviewed in depth various individuals from MOH, other GOS Ministries, USAID/Swaziland, IHAP/Swaziland, and government and missionary hospitals (Annex C); made field site visits; and reviewed project reports, memoranda, workplans, AID/IHAP Grant Agreements, Amendments I and II, the project proposal, the six-month extension proposal, the mid-term evaluation report, and various consultancy reports.

## **VII. PROJECT BACKGROUND**

Swaziland is a small, land-locked country slightly smaller than the state of New Jersey, bordered on three sides by the Republic of South Africa. The mid 1984 population was estimated at 651,000. Average per capita income is \$940 (1982 dollars). The child and infant mortality rate is 105/1000 (1984), and the population growth rate is estimated at 3.4%. Swaziland has 9 hospitals, 9 health centers, 118 clinics and 6 public health units. Health care is provided through government hospital and their associated clinics, or through missionary (of "mission") hospitals and clinics. Approximately 70% of the population is believed to live within 8 kilometers of a health facility.

The health system has grown rapidly in recent years and has outstripped the ability of the MOH management and administrative systems to support it. The following constraints characterized the setting in which the Health Planning and Management Project was initiated:

- inadequate health service infrastructure organization
- inadequate health data and use
- inadequate health service manpower production, distribution, and utilization
- fragmentation of service
- poor coordination between service limits and between government and missionary health facilities.

The Swaziland Health Planning and Management Project (645-0215) was obligated as a three-year Operational Program Grant (OPG) to International Human Assistance Programs, Inc. (IHAP), a private voluntary organization located in New York, on August 12, 1981, in the amount of \$996,000. IHAP's proposal had been developed jointly with the Government of Swaziland, Ministry of Health during 1980.

The purpose of the grant was "to expand the capability of the Ministry of Health (MOH) in the Kingdom of Swaziland to carry out effective planning, management, and policy development."

The total project budget was originally \$1,609,780, with a PACD of August 11, 1984, as follows:

AID	\$996,000
GOS	535,460
IHAP	78,320
	<u>\$1,609,780</u>

An interim evaluation was conducted in July 1983, and found that overall implementation of the project had been proceeding successfully. On the basis of this positive evaluation, Amendment I to the OPG was concluded on April 16, 1984, extending the grant one year to August 11, 1985, and laying out its primary and secondary objectives in greater specificity. The status of these objectives are summarized at Annex D. Amendment 2 was concluded on July 26, 1985, further extending the PACD by six months to February 14, 1986, and adding \$130,000 for additional technical assistance. The GOS and IHAP contributions remained unchanged; thus the final project budget was:

AID	\$1,126,000
GOS	535,460
IHAP	78,320
	<u>\$1,739,780</u>

One further no-cost amendment is anticipated, to extend the PACD to May 15, 1986 in order to permit the Personnel Management Advisor, David Alt, to overlap with the technical assistance arriving under the follow-on project. The follow-on \$5.7 million project, "Swaziland Primary Health Care (645-0220) was authorized on August 21, 1985. It will be implemented via a contract, the contractor will be required to have technical assistance in place by about March 1986. IHAP, for internal administrative reasons, has decided against submitting a proposal for the Phase II project, but this should not be construed in any way as a criticism of IHAP's performance, or as any indication of IHAP disenchantment with its Swaziland experience.

#### **VIII. EXTERNAL FACTORS**

Shortly after the project commenced, King Sobhuza II died after 60 years of rule. The absence of a strong leader since then may have discouraged major changes or decisions regarding national development; senior government officials may have been reluctant to be associated with new policy initiatives during the power vacuum. The successor Prince is expected to be crowned in late 1986. Thus policy changes in the health sector, under this project, and appointment of key officials, may have been slowed by these external political influences.

#### **IX. REVIEW OF PROJECT ACTIVITIES IN TERMS OF MAJOR DESIRED OUTCOMES**

##### **A. Decentralization of MOH Management Structures**

##### **1. Accomplishments**

As outlined in the original project grant agreement and subsequent amendments, a principal focus of the IHAP Health Planning and Management Project has been to advise and assist the

Government of Swaziland on the design and implementation of a decentralization process for the Ministry of Health. In the achievement of this objective, the following activities were to be undertaken:

- (a) Develop and initiate implementation of a plan for decentralizing the management of health services.
- (b) Develop recommendations/strategies to increase co-ordination between Government and Mission Health care providers.
- (c) Develop recommendations for a uniform fee structure between Government and mission health sectors.
- (d) Develop a plan for integrating services at the primary level, including vertical programs (immunizations).
- (e) Review and revise the Ministry of Health's organizational structure.

The development and implementation of a plan for decentralizing the management of health services is well underway at both the central headquarters level and within each of the country's four regions - Shiselweni, Manzini, Lubombo and Hhohho. (The extent to which the decentralization process has been institutionalized is addressed in Section B2 - Assessment of the Process.) Based on a 1983 consultancy undertaken as part of the IHAP grant, the project developed and submitted to the Government of Swaziland a framework and process for the decentralization of the Ministry of Health. The process which entailed a "bottom-up" approach to the development of a decentralized system was accepted in July 1983. Actual implementation began one year later (July 1984) following the March 1984 recruitment of a long term Health Management Advisor (HMA), Mr. Kess Hottle, whose principal responsibility was the implementation of the decentralization plan.

To oversee and guide the work of the HMA, a Decentralization Task Force was established in 1984 composed of key health sector officials drawn from the Ministry of Health's headquarters staff and from each of the four regions. Included among the task force membership were the Under Secretary MOH, who chairs the Task Force; the Senior Health Planner, MOH; the Deputy Director of Health Services, MOH; Chief Nursing Officer, MOH; the Administrator of Raleigh Fitkin Memorial Hospital representing the Manzini regions; the Matron, Mbabane hospital representing the Hhohho region; the Senior Medical Officer, Good Shepherd Hospital representing the Lubombo region; and the Senior Medical Officer representing the Shiselweni region. The four Regional Health Administrators participated as ex-officio members of the Decentralization Task Force.

The decentralization strategy, perceived by the participants as a developmental process, entailed the establishment of Health Advisory Councils and Regional Management Teams (RMT) (also known as Regional Health Management Teams--RHMT) in each of the four regions. The Regional Management Teams are composed of the Senior Medical Officer and Senior Matron from each Government and Mission Hospital in the region; the Regional Health Administrator; Health Inspectorate Unit Head; Public Health Unit Head and other key officials as might be appropriate. With the RMTs in place, a series of workshops were then undertaken in each of

the regions; the objectives of which being: (1) the definition of the proposed structure for decentralization; (2) the clarification of Regional Management Team's role within the decentralized structure; and (3) the provision of training in regional health planning. The series of workshops culminated with a problem identification/problem solving workshop where program priorities were established for each region and management problems and their solutions were considered. During the time in which the present evaluation was being undertaken, the RMTs were actively engaged in the process of fleshing-out regional health plans based upon the Regional Health Program priorities established during the problem identification/problem solving workshops.

Employing as input the recommendations derived from the Regional Workshops, a basic reference document was prepared which outlined general guidelines for the operation of the decentralized health system. This document served as the basis for a three day National Workshop (October 21-31, 1985) held to finalize recommendations for decentralizing Ministry of Health programs and outlining the management structure under decentralization.

As a result of the discussions held during the workshop, the "Guidelines for Future Operation of Health Services in Swaziland," was revised and edited. The document which will have been submitted to the Decentralization Task Force for adoption after the completion of the present evaluation,

- (1) Elaborates the basic structure for regional and community health services organizations, including the role of the Regional Health Management Teams and Advisory Councils and Committees at national regional and community levels.

- (2) Provides job descriptions for key MOH officials and unit heads (Regional Health Administrator, Senior Medical Officer, Senior Hospital Matron, Regional Public Health Nurse, and Senior Regional Health Inspector). Incorporated within the job descriptions is an explanation of how the positions will function under the decentralized management structure; and

- (3) Notes appropriate strategies for future decentralization of management of the Ministry's "vertical" programs (e.g. T.B., Health Inspection, E.P.I., etc.)

In summary, the "Guidelines" are viewed by participants in the decentralization process as a "blueprint" for systems development.

Turning to the area of increasing coordination between the Government of Swaziland and Mission Health care providers, three potentially significant accomplishments may be noted (a fourth area, the development of a uniform fee structure shall be addressed separately):

- (1) The integration of mission health care providers within the decentralization process - Mission units which fulfill a significant health care role in the provision of health care services, particularly in the Manzini and Lubombo regions, are represented on the Decentralization Task Force. On an operational basis mission units have taken an active and constructive role within the RMTs. At the time

present evaluation representatives of mission units (Raleigh Fitkin and Good Shepherd Hospitals) were chairing the RMT in their respective regions;

(2) The shared professional supervision of government and mission clinic services - In line with the decentralization of services, agreements have been executed between the Government and missionary groups to permit MOH medical and nursing supervisors to oversee mission clinics and vice versa. With the Regional Hospital providing the medical and nursing supervision of clinics within its region, Raleigh Fitkin, a Nazarene Hospital, has assumed the supervision of MOH clinics in the Manzini region. The supervision of Nazarene clinics, located outside the Manzini region is being provided by the MOH and Good Shepherd Hospital, another Mission unit;

(3) The establishment of a formal working agreement between the MOH and a large missionary unit - The World Mission Department of the Church of the Nazarene has negotiated a five year interim operational agreement which defines each party's duties and responsibilities as they are related to the administration, operation, staffing and funding of the Raleigh Fitkin Hospital, its rural clinics and its school of nursing. Participants view the interim operational agreement which at the time of the evaluation has been accepted by both parties, as a model for similar type agreements between the MOH and other non-governmental providers. This agreement has yet to be approved by central Government, but its approval is likely to be forthcoming.

As previously indicated, a uniform fee structure for the government and mission health sectors has been developed and implemented. The absence of a uniform fee schedule had been perceived by MOH and project officials as a significant barrier to the development of an integrated and coordinated health care delivery system. However, the extent to which there is uniform application of the fee schedule remains problematic. (As project participants have noted, the situation may be attributable in part to the manner in which the fee schedule was introduced to health care facilities; there were little or no instructions or orientation provided.) Moreover questions have been raised regarding the effect of the uniform fee schedule on overall utilization as well as changes in utilization patterns. There are some indications which suggest the implementation of the uniform fee structure has resulted in an overall decline in utilization as well as a shift towards over utilization of non-governmental facilities (it is believed that patients are by-passing government facilities in favor of Mission facilities which are perceived to provide a higher quality of care for the same fee.) However, to the extent that some Mission units were under-utilized prior to the new uniform fee schedule, one of the objectives of the fee revision has been met. The impact of the uniform fee structure is presently being assessed. Recommendations for revisions in the fee schedule, as well as a financial impact analysis of current and recommended fee schedules are being prepared by the IHAP project. However, final recommendations will not be available during the present evaluation.

The development of a plan for integrating services at the primary level, including vertical programs, has been incorporated within the overall decentralization effort. The project has assisted headquarters management and program unit heads with the development of strategy papers for the decentralization of their management structure. The

papers were presented and discussed during the October 1985 national workshop on decentralization. As noted in the project reports, headquarters officials left it to the HMA to promote planning for decentralization of vertical programs; headquarters officials became active only in the final review stage.

As with the other items included in the workshop agenda, the outcome of the discussions on the vertical program units is viewed by the participants as providing the basis for subsequent steps in integrating services at the regional and service delivery levels. However, it should be noted that while most headquarters or central program units did eventually participate in the process, the financial management and personnel units have resisted cooperation. As project personnel suggest, the various delays in developing a plan for integrating services has ruled out the possibility of embarking on an effort to work with local officials regarding their increased responsibilities under decentralization during the remainder of the project.

Turning to the final element in the decentralization of the MOH management system, the Ministry's organizational structure had been reviewed and revised early in the project in response to the expressed MOH need to clarify lines of communications between units of the MOH. The MOH organizational structure was reviewed and an alternative for a new structure at the headquarters level was developed. The proposed structure was accepted on an interim basis following modifications by the Headquarters Management Committee, based on input from the various regional and national workshops, and the Decentralization Task Force. The proposed organizational structure which is pending review and approval by the MOH Policy Committee provides for the central program units to adopt a technical support role for the regional health units. Moreover, the proposed structure incorporates intersectoral cooperation and community involvement through the establishment of advisory councils and committees at the community, regional and national levels.

## 2. Assessing the Process

At the present time neither the extent to which decentralization has been achieved, nor the project's impact upon health status can be evaluated. Moreover, one might legitimately question whether such criteria can reasonably be employed in evaluating the IHAP project, a planning rather than implementation-oriented project.

Given the nature of the project, and the recognized need to strengthen the Ministry's planning and managerial capacity, the assessment would more appropriately focus on the process for decentralizing the Ministry of Health's management structure. In undertaking such an assessment a basic criterion for measuring success is the extent to which the process has resulted in or appears to have facilitated the institutionalization of the decentralization process.

The decentralization process adopted and pursued by the IHAP project was developed within a ministerial environment which is not conducive to institutionalization. The environment may be characterized by the following factors:

(1) extended absences of key Ministry of Health officials - The Ministry has been plagued by the frequent absence of key officials as a result of their attendance at conferences, training sessions and workshops. The situation has been further exacerbated by the Principal Secretary's forced six months leave during the second half of 1985; the Government is requiring officials to take their accumulated leave during this period. With the absence of key officials, there have been temporary though frequent shifts in leadership positions within the Ministry; subordinates have been shifted from their normal responsibilities to fulfill these temporarily vacant posts. While it is acknowledged that the replacements have done commendable jobs in their "acting" capacities, the lack of continuity has hampered decision-making within the Ministry, particularly as it relates to efforts at institutionalizing the decentralization process.

(2) the absence of counterparts at headquarters level - Counterpart availability has remained an issue throughout the project cycle. This may be attributed to the fact that counterpart recruitment and training, perhaps by necessity, had been designed to occur during the active phase of the project. Moreover, the temporary shifts in leadership positions noted above have tended to separate advisors from those counterparts who are in-country. As a consequence, the counterparts have been absent or fulfilling temporary posts most of the time the advisors have been in-country, effectively reducing the amount of time available for the advisors to work with counterparts to transfer skills and institutionalize the planning and management activities critical to the decentralization process.

(3) pressure for advisors to perform routine administrative functions rather than focusing on development issues. It has been suggested that such pressure may in part be attributable to serious staff shortages and the large number of expatriates holding decision-making positions within government.

(4) an excessive reliance and over-dependence on expatriates - With expatriates assuming highly visible and what is perhaps an excessive role within government, there is a tendency for Swazi nationals to question the impetus for the specific decentralization plan and the level of commitment among key Ministry officials for the decentralization efforts being undertaken.

Turning to the decentralization process, a number of factors can be identified which adversely affected institutionalization. Included among these factors are:

(1) The absence of effective communication between the Ministry of Health headquarters staff and members of the regional management teams. With a decentralization strategy which called for the establishment of basic decentralized management structures (the Regional Management Teams) while simultaneously fleshing out the details of the decentralized management system, it is critical for there to be effective communication between headquarters and regional level staff. Unfortunately effective two-way communication has not been achieved. For example, the Hhohho Regional Management Team had not been informed of specific personnel transfers in the Piggs Peak area; the Lubombo Regional Management Team was not notified of the selection of sites for

additional clinics; headquarters staff set up a series of meetings which interfered with in-service training set-up by the Manzini Regional Management Team.

In each instance the Regional Management Teams were left with the perception that headquarters did not wish to deal with the regional structures and were not committed to decentralization.

(2) The roles of Regional Management Teams and central headquarters staff are not well understood by those involved in the process. The lack of understanding regarding the specific responsibilities of the regional and headquarters personnel - a situation closely linked to the communications issue - can be seen in the Lubombo and Nhohho examples previously cited. It was suggested by members of the respective management teams that headquarters staff were overstepping their authority and assuming responsibilities delegated to the Regional Management Team (selection of clinic sites and the responsibility for personnel transfer respectively). What is significant about these illustrations is not whether the Regional Management Teams were correct in their interpretations, but rather the fact that definition of responsibility remains an issue.

(3) The lack of involvement of the personnel and finance units in the decentralization process - The lack of involvement has curtailed the development of necessary management support systems (finance/budgeting) at the regional level. A situation has been created in which the Regional Management Teams having completed their problem identification and prioritization exercises yet lacking necessary resources, they do not know how to deal with the problems. As suggested by members of the Manzini Regional Management Team, the inability to provide the regions with the necessary resources (e.g. budget and authority) will within a year destroy the region's enthusiasm for decentralization.

The above notwithstanding, the decentralization process has contained elements which have had a positive impact on institutionalization, principal among which are:

(1) The use of the team approach in decentralization which has broadened the base of support for the process and has begun to address the issue of over reliance on expatriates within the system.

(2) Bringing the traditional chiefs - an important force within the country - into the decentralization process at the regional level through their participation in the advisory councils and committees.

In summary, the decentralization process as pursued by the project has resulted in the establishment of the basic decentralized management structure in each of the country's four regions. The Regional Management Teams, supported by their local advisory councils, are on the whole, operating with great dedication and enthusiasm. Though having expressed concern as to whether decentralization is a "project or a program", the members of the Regional Management Team generally tend to accept the view that decentralization is a program (implicit in the former term is the notion of a short term undertaking which will terminate and be over; the latter is viewed as on-going and continuous). With acceptance of decentralization by the Regional Management Teams the process of

institutionalizing decentralization has been successfully initiated at the regional level. However, as infrastructure development (management and logistical support systems) has not kept pace with the development of the Regional Management Teams, the Regional Management Teams will continue to require long-term support from headquarters staff. Unfortunately at the Ministry's headquarters level, the process of institutionalizing decentralization remains at an earlier and more precarious phase. Headquarter's roles require better definition moreover, a new commitment to fill vacant headquarter's positions, expedite the development of management and logistical support systems (e.g. budget, personnel) and actively support regional operations is needed.

### 3. Issues Outstanding

To preface the discussion of "Outstanding Issues," it should be emphasized the evaluation team views decentralization as a dynamic, and evolving process. With the project's objective being the development and initiation of a decentralization process, it is unreasonable to expect that most major decentralization issues will have been resolved prior to the project's conclusion.

The previous remarks notwithstanding, the following issues require resolution if the decentralization process is to produce a management system capable of assuring the delivery of efficient and effective health care services:

(1) The commitment of the senior Ministry of Health personnel to decentralization - The fundamental issue which underlies all aspects of decentralization and which for many remains unresolved, is the level of commitment of key senior Ministry of Health personnel to the decentralization process. Doubts which have arisen over the course of the project have been reinforced by the lack of participation by the Principal Secretary, and Principal Personnel Officer in the National Workshop on "Guidelines for the Future of Health Services in Swaziland" - the workshop being viewed as the culmination of an 18 month process for defining decentralization. The Principal Secretary's failure to attend was perceived by the participants as a lack of commitment on his part. The absence of the Principal Personnel Officer was criticized similarly as his function is critical to the decentralization process. Though it might simply be a question of perceptions (key MOH personnel may in fact be deeply committed to decentralization) these perceptions must be changed. The question of commitment on the part of senior level MOH officials must be clearly and unequivocally resolved, to maintain the necessary enthusiasm on the part of the regional management teams, community, regional and national advisory councils, and to gain the active cooperation of non-governmental providers, and other ministries.

(2) Lack of planning/budgeting capacity at the regional and community (unit) level - Under decentralization, annual plans which require the linkage of the planning and budgetary functions will be prepared at the regional and community (unit) levels. These plans would be forwarded to the central health planning unit for integration into the national health planning and budgeting process and be distributed to technical units at the headquarters level as a basis for organizing technical support services. Participating in the process will be MOH and

non-government health care providers as well as members of the regional and community advisory councils and committees. While some of those who will be actively involved in the planning/budgeting have the necessary skills, and/or participated in the project's needs assessment workshops, it has been suggested that they are in the minority. Moreover, there is some question as to the effectiveness of the needs identification workshops. Members of the Manzini Regional management team noted that although the workshops enabled them to identify and define regional needs, they do not know how to proceed in addressing those needs. The MOH has prepared budgeting and planning manuals which is a first, though important step in addressing the issue. Nevertheless, training in planning and budgeting is required. Furthermore the Ministry's health planning and/or financial unit should designate an individual to be responsible for (a) monitoring the work of the regional and community health advisory councils and committees, and (b) assuring that proper staff support is provided to each. At present neither unit has personnel available for such purposes. Moreover, it has been suggested that the Ministry of Finance, which has resisted cooperating in the Ministry's decentralization efforts, lacks staff who are prepared to monitor program budgets at either the central or regional levels.

(3) The development of a management information system and evolution of the statistical unit into a data processing unit - The planning/budgeting process envisioned under decentralization requires a two-way flow of financial and patient data; data collected at the local level must be returned to the local level within a reasonable period and in a form which provides additional information previously not available to the unit (analysis). Though the statistical unit has made tremendous strides over the life of the project (computerization of patient data, the analysis of immunization data to focus an immunization campaign etc.), the tendency is to collect a narrow range of data which flows upward from the units to the central level. When data flows back to the units after a delay of approximately 6-8 months it generally returns without an accompanying analysis. Given that (a) the scope of data collected by the statistical unit needs to be expanded (financial data etc) to meet the system's needs under decentralization and (b) the statistical unit at present does only limited data analysis, the issue of creating a true management information system and allowing the statistical unit to evolve into a data processing unit should be addressed (the Ministry might seek an epidemiologist to furnish the type of analysis which the data processing could not provide).

(4) Lack of personnel and budgetary flexibility  
Decentralization of the planning process is inexorably linked to the issues of personnel and budgetary flexibility. Having identified programmatic needs and established priorities for services, regions require the ability to order their personnel and financial resources in a manner calculated to best meet those needs. At present the region and center headquarters have only limited ability to shift personnel posts from one responsibility unit (hospital, clinic etc.) to another.

It has been suggested that in order to obtain budgetary flexibility it will be necessary to demonstrate to the Ministry of Finance and Treasury that the delegation of financial authority to the regional level can be safely achieved, that delegation of authority is

linked to appropriate financial controls and monitoring procedures. Consequently, the financial management capability of regional health officials and accounts staff needs to be improved. This entails the development of regional financial management systems, preparation of central monitoring procedures, training in the use of such systems and procedures and long-term follow-up and support to assure that the systems become institutionalized.

(5) Integration of mission personnel and facilities into the decentralized regional structure--As indicated in Section IX-A-1 (Accomplishments) the project has initiated a number of preliminary steps designed to integrate mission health care providers within the regionalized structure--the inclusion of mission personnel in the Regional Management Team, community regional and central level advisory councils and committees, as well as the Decentralization Task Force; formalized interim agreement governing the operation of Raleigh Fitkin Memorial Hospital etc. However, to advance the integration process to its natural conclusion--a single merged health care delivery system--it will be necessary to confront the issue of the development and implementation of a common set of policies and procedures for MOH and mission facilities in the following areas (a) planning/budgeting, (b) financial management, (c) personnel, (d) control and supervision, (e) logistical support systems including drug supply and maintenance. It is not reasonable to expect completion of the full agenda within the near or perhaps long-term future. However, the Ministry must remain cognizant of the issues and their implications for the decentralization of management structures as the decentralization process is implemented.

(6) The development and capacitation of advisory councils and commissions--To the credit of the project and Ministry of Health, a series of advisory councils and commissions have been established as integral parts of the decentralization process. However, to effectively fulfill their responsibilities as laid out in the "Guidelines for the future operation of health services in Swaziland," it will be necessary for the Ministry of Health to provide training for these individuals and make personnel available to assist these groups and monitor their performance.

(7) The establishment of the regional public health matron posts - The posts for regional public health matrons are critical to the decentralized health care delivery system. Under the decentralized system the public health matron will be responsible for coordinating public health activities within their respective region including supervisory support of clinic nurses and programs for communicable disease control, MCH and Family Planning. Despite the critical role envisioned for the matron under decentralization, the posts for public health matrons have not received formal approval at the time of the present evaluation.

(8) Cooperation with other ministries - Decentralization has occurred with only minor cooperation from other ministries. As the regional management teams begin to assume greater responsibility and become more active in regional health care delivery, cooperation with other government ministries will become more critical. While cooperation

can be forged at the regional level, the necessity for senior MOH officials to take an active role in furthering inter-ministry cooperation remains.

(9) Overlap with the primary health care project - The IHAP planning and management project has successfully initiated a far reaching process which due to a lack of counterpart availability has not been institutionalized at the central headquarters level. This lack of institutionalization makes it critical that provisions be made to assure the overlap of IHAP advisors and the new primary health care staff through an extension to the IHAP project to May 1986.

#### **4. Relevance to Follow-on Project**

The goal of the follow-on project, Swaziland Primary Health Care is to improve the health status of Swazi children under five years of age and women of child bearing ages. To achieve this objective the project has adopted a two-pronged approach which focuses on both the clinical and managerial aspects of health care delivery.

As acknowledged by the GOS and USAID/Swaziland the first steps in rationalizing the management of the health care delivery system and improving the management of health resources is the decentralization of the Ministry of Health structure. The process of decentralization initiated under the IHAP project establishes the basis upon which the management and systems support activities contemplated within the Primary Health Care project will be undertaken.

#### **B. Improving MOH Personnel Functions**

##### **1. Accomplishments**

Another principal focus of the IHAP Health Planning and Management project has been to advise and assist the Ministry of Health in strengthening its personnel management functions. The following activities were to be undertaken to achieve this objective:

- (a) Develop recommendations for strengthening the MOH personnel system.
- (b) Institutionalize newly-adopted personnel policies, systems and procedures.
- (c) Conduct job analyses and revise job descriptions for MOH personnel.
- (d) Prepare a continuing education/in-service training plan for MOH personnel.

A comprehensive report detailing recommendations for strengthening the MOH personnel system was completed in April 1984, after a thorough two-month review of the personnel functions in the MOH. Implementation and institutionalization of the report's recommendations began in July 1984 and are currently at varying stages of accomplishment. To provide technical assistance to the MOH in the implementation of these

recommendations, IHAP hired one of the consultants who prepared the report to join the IHAP project as Personnel Management Advisor, in place of the departing Health Manpower Advisor.

**a. Develop Recommendations for Strengthening MOH Personnel Systems**

IHAP/S organized a 3-person consultancy effort (but funded by the University of Hawaii/MEDEX) to:

- (1) conduct a review of the personnel management functions in the Ministry of Health;
- (2) provide specific assessments, recommendations and management tools and structures with which the MOH can use to implement an efficient personnel management system; and
- (3) develop a plan for implementing new management policies, procedures and practices.

The consultancy team's final report, "A Review of Personnel Management Policies, Procedures and Practices, Ministry of Health, Government of Swaziland" and its "Addendum", addressed a number of personnel management issues and provided recommendations in three broad areas:

- (1) Personnel Management Organization and Functions;
- (2) Personnel Information Systems;
- (3) Career-related concerns (such as supervision, allowances, upgrading, training, probations reporting, and scheme of service)

The report and its addendum were both accepted by the Ministry of Health.

**b. Initial implementation of the Personnel Management Report's Recommendations.**

With the PMA's encouragement, guidance and many times actual work by himself (since counterparts were frequently not available), the following recommendations from the report were acted on:

- (i) Establishment and strengthening of the MOH Personnel Unit - The efforts to strengthen the Personnel Unit involved recruitment and training of Personnel Unit officers and restructuring job and Unit functions. Specific accomplishments include:

- post of Personnel Officer was created and filled in August 1985.
- post for a Health Training Officer was created, but not filled at the time of this evaluation.
- post for Assistant Personnel Officer was created from the Executive Officer post.

- the responsibility for and the staff related to transport, registry, typing pool, storekeeping, security and communications were shifted from the PPO to the Senior Health Administrator.
  - job descriptions for all posts in the personnel unit were revised to reflect the changes in duties brought about by the creation of new posts and the shifting of responsibilities.
  - the PPO, who had no health background, participated in a primary health care course at the University of Hawaii.
  - training for the new PO was not needed as she already received formal training in management in Australia and at IDM, Botswana.
- (ii) implementation and institutionalization of the use of a computerized manpower inventory system.

With the PMA's assistance, the Personnel Unit established a computerized manpower inventory system. This system is capable of generating regular reports on the numbers, types, and location of establishment posts; vacancies; due dates for probation reports; due dates for retirements, and a detailed staff list. This system provides the data necessary to project staff attrition rates for use in making manpower needs assessments, to monitor reporting on probationary employees, to prepare documentation for the timely notification of persons due to retire and to begin recruitment for posts about to be vacated through retirement.

A manual explaining the computerized manpower inventory system was prepared; titled "Ministry of Health, Government of Swaziland: Manpower Inventory". Upon the manual's completion, the Ministry of Labor and Public Service was briefed by the PPO and PMA on the inventory system. A similar system is being contemplated for use on a government-wide basis, as a result of the achievements of MOH's system.

- (iii) Development of a Mission sector personnel inventory system and institutionalization of its use.

With the PMA's assistance, a Mission sector personnel inventory system is being created, because of the large subsidies provided by the MOH support various Mission health activities. Data has been compiled and inputted in the computer. Computer printouts of staff lists have been returned to Mission facilities for updating and a report has been prepared based on this updated information.

- (iv) Development and institutionalization of a computerized registration and reporting system for the Swaziland Nursing Council.

A revised registration system for nursing personnel in Swaziland was determined to be needed to allow analysis of needs for nursing personnel in all sectors in Swaziland. The MOH had information only on those nurses working for the Ministry. The new information will allow the Ministry to make better informed decisions on intake levels at the 3 nurse training institutes, which it funds. With the assistance of the PMA, this system is still being established. Based on a proposal that the PMA drafted to change the system for registering nursing personnel to one that could be computerized and that would provide more useful information for manpower planning purposes, the Chief Nursing Officer directed the Nursing Council staff to implement the new system. New registration cards have been printed and the records on all registered nurses, enrolled nurses and nursing assistants who paid their fees in 1985 have been transferred to these cards. This information is being inputted into the computer.

- (v) Preparation of a revised Scheme of Service for the nursing cadre.

A Scheme of Service defines the functions of a cadre, the qualifications for entry to a cadre, and the career prospects and requirements for progress within the cadre.

With the PMA's assistance, the Chief Nursing Officer developed a new strategy for revising the Schemes of Service for nursing. The new approach was to handle the issue as a series of separate specific requests to the DET rather than ask the DET for the entire scheme to be changed at once. The latter had been attempted twice without success. Since certain nursing personnel changes required urgent action, requests for these changes were submitted first to the DET. They include:

- a request to upgrade Family Nurse Practitioners and Public Health Nurse by one grade - as recognition of the increased training and responsibilities they had assumed.
- a request to provide a 10% stand-by allowance to those nurses and nursing assistants providing evening and weekend emergency care at hospitals and clinics.

Both requests (as above) were referred to a salaries Commission which is to report its findings in April 1986.

-- a request for a Matron II post for each region, which would be in charge of all community health nursing services in the region and a request for upgrading the present Public Health Matron post from Matron II to Matron I. A decision on these requests will be known by March 1986. These changes are being requested to allow public health supervisors to oversee community health nursing staff rather than having the hospital (curative oriented) supervisors perform the supervision task.

-- Based on a observation tour of nursing assistant training programs in Zambia and Kenya undertaken by the Principal Tutor for the Good Shepherd Hospital Nursing Assistant School and the education representative to the Swaziland Nursing Council it has been recommended that the Nursing Assistants in Swaziland be trained as midwives. Once midwifery is included as part of the Nursing Assistants' responsibilities, a request will be made to the DET to acknowledge the midwifery qualification with an increase of a grade

(vi) Assistance to the Department Heads and Personnel Units to conduct job analyses and prepare updated job descriptions.

With the PMA's encouragement, job analyses were begun in early October 1985. This involved conducting various sessions with heads and deputy heads of the headquarters technical and administrative units, the RHMT members and the Personnel Unit staff, where the tasks and responsibilities of various positions were discussed and assigned.

Drafts of the job descriptions were begun by the PMA in November. Out of a total of 200 to 250 job descriptions required for the MOH (covering about 127 different kinds of MOH posts), approximately 40 have been drafted at the time of this evaluation.

(vii) Development and implementation of a training policy, a system for conducting in-service and pre-service training needs assessments, a system for preparing an annual training plan, and a system for reviewing and ranking candidates for in-service training.

Accomplishments under this activity include:

-- a training policy drafted and approved by the Training and Personnel Management Committee.

- a training needs assessment conducted in the 4 regions by the PMA and the Health Education Unit.
- a 2-year training plan drafted by the PMA and reviewed, revised and approved by the Training and Personnel Management Committee.
- a system for reviewing and ranking candidates for in-service training drafted but not implemented. Candidates for USAID scholarships were reviewed and ranked by the Committee but the time given to accomplish this task was too short and the information provided by AID/DET too incomplete to use the recommended system.

(viii) Strengthening the role of the MOH Training and Personnel Management Committee.

Accomplishments in this activity include:

- the Committee's statement of function was revised to more clearly define the responsibilities of the Committee. Decisions previously taken by individual officers were made the responsibility of the Committee e.g., the number of students to be trained at the nursing and health inspector courses, the type of courses to be offered, and the selection of candidates for training.
  - an annual calendar of actions to be taken by the Committee was drafted to guide the Committee.
  - the Committee met more regularly and dealt with more issues of substance than it had previously.
  - the Principal, IHS was made a regular member of the Committee in order to improve communications between Headquarters and the Institute and to benefit from the Institute's perspective on training issues.
- (ix) Development and institutionalization of procedures for identifying, priority ranking and requesting new required posts and/or modifying Establishments' existing posts.

Despite certain constraints, the Training and Personnel Management Committee, with the PMA's assistance, prepared submissions to DET requesting new posts for 1985-86. Based on these submissions, the MOH was given more than 100 posts by the DET. This was in contrast to 1984-85 when the Ministry had gained 12 posts and 1983-84 when the Ministry lost 5 posts.

For 1986-87, all field and Headquarters units were asked to identify redundant posts and new posts required. A total of 550 posts were requested. The Training and Personnel Management Committee reviewed

these requests and prepared submissions to DET requesting 100 posts. For the 1986-87 exercise, forms were developed and the exercise was carried out as scheduled on the calendar of activities for the Training and Personnel Management Committee. The same tools and procedures can be used in future years.

In relation to the post request exercises, the PMA completed an analysis of growth of posts in the MOH as compared to the growth in other Ministries and in the Civil Service as a whole. The analysis shows that MOH grew very moderately relative to the other services in spite of having very legitimate needs for more personnel. Copies of this analysis were sent to the Principal Secretary and senior staff of the Ministry of Labour and Public Service from the Principal Secretary of the Ministry of Health. It was thought this information could be useful in future discussions with the DET on the need for new posts.

## 2. Issues Outstanding

The establishment and strengthening of the Personnel Unit was the key recommendation in the consultancy report for instituting a personnel management capability in the MOH. In fact, this recommendation was considered the prerequisite for achieving all other recommendations in the report.

The MOH followed up on this recommendation by establishing a Personnel Unit in the Ministry and obtaining posting to staff the Unit with five personnel ranging from the Principal Personnel Officer, the Personnel Officer, the Assistant Personnel Officer, and the Senior and Junior Clerks. Training was provided by the project for the PPO in primary health care, as he had no previous background in this area. Also, with the PMA's guidance, the responsibilities of the Unit as a whole and of the individual staff members were defined and some activities shifted out of the Unit to free the staff to fully assume the responsibilities and tasks of managing the Ministry's personnel matters.

Despite these improvements, the actual implementation of the personnel management system has been done with little counterpart participation. As has been the case in the decentralization effort, this implementation has been hampered by the extended absence of key MOH officials, due to their attendance at conferences, training sessions and workshops, as well as the Principal Secretary's forced six-month leave.

Since the PPO is the next in line in the Ministry after the Undersecretary, the PPO since his joining the Ministry in June 1984 has on frequent occasions been called to fill as Acting Under Secretary while the Principal Secretary or Under Secretary are away. With the Principal Secretary currently on forced leave from August 1985 to January, 1986, the PPO will not be assuming his normal duties for most of the remaining six months of the project.

The Personnel Officer, with whom the PMA was to work as a counterpart since the PPO had assumed the Under Secretary's duties, joined the MOH only in August 1985. One month later she was assigned to temporarily fill the vacant PPO post while the PPO serves as acting Under Secretary. This has left little time for her to focus on personnel management development issues, as she has been busy with the day to day matters of the Personnel Unit.

Implementation of personnel/training systems have also been hampered by factors outside of the Personnel Unit. Though the Training and Personnel Management Committee had received increased responsibility for training and personnel decisions, the Committee has not had adequate opportunity to exercise this responsibility. The Committee meetings have often been cancelled or scheduled irregularly due to the frequent absences of senior headquarters staff who are members of the Committee. Also with the PPO's and PO's other demands, the PMA has had to assume on his own much of the proposal and plan preparations for the Committee.

In the Personnel Development Unit, the MOH recently received a post for a Health Training Officer (HTO). The position has not as yet been filled, through interviewing of candidates was being done at the time of the evaluation. It is with this HTO that the PMA was to work on developing the training management functions of the Ministry. With 2½ months remaining in the project, there will be very little overlap from the time the HTO assumes the post and the time the PMA departs.

Since there has been little direct involvement of the headquarters staff and the Personnel Unit counterparts in the implementation of the personnel system, the system will not be sufficiently institutionalized by the projects termination and the PMA's departure to assure the systems continuation after the project.

The manpower inventory system was established mainly by the PMA with the assistance of the Personnel Unit's Clerical Officer. Though a manual has been prepared, no one above the clerical level is sufficiently familiar with the system. The Mission sector personnel inventory system was done by the PMA himself. The nursing registration and records data was collected by the Nursing Council staff, but with the PMA inputting the data himself in his spare time. These three information systems run the risk of not being updated and properly distributed after the project's termination, as no one of responsibility in the Ministry is thoroughly familiar with the mechanisms of these systems. This is also true for the procedures established for conducting the training needs assessment, and other personnel post needs assessments to be presented to the Training and Personnel Management Committee and the preparation of training and personnel plans resulting from the Committee's decisions, as these were also done primarily by the PMA as counterparts were not available.

No other issue is as important to the personnel management objective as the availability of MOH staff to provide continuity to the personnel training systems already established and the implementation of the remaining personnel management recommendations listed in the consultancy report.

### **3. Relevance to Follow-on Project**

The following is a list of recommendations for the Ministry of Health for the continued implementation and institutionalization of the recommended project management functions in the Ministry of Health. If the new health project can assist the MOH in these efforts while conducting regular project activities, it would be most useful not only to the overall functioning of the Ministry but to the success of the specific project activities as well.

a. Once the Principal Secretary has returned from his leave, and the various officers have resumed their normal duties, it is strongly recommended that:

(1) the PPO, PO and HTO make every effort to follow-up on the development activities in personnel and training to ensure their continuation and progress. Specifically the PPO and PO must become more involved in the personnel information system and its mechanisms

(2) the Principal Secretary and Under Secretary be aware of these new personnel and training systems/procedures, encourage their continuation and effectiveness, and feel free to demand that vacancies be declared and filled in a timely fashion, that staff be confirmed in appointment and retired on time, that training needs be assessed and training plans be prepared and implemented, that training and personnel staff become fully involved with the RHMTs.

b. Since the personnel management objective was just being initiated, there has been little attention on connecting the personnel management functions with the Ministry's decentralization effort. It is recommended therefore that a review of the personnel management functions under a decentralized system be made and recommendations provided for decentralizing these personnel functions as much as possible.

c. **Decision-Making Procedures for Training and New Post Issues**

(1) the new Health Training Officer must assume responsibility for training related activities formerly carried out by the PMA.

(2) the new Health Training Officer should participate in the "Managing the Training Function" course being offered by Management Sciences for Health in Boston, Massachusetts, USA, in June 1986.

(3) in conducting future training needs assessments the Training Officer and the Committee must pay more attention to the Mission, Industrial, and Private sector's training requirements.

(4) as an urgent priority for both posting and training decision-making, an updated manpower plan should be prepared which covers all categories of posts in the Ministry and which specifies where and how the proposed new manpower will be used must be prepared. Particular attention should be spent on cadres such as medical equipment maintenance technicians and medical records staff. The Regional Health Management Teams and the heads of responsibility centers should be involved in this exercise. Also the unit heads at headquarters should be involved in the final review and the setting of priorities in the plan. The Training and Personnel Management Committee with certain invited guests would be a good forum for this review. If necessary, an outside short-term consultant should be brought in to assist the Swazi Health Planner in charge of manpower planning.

(5) the Principal Secretary should require all top headquarters officers to prepare an annual plan for travel outside Swaziland. These plans should be carefully reviewed and the amount of travel restricted to a level which will allow the Ministry to function efficiently and effectively.

(6) continue to work as closely as possible with DET to make them better informed and more supportive of the needs of the Ministry.

**d. Training and Personnel Management Committee**

(1) the PPO, PO and Training Officer must take a more active role in setting agendas on substantial issues and doing advance staff work so meetings can be conducted more efficiently.

(2) the Under Secretary, PPO, and Training Officer should make special efforts to see that the Committee as it is mandated meets fortnightly or more frequently as required.

(3) headquarters staff must attend more meetings if the multi-disciplinary inputs into decision-making that the Committee is designed to achieve are to be achieved.

(4) the Training Officer should be made a regular member of the Committee.

**e. Job Analysis and Job Descriptions**

(1) all remaining job descriptions should be completed, reviewed, and approved using consultant assistance if necessary.

(2) the binders prepared for the Principal Personnel Officer, Personnel Officer, Open Registry (for checking out), Health Training Officer, Senior Health Administrator, Regional Health Management Teams, the Department of Establishments and Training should be completed and distributed.

(3) a complete set of job descriptions should be prepared in a binder or folder for each responsibility center. Only those job descriptions for posts on the Establishment Registry for that center should be included in these binders and folders.

(4) copies of the new job descriptions should be made so that every employee in the Ministry is given a copy of his/her job description. These copies should be made at headquarters and distributed to the heads of departments for distribution to their respective employees. In distributing these copies the supervisors should discuss the duties with the employees. After the initial distribution each responsibility center will be responsible for making and distributing copies to new employees.

**f. Manpower Inventory System**

(1) the PPO and PO who have not been involved on a daily basis in implementing the manpower inventory system must become more involved.

(2) the present dBase II programs must be converted to dBase III to give the Ministry more flexibility in formats for the various reports and to allow for faster running of programs.

(3) once regional Health Administrators (RMA) and Regional Health Management Teams become involved in personnel actions in the regions the program should be revised to provide an Establishment/Staff Register for each region to be printed and distributed on a quarterly or semi-annual basis.

**g. Mission Sector Personnel Inventory System**

(1) this activity should be added to the job description of the Personnel Officer or transferred to the Health Planning Unit as a part of its manpower planning function.

**h. Computerized Registration and Reporting System for the Nursing Council**

(1) the Health Planning Advisor under the new Primary Health Care project should continue this activity. The first step should be to run the reports called for in the proposal for the 1985 registration data.

(2) the 1986 registration data should then be entered and the reports for 1986 generated.

(3) an arrangement should be made under which the Nursing Council would make an "in-kind" payment to the statistics unit for the computer time, the operator's time, and the materials used for entering data and producing reports. Once a value is placed on this and mutually agreed to, the Council would purchase that amount of paper, diskettes, ribbon, etc. for the Statistics Unit each year in return for the computer work and printouts.

(4) if it is found that the reports generated are useful in manpower planning and pre-service training decisions a similar system should be implemented for the health workers registered with the Swaziland Medical and Dental Council.

**i. Nursing Scheme of Service**

(1) the Ministry staff and technical advisors under the new Primary Health Care Project must continue to attempt to educate DET on the merits of primary health care and to press for improved terms and conditions for workers in the primary health care network.

**j. Implementation of Other Recommendations in the Personnel Management Consultancy Report**

(1) of high priority - the Personnel Unit, with consultant assistance if necessary, should develop a basic induction/orientation program for new employees.

(2) a medium priority until the personnel management function under decentralization is more clearly defined - the preparation and distribution of a simplified personnel management

procedures handbook to MOH supervisors and other managers. A consultant working with the MOH and Central Personnel Agencies is recommended for preparing this handbook.

(3) a low priority for the near future - the development of simplified staff performance appraisal reports, leave applications, sick sheets, and request for DET and Civil Service Board approval for using the same on a trial basis. If the Personnel Unit's performance in other areas improves significantly, this activity could be undertaken in 2 - 3 years.

(4) in 2 - 3 years time if other activities are well under control, the Personnel Unit should request permission from DET and Civil Service Board to experiment with a reduced probationary period and more frequent appraisals of probationary employees.

### C. Health Policy Developments

A National Health Policy statement was prepared, and approved by the MOH in July 1983. Technical Assistance provided under the project had worked with MOH personnel in conceptualizing, drafting, and disseminating ideas contained in the statement. A booklet containing the statement was distributed within the Ministry, to other GOS officials, to donors and other international organizations. The policy statement redirected the nation's health efforts toward maternal and child health, primary and preventative services, and health promotion activities. It called for increased investment in the health sector, and identified ten priorities:

- 1 to develop health education programs focusing on the major health problems
- 2 to promote the development of clean water supplies and basic sanitation
- 3 to increase immunization coverage
- 4 to promote sound nutrition
- 5 to provide basic medical care services and essential drugs
- 6 to expand and strengthen maternal and child health services including family planning
- 7 to develop services in the rural areas so that all people will have access to health services
- 8 to develop mechanisms for grass-roots participation in the planning and implementation of health programs
- 9 to speed up the process of localization by expanding appropriate health manpower training programs
- 10 to increase the effectiveness of the hospital services by improving efficiency.

The Cabinet accepted the statement as the first official health policy of the Government of Swaziland. Government officials have quoted from the statement in public interviews.

The Health Planning Advisor provided under the project also worked closely with the GOS Department of Economic Planning and Statistics, with heads of MOH programs and with senior MOH officials, in devising the health sector component of the GOS Fourth National Development Plan (for the five year period 1983/84 - 1987/88). The health component of the Five Year Plan (FYP) was based on the policy guidelines developed in the Health Policy Statement. In December 1984, the FYP was accepted by Parliament.

#### **D. Health Budgeting, Finance, and Statistics**

##### **1. Budgeting**

One of the outputs called for under the project was a set of recommendations for rationalizing health sector financing. The first consultant in this area under the project, Mr. Yaw Adu-Boahene, recruited from the East and Southern African Management Institute (ESAMI), went to Swaziland in early 1984 and submitted a report and recommendations dated February 1984, entitled "Health Services Fee Structure Rationalization and Government Financial Relationship with Mission Sector Health Services." Among other things, he recommended equalizing government and mission fees, a policy that was formally introduced by the GOS on October 1, 1984. He also recommended that the system of GOS subventions for mission hospitals be rationalized, and changed to permit the GOS to review annual estimates of mission revenues vs operating costs by specific activity and item, rather than in toto as was then the practice.

He also recommended that the MOH acquire a fiscal expert with experience in health finance, to oversee MOH budgeting activities and analysis. As of the date of this evaluation, the MOH fiscal staff contained only an accountant seconded from Ministry of Finance. However, plans were being laid to establish a position of MOH comptroller in the near future. Also an ODA comptroller (British AID) is expected in early 1986 tasked with strengthening and streamlining accounting procedures.

The fee equalization issue had been supported and promoted by Dr. Richard Yoder, the IHAP Health Planning Advisor. The project funded a statistical analysis of the impact of inpatient fee equalization which was conducted by Yoder and Herman. This study showed the expected results: fees at government hospitals had been increased some 400 percent, while fees at mission hospitals were significantly reduced. With respect to outpatient and clinic fees, government units had large increases (the first increases since 1966) while at missionary units fees remained essentially unchanged. Since Swazis generally regard the mission hospitals as superior, it was hardly surprising that utilization of mission hospital services increased (which was one of the objectives). Since government hospital fees were greatly increased, it was also hardly surprising that in response to the higher price, demand had fallen.

## 2. Finance

A consultant was provided under the project to prepare additional recommendations for rationalizing health sector financing. Mr. Carl Stevens (U.S., based in Portland, Oregon) went to Swaziland for seven weeks in October/November 1984, and prepared a 138 page report and Plan of Action. The report was circulated and discussed among officials in the Ministries of Health, Finance, the Treasury, the Department of Economic Planning and Statistics, and the Office of the Accountant General. The report's basic recommendation called for significant increases in fees charged for government and missionary in-patient hospital services; that government hospitals retain the revenue from fees charged rather than being reverted to the central treasury; and that government hospitals have greater management flexibility, including areas related to personnel policies. The report further recommended that in order to achieve equity objectives a large part of (the revised, higher) hospital fees be funded through an insurance scheme rather than financed by out-of-pocket payments by patients. A kind of prepay or health insurance scheme with a modest annual premium per household (above a certain minimum income level) was proposed. The resulting insurance pool which would be sufficient to defray hospital costs, would be combined with other such insurance schemes in the public and private formal and informal sectors, (e.g. farmers cooperatives, etc.)

Major personality conflicts which emerged during this consultancy resulted in GOS officials being unwilling to seriously consider the recommendations contained in the consultancy report. The issue of health sector financing has for the most part remained on hold over the past year. However, in fairness, it should be pointed out that due to the sensitive nature of the topic, attitude problems and resistance by central Ministries might have resulted in a negative reaction to any consultant, not just Mr. Stevens. Current plans involve bringing another consultant to Swaziland in the last three months of the project, to address the issue of Health Sector Financing. It is hoped that this consultant will be more favorably received.

Finally, another consultant, Don Grant, (U.K. expatriate - CIPFA Of London) went to Swaziland in November 1985, to review the current operation of fee schedules. He pointed out that in reaction to the revised fee schedule, of October 1984 outpatient attendance has fallen by an estimated 17 percent. In the preliminary recommendations it was suggested that immunization and other preventive health services be administered free of charge; and that in general there should be no major upward revision in fees. As the consultant report was in preliminary form at the time of the evaluation, it could not be adequately assessed.

## 3. Statistics

Another objective of the project was to strengthen and computerize the MOH's health information system. This process was started with the establishment of a computerized system within the Statistics Unit (which formerly compiled data by hand) and the improvement of the relevancy of data collected and compiled. The Swazi Health Planner and the initial IHAP Advisory team worked closely with

the Statistical Unit to implement these changes. Activities included defining routine data sets required for MOH planning and management purposes, developing appropriate data reporting forms to obtain the desired data from the field, equipping the Statistics Unit with two personal computers and appropriate hardware and software funded by the project, and hiring a computer consultant for 18 months to set up computer programs for each of the various kinds of health information collected.

The Statistics Unit is now a well functioning office. Trained Swazi officials are working in the Unit, including the Health Statistician who will be the head of the Statistics Unit; the Statistical Assistant who has the major responsibility for programming; and a clerk trained on-the-job for data entry. The MOH budgeting process and personnel inventory systems have been computerized as well as health statistics. Mr. Dale Herman, the present MOH Health Statistician, and his predecessor, Ms. Cathy Connolley, both have contributed to the strengthening of the computerized system.

Data now generated by the Statistics Office has been used for situating clinics, for budget determinations, for determining training and posting needs, for analyzing the Mission and government fee structure, for allocating resources, and for other planning and management purposes. The application of this project input to expanding immunizations is illustrated below:

Each year the Ministry of Health conducts an immunization survey in the country to determine the levels of immunization coverage among children under two years of age. In 1984 the computer was used for the first time to assist in analyzing these data. Clinic immunization data had been stored on computer files since the beginning of 1983. With the 1984 survey it became possible for the first time to compare the survey data with the clinic data. A very high correlation was found between the survey data and the clinic immunization data. However, this analysis pointed out some of the weaknesses in the immunization program. Since it was the first detailed information on the immunization program which people had to work with, it prompted a great deal of interest and sufficiently motivated people to take action: a major campaign was launched to improve the immunization coverage.

Part of this campaign is a series of workshops for clinic nurses dealing exclusively with the immunization program. The Health Statistician speaks with the nurses each week illustrating the data which are collected and the uses which can be made of these data. A further analysis of the immunization data which had been stored on the computer through June 1985 has been used in these workshops for clinic nurses.

The current project advisors are now working closely with the Statistics Unit in the compilation/computerization of data related to manpower inventory and personnel information and in linking the health statistics process with the decentralized management system being instituted.

Three issues remain concerning the functioning of the Statistics Unit: the need to improve the accuracy of the data, the need to improve the linkage between the data and their use in the decision-making process, and the need to develop greater depth in staff members in anticipation of some staff moving to the private sector.

#### **E. Institutionalization of MOH Planning and Management Capabilities**

The underlying goal for all the project components has been institutionalization of improved MOH planning and management processes. While regional staff in the field have exhibited enthusiasm for new decentralized planning and management systems, headquarters staff have not. Certain initial steps/processes have been taken to this end (i.e. recruitment for new posts, training etc.) but actual assumption of the planning and management functions called for under the project have not been taken by the headquarters staff. The process therefore, has now stalled. Six areas of concern need to be addressed by all parties:

1. The MOH's commitment to institutionalizing the planning and management systems - The evaluation team believes there exists a commitment by the MOH official to the "concept" of a decentralized structure. Nevertheless, headquarters level officials have failed to initiate the specific actions which are required to institutionalize the proposed structures. It is in the area of implementation that the commitment of headquarters level staff appears to have failed.

2. The lack of leadership at the MOH to direct and enforce the institutionalization process - One reason why the MOH has not taken the actions necessary to assure institutionalization, has been the lack of leadership at headquarters level which manifests itself in two areas:

- a. with frequent absences and turn-over in headquarters' staff, the Ministry has been unable to rely on the presence of a stable cadre of personnel to direct and enforce the adoption of these systems.
- b. due to the political uncertainties in Swaziland since the death of the King, Ministry officials have been unwilling to be associated with or to introduce new or risky policies and procedures that would place them in the forefront of decentralization and leave them susceptible to possible maneuverings.

3. Constraints on the Ministry of Health from the central Ministries.

There are several planning and management concerns for which the concurrence/approval of the central Ministries is needed to adopt and institutionalize the new systems developed under the project. Throughout the project, central Ministries have not been very supportive of these efforts. Lack of support may be attributable to the following factors:

- a. the central Ministries have a different agenda that may not coincide with the concerns of the Ministry of Health;

- b. the central Ministries are themselves disorganized and short-staffed and therefore are not readily able to respond efficiently to the Ministry of Health's concerns;
- c. the central Ministries have been ambivalent and reticent to accept the changes required to establish the decentralized management system.

Leadership at the MOH again is needed to work with central Ministries to strongly encourage their support and assure a better understanding of the concerns and directions of the Ministry.

#### 4. The Timing, Length and Kind of Training for Swazi MOH Counterparts

An essential part of the institutionalization process in the project was to be the on-the-job training of Swazi counterparts by the project advisors, after receiving long-term formal training. This on-the-job training however was never realized, as the overlap periods planned for the advisors and counterparts never materialized (even despite the 1 1/2 year extension of the project). This was in part due to the length of the formal training they received which kept them away from the Ministry for most of the time the advisors were present. Future training activities therefore should be reassessed with a view to providing more short-term training courses instead of long-term degree programs. This change in training orientation would allow more time at headquarters for the advisors and counterparts to work together.

Another aspect of the training issue to reconsider is the use of formal training (Masters degrees) as an incentive for employees to remain at the Ministry. By providing long-term training to a Master's level at the beginning of counterparts careers, the project and other AID-funded training programs at the Ministry may have discouraged the desire and incentive of new graduates to stay on-the-job. Armed with Masters degrees from U.S. universities, they are highly marketable elsewhere, and have often attained the highest grade level possible in government service. The result has been a number of resignations of qualified staff in key posts.

The need for training staff at the Masters level at all should also be reassessed.

#### 5. The Absorptive Capacity of MOH Personnel

With so many components to undertake, the project may have slowed the institutionalization effort, by overloading the system. By forcing the staff to focus on a number of issues at the same time, their ability to absorb what they have learned was most likely diminished.

6. Continuity in the short-term consultants to be used in the Primary Health Care Project - One function of the follow-on PHC project will be to focus on getting headquarters to take concrete actions on developing basic administrative systems in the Ministry, through the use of short-term consultants. It is believed that instituting these systems would benefit from a continuity in the consultants to be used. By having a consultant work with specific counterparts over the course of the project, a rapport can be developed between the consultant and

counterparts, a continuity maintained on the issues being addressed and a willingness on the part of the consultant to work in a collaborative manner with the counterparts as his consultancy trip is not seen as an assignment in itself to be completed before he/she departs the country.

### **Ministry of Health Planning Unit**

The MOH Planning Unit was the office where the greatest institutionalization effort was focused, but where this effort has had the least success. This effort was hampered in large part by the length and timing of the training provided for the unit, as discussed above.

The Planning Unit was the unit from which the various planning and management systems of the project were to be initiated and coordinated with the rest of the Ministry. To strengthen the Planning Unit's capability in this planning and coordinating role, two new planning officers were hired to increase the Unit's staffing to three, and then sent to the U.S. for long-term Masters degree training in Public Health. In addition, two long-term advisors were provided and based in the Planning Unit to provide on-the-job training for the Senior Health Planner already in the Unit and for the two new officers upon their return from training.

The timing for the recruitment and training of the two new officers, however, did not go as planned. As a result of the delays in both the recruitment process and arrangements for training, the overlap time, where the on-the-job training was to be provided, was inadequate.

On the other hand, the long-term advisors were able to work closely and effectively with the Senior Health Planner (already in the Unit) for the first few years of the project. She however has since left the Ministry to live in Kenya. The Senior Health Planner post has not been filled since her departure (about a year), but a U.K. expatriate advisor, is serving as Acting Senior Health Planner until her departure in May 1986. It was hoped that there would be sufficient overlap of the new expatriate advisor and the two newly trained officers before the advisor's departure. Unfortunately, one of the officers has had to take extended sick leave some months after her return from training and will not be back in the Ministry until January 1986. The other officer is not scheduled to return from his training until June 1986.

By about June 1986, the Planning Unit will have two inexperienced Planning Officers and no Senior Health Planner. The budgeting and planning procedures instituted and developed in the Unit during the project will not have necessarily been passed on sufficiently to the returning Planning Officer - leaving the capabilities of the Planning Unit essentially the same as when the project first started.

## **X. STATUS OF INPUTS**

The table on the following page shows the status of disbursements under the IHAP grant. Of the total authorized amount of \$1,126,000, it is estimated that only \$30,606 will remain undisbursed. This takes into

TABLE I

## IHAP OPG - STATUS OF FUNDS

.....US DOLLARS .....

Item	(A) Total Authorized	(B) Net Outlays as of 10-13-85	(C) Unobligated Balance as of 10/31/85	(D) Est'd Expenses 11/85 2/86	(E) Est'd cost of Extension to 5/15/86	(F) Est'd total outlays as of 5/15/86	(G) Est'd un- obligated balance at 5/15/86
Technical Assistance							
Long Term	486,000	454,198	31,802	27,900	28,500 <u>3/</u>	510,598	(-24,598)
Short Term	233,000	168,546	64,454	41,500		210,046	22,954
Equipment & Supplies <u>1/</u>	47,000	44,891	2,109	300		45,191	1,809
Training, Seminars, & Workshops	70,000	48,709	21,291	9,000		57,709	12,291
Monitoring & Evaluation	19,500	9,254	10,246	14,000 <u>4/</u>		23,254	(- 3,754)
Local Admin. Costs	24,500	9,894	14,606	1,500		11,394	13,106
Contingency	25,000	1,905	23,095	2,400		4,305	20,695
IHAP COSTS							
Direct	49,000	54,635	(- 5,635)	7,000	6,000	67,635	( 18,635)
Indirect	172,000	155,912	15,088	8,350		165,262	6,738
TOTAL	1,126,000	984,945	177,055	111,950	34,500	1,095,394	30,606

1/ includes project vehicle2/ partially estimated3/ David Alt, of which \$24,000 Salary and \$4,500 airfare and per diem4/ Includes the present evaluation.

account the anticipated extension of the project (column "E") which USAID/Swaziland is considering to May 15, 1986, which will extend the Personnel Management Advisor, David Alt, another three months beyond the current PACD to provide overlap with the technical assistance arriving under the follow-on project.

The evaluation team does not have any recommendations for reprogramming the residual \$30,606. It may be prudent to leave that amount to cover final unanticipated expenses which may arise in the next half year.

#### A. Technical Assistance

The first long term advisor to the project, Dr. Rick Yoder, Health Planning Advisor, arrived in January 1982 to assist the MOH Planning Unit in general strengthening of the Units's planning activities, including policy development. Although Dr. Yoder's counterpart, Dumsile Nxumalo was available to collaborate with the advisor, she departed in 1984 to join her new husband in Kenya, leaving the Senior Health Planner post vacant. The post has not been permanently filled. The Senior Health Administrator Advisor, an expatriate, assumed the role of MOH Health Planner. Dr. Yoder departed Swaziland in December 1984 after completing two years of assistance to the Planning Unit.

The second team member, Mr. Julian Fleet, Health Manpower Advisor, also arrived in January 1982 to work with the Planning Unit to assist in strengthening the Unit's manpower assessment planning activities. Initially, the counterpart position of Assistant Health Planner was vacant, although the MOH recruited Ms. Thenjiwe Masina for the post in January 1983. Ms Masina worked with Mr. Fleet for approximately six months when she departed for M.A. level training in Health Planning at Tulane University, New Orleans, LA. Because she did not return before his departure in July 1984, Mr. Fleet worked without a counterpart for the majority of his assignment in the Health Planning Unit.

Mr. Kess Hottle, Health Administration Advisor, arrived in March 1984 to assist in strengthening the Health Administration Unit and in planning the decentralization process adopted by the GOS. In January 1985, Mr. Hottle succeeded Dr. Yoder as Project Chief of Party. Mr. Hottle's designated counterpart, Ms. Bongiwe Nsibandze, worked with Mr. Hottle (for about 3 months) until June 1985, at which time she also departed for marital reasons. The advisor refused to extend his assignment with the project unless a counterpart and key headquarters officials were made available to work with him for the remainder of his assignment. Subsequently, Mr. Musa Mdladla was named as candidate for the Senior Health Administrator position, and has functioned in that capacity and as counterpart to the advisor since mid-July 1985.

Mr. David Alt, Personnel Management Advisor, arrived in July 1984 to assist in developing the MOH Personnel Unit and to continue the assistance in manpower development previously begun by Mr. Fleet. Mr. Alt also worked without a counterpart until the position of Personnel Officer was established and filled by Ms. Zandile Magagula in August 1985. Unfortunately, since that time, Ms. Magagula has not been fully available to the advisor because she has been required to function as Acting Principal Personnel Officer (PPO) in the absence of the PPO who was assigned as Acting Undersecretary.

Both Mr. Hottle and Mr. Alt will continue their assistance to the Ministry through the project until the PACD of February 14, 1986.

All four long term advisors to the project were very well received by the GOS both within the MOH and elsewhere in the Government. Each individual was perceived to be professionally well qualified for the scope of project activities, although it was mentioned that the Health Manpower Advisor lacked a comparable level of experience, both professionally and cross-culturally, as the other advisors. Frequently during this evaluation, MOH staff volunteered their positive impressions of the technical assistance including the advisors' effectiveness in implementing project activities within the constraints of the system and their sensitivities to the need for institutionalization of planning, personnel, and decentralization activities.

Numerous short term technical assistance was provided during the project's four years in the areas of health services, financing/budgeting, decentralization, personnel, and medical supply systems. A complete list of these consultancies is provided in Table 2. In general, the recommendations of these short term consultancies were well received by the MOH and, for the most part, the recommendations were incorporated into MOH operations.

#### **B. Training and Counterpart Participation**

Training of staff counterparts for the MOH Planning Unit was a major project input.

Ms. Thenjiwe Masina, Sr. Assistant Planning Officer, the counterpart to the IHAP Health Manpower Advisor (Julian Fleet) in the Planning Office, was sent for 1½ years (August, 1983 - January 1985) training at Tulane University to obtain a Master's degree in Public Health. She completed her degree and returned to Swaziland in January 1985. However, she has been unable to return to work at the MOH thus far due to pregnancy complications. Her expected return to work is January/February 1986, but unfortunately this will provide limited overlap with the Acting Health Planner who is scheduled to depart Swaziland in April 1986.

The second trainee under the project is Mr. M.H. Hlope, Assistant Planning Officer, counterpart to the IHAP Health Planning Advisor, Julian Fleet. He worked with Mr. Fleet for five months, and was scheduled to go to ESAMI for diploma level training in management. However, ESAMI cancelled its diploma course, and a decision was taken to send Mr. Hlope to a year's Masters (in public health management) program at the University of Pittsburgh. He is currently away at training, and is expected to return in June 1986. (Note: the University of Pittsburgh training is being funded under another AID project). Returning only two months prior to the departure of the Acting Senior Health Planner, Mr. Hlope will not have much of an opportunity to work with his counterpart after completing training.

The third counterpart in the MOH planning unit, Ms. Dumsile Nxumalo (the Senior Health Planner), received long-term training under a prior USAID project, but did benefit from on-the-job training by working with her counterpart, the IHAP Health Planning Advisor Dr. Yoder, for a period of two years. Unfortunately, she then married an American and

moved out of Swaziland to Kenya. The Senior Health Planner post, made vacant by her departure, remains unfilled. An Acting Health Planner (U.K. expatriate due to leave in April 1986) currently fulfills the planning function.

Other forms of training undertaken during the course of the project included the in-service, in-country training of more than 300 MOH staff in various workshops concerned with decentralization, planning, and budgeting. These workshops were critical in assuring the institutionalization of the innovative management and planning procedures established by MOH headquarters with the assistance of the technical assistance team.

The project also funded a variety of supplemental training activities including a study tour for a five-member MOH team to visit the decentralization project in Lesotho during 1982; a study tour for two nurse educators to examine nursing assistant programs in other African countries; and the participation of two Swazi nurses to the 1985 International Congress of Nursing held in Tel Aviv.

### C. Commodities

The project supported the MOH through the purchase of various commodities, including two vehicles, two microcomputers, computer hardware and software, and office supplies and furniture. A list of these is provided in Table 2.

**TABLE 2**

**LIST OF TECHNICAL ASSISTANCE, TRAINING AND  
COMMODITIES PROVIDED BY THE PROJECT**

**A. Technical Assistance**

**Long Term**

- ° Dr. Richard Yoder, Health Planning Advisor, (January 1982 - January 1985)
- ° Mr. Julian Fleet, Health Manpower Advisor, (January 1982 - July 1984)
- ° Mr. Kess Hottle, Health Management Advisor, (March 1984 - February 1986)
- ° Mr. David Alt, Personnel Management Advisor, (July 1984 - February 1986)

**Short Term**

[Note: The following is a list of the individual consultancies and the title of the reports submitted to the Ministry of Health. The dates indicated are not the consultancy dates, but date of the report submission]

- ° Stevens, Carl, Alternatives for Financing Health Services in Swaziland, November 1984.
- ° Grant, Donald, Assessment of Health Services Fee Structure, November 1985.
- ° Yoder, Richard, Fees, Travel Time and Patterns of Facility Utilization, June 1985.
- ° Yoder, Richard, Regional Budgeting Manual, April 1985.
- ° Yoder, Richard, Decentralization Survey, Phase I, December 1985.
- ° Adu-Boahene, Yaw, Health Services Fee Structure Rationalization, February 1984.
- ° Thompson, H. Daniel, Five Year Plan for Strengthening the Rural Health Motivator Program, November 1982.
- ° Hottle, Kess, Decentralization of the Management of Health Services, July 1983.
- ° Alt, David, Frank White, and Ernest Petrich, A Review of Personnel Management Policies, Procedures and Practices, April 1984 (organized but not funded under the project.)

**Table 2** continued

- Dougherty, Patrick, Drug and Medical Supply System Report, December 1983.
- Makhubu Lydia and Ted Green, Traditional Healers in Swaziland and the Development of Government Policies. 1983

**B. Training**

- Four students enrolled at the Institute for Development Management, Botswana, for 9 month certificate program in Health Care Administration (1985).
- Thenjiwe Masina, Health Planner, MOH to Tulane University, New Orleans, LA. M.A. Health Planning (July 1983 to January 1985)
- Siphon Hlope, Principal Personnel Officer, MOH to University of Hawaii for short course in Primary Health Care.
- Nester Dlamini, Nursing Council, and Jostina Mkhabela, Principal Tutor, Nursing Assistant's Training School, Good Shepherd, went to Zambia and Kenya for a study tour to examine nursing assistant programs (October - November 1985).
- Two nurses from the Swaziland Nursing Council to attend the International Congress of Nursing meeting, Tel Aviv, Israel. June 1985.
- Five members from the Ministry of Health (Principal Secretary, Deputy Director of Medical Services, Health Planner, Health Planning Advisor and Health Manpower Advisor) to Lesotho to examine decentralization system. (1 week, 1982).
- Approximately 300 persons participated in in-country, in-service training (workshops) for decentralization, planning, and budgeting.

**C. Commodities**

- Two Project vehicles
- One used Olivetti Typewriter
- Four Draw file Cabinets
- Storage Cabinet
- Various computer supplies
- Two Sirius personal computers \$13,420
- Mannisman Tally printer (which was later traded for an Epson FX 100 printer)
- One Omnitech 600 uninterruptible power supply
- Floppy discs
- Software (including Wordstar, dBase II, Multiplan Graphics tool kit, and an Audio tool kit) \$780

**ANNEXES**

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<p><u>Project Goal:</u></p> <p>To improve the delivery of health care services to the people of Swaziland, with special emphasis on increasing the quality, quantity, and distribution of preventive and promotive services.</p>	<p>Increased use of health care services</p>	<p>Health facility records</p>	<p>There are no cultural or social factors beyond the scope of the project which will inhibit the use of expanded services.</p> <p>People will continue to be able to afford health care services.</p> <p>Recurrent budget of the NCM will be sufficient to support planned expansion of services during the project life.</p> <p>Coordination and cooperation with non-Government agencies will expand at a rate consistent with project needs.</p>
<p><u>Project Purpose:</u></p> <p>To expand the capability of the NCM to carry out effective planning, management, and policy development.</p>	<p><u>End of Project Status</u></p> <p>Long-range strategy developed and initiated for improving the delivery of health care services throughout Swaziland</p> <p>Functional operation and related organizational structure improved at both central and district levels.</p> <p>Planning functions of the Ministry being carried out effectively by Swazi nationals.</p>	<p>Interviews with key NCM officials.</p> <p>Interviews with selected rural clinic nurses.</p> <p>Project evaluations.</p>	

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<b>Objectives:</b>			
Comprehensive long-range plan for MNH developed and initiated.	Individual components of plan developed and implemented in accordance with project implementation schedule.	Project records	The MNH maintains a strong commitment to health planning and management.
Manpower assessment completed.	Assessment completed and analyzed by 1982, and results incorporated into manpower plan and other related project activities.	Project evaluations	GOS will encounter and/or establish the required posts.
Health facility survey completed.	Survey completed and analyzed by 1982, and results incorporated into plan for upgrading health facilities.	Review of relevant documents	Suitable candidates will be available for training.
Capacity of health information and statistics unit expanded.	Capacity expanded to meet increased planning and evaluation requirements as well as nutrition surveillance, by 1982.	Interviews with key MNH officials.	Trained personnel will return to work in the positions for which trained.
Health sector component of Fourth Five-Year Development Plan prepared.	Sector plan prepared according to GOS requirements by 1983.		
Social counterparts trained and in post by 1983.	Manpower Development Officer and Senior Health Administrator trained to Master's level; Program Development Officer trained to diploma level by June 1983.		
Strategy developed and initiated to increase coordination and integration of Government and non-Government health service providers.	Strategy developed and incorporated into long-range plan by 1982.		
Recommendations developed to encourage stronger ties between traditional and Western medicine.	Recommendations developed by 1983 (implementation in Phase 2).		
Continuing/in-service training programs designed to meet high-priority needs.	Continuing education and in-service education programs designed by 1984, based on priorities established in manpower plan (implementation in Phase 2).		
Strategy developed to improve MNH personnel systems.	Strategy developed, including priorities for implementation, by 1984 (implementation in Phase 2).		

2-1

**NARRATIVE SUMMARY**

**OBJECTIVELY VERIFIABLE INDICATORS**

**MEANS OF VERIFICATION**

**IMPORTANT ASSUMPTIONS**

**Outputs (Cont'd):**

Seminars/workshops developed and presented at national, district, and local levels.

Capability provided to coordinate health-related components of the national nutrition program.

Seminars and workshops concerning MNM policies and programs developed and presented during each project year (national-level only during first year).

Activities expanded to include nutrition surveillance, liaison function, and backup for proposed national nutritional survey, in accordance with OOS decisions.

**Inputs:**

**Technical Assistance**

Long-term: 6 person-years

Short-term: 1.67 person-years

**Local Salaries**

Academic Training: 5 person-years

**Vehicles**

**Equipment and Supplies**

Transportation, Accommodation, and Other Local Costs

**Monitoring and Evaluation**

**INAP Indirect Costs**

**Contingency**

**INAP Cash Contribution**

**Total Inputs**

	<u>USAID</u>	<u>COS</u>	<u>INAP/OTHER</u>	<u>TOTAL</u>
Long-term: 6 person-years	\$ 470,410	--	--	\$ 470,410
Short-term: 1.67 person-years	125,160	--	24,120	149,280
Local Salaries	--	356,970	--	356,970
Academic Training: 5 person-years	90,500	--	--	90,500
Vehicles	19,080	--	--	19,080
Equipment and Supplies	21,620	26,690	27,720	75,430
Transportation, Accommodation, and Other Local Costs	34,210	152,670	--	186,880
Monitoring and Evaluation	38,320	--	--	38,320
INAP Indirect Costs	155,280	--	--	155,280
Contingency	95,460	--	--	95,460
INAP Cash Contribution	--	--	26,480	26,480
<b>Total Inputs</b>	<b>\$1,050,040</b>	<b>\$535,730</b>	<b>\$78,320</b>	<b>\$1,664,090</b>

AFRICA BUREAU GUIDELINESI. WHAT CONSTRAINT DID THIS PROJECT ATTEMPT TO RELIEVE

This project attempted to overcome health planning and management constraints that inhibit the Government of Swaziland's Ministry of Health from effectively expanding and institutionalizing its capacity to plan, manage and develop policy to increase health services among rural people.

II. WHAT TECHNOLOGY DID THE PROJECT PROMOTE TO RELIEVE THIS CONSTRAINT?

This project provided long-term technical support to improve and institutionalize the functional operation and related organizational structure of the GOS's MOH; and developed a comprehensive long-range plan incorporating manpower, facilities, services, and financial resources.

III. WHAT TECHNOLOGY DID THE PROJECT ATTEMPT TO REPLACE?

The MOH has traditionally been faced with a critical shortage of experienced headquarters staff to perform effectively in the areas of health planning and management. This project provided the necessary expertise to develop planning and management capabilities to overcome difficulties in implementing health development programs.

IV. WHY DID PLANNERS BELIEVE THAT INTENDED BENEFICIARIES WOULD ADOPT PROPOSED TECHNOLOGY?

The institutionalization of health planning and management should upgrade the delivery of health care services throughout the country by developing programs and projects relevant to the needs of the country.

V. WHAT CHARACTERISTICS DID THE INTENDED BENEFICIARIES EXHIBIT THAT HAD RELEVANCE TO THEIR ADOPTING THE PROPOSED TECHNOLOGY?

Operational and program support problems have continuously constrained the effective delivery of health services in the country. These pertain to logistics, supplies, the health information system, and the MOH personnel systems. In addition, MOH personnel identified the lack of co-ordination between government and non-government health care providers and the lack of integration between preventive and curative services as factors affecting the delivery of health services in the country.

VI. WHAT ADOPTION RATE DID THIS PROJECT ACHIEVE IN TRANSFERRING THE PROPOSED TECHNOLOGY?

The health policy plans formulated under the project have been adopted.

VII. DID THE PROJECT SET FORCES INTO MOTION THAT WILL INDUCE FURTHER EXPLORATION OF THE CONSTRAINT AND IMPROVEMENTS TO THE TECHNICAL PACKAGE PROPOSED TO OVERCOME IT

The project incorporated a system of continuous evaluation and replanning of health development projects, as well as improving overall ministry planning and management capabilities.

VIII. DO PRIVATE INPUT SUPPLIERS HAVE AN INCENTIVE TO EXAMINE THE CONSTRAINTS ADDRESSED BY THE PROJECT AND TO COME UP WITH SOLUTIONS?

This question is not applicable to the project.

XI. WHAT DELIVERY SYSTEM DID THE PROJECT EMPLOY TO TRANSFER TECHNOLOGY TO INTENDED BENEFICIARIES?

The project incorporated a multi-sectoral approach for developing implementation plans to provide improved health services to the nation. The project sought the cooperation and support of other government ministries and departments whose work is not directly related to health. In addition, all health delivery plans were developed in conjunction with those GOS departments implementing the plans.

X. WHAT TRAINING TECHNIQUES DID THE PROJECT USE TO DEVELOP THE DELIVERY SYSTEM?

The project provided long-term training to one MOH counterpart and four regional health administrators, as well as various short term training.

LIST OF INDIVIDUALS INTERVIEWED

- Mr. H.B. Malaza, MOH Acting Principal Secretary
- Ms. Q.Q. Dlamini, MOH, Head of Maternal and Child Health, Acting Dep. Director
- Ms. Lucy Gilson, MOH, Acting Health Planner (UK expatriate)
- Mr. Dale Herman, MOH, Statistician, (US expatriate - Mennonite Central Committee).
- Mr. Musa Mdladla, MOH, Health Administrator (counterpart to IHAP Health Management Advisor)
- Mr. Kess Hottle, IHAP Health Management Advisor located in MOH (US expatriate)
- Dr. E. Mdluli, Acting Regional Health Administrator for Manzini District, hospital administrator for Raleigh Fitkin Hospital
- Mr. O. Chwane, Assistant Hospital Administrator, Raleigh Fitkin Hospital
- Dr. David Falk, Raleigh Fitkin Hospital (Canadian expatriate - Church of the Nazarene)
- Mr. N. Nhlabatsi, Regional Health Administrator for Hhohho District
- Dr. Dave Alt, IHAP Personnel Management Advisor located in MOH (US expatriate)
- Mr. Sipho Hlope, MOH Principal Personnel Officer; Acting Undersecretary (Counterpart to IHAP Personnel Management Advisor)
- Dr. Aby Philip, Sr. Medical Officer, Good Shepherd Hospital, Siteki; Acting Chairman, Lubombo RHMT
- Sister Abigail Dlamini, Nursing Supervisor Lubombo District, Member Lubombo RHMT
- Mr. Ronald Dlamini, Health Inspector, Lubombo District; Secretary Lubombo RHMT
- Sister Justine Mathabela, Nursing Tutor, Good Shepherd Hospital; Member Lubombo RHMT
- Ms. Anne Zwane, Matron, Good Shepherd Hospital, Member Lubombo RHM.
- Mr. A. Mbingo, DET, Training Section.
- Mr. Kenneth Charles, (UK expatriate), DET

## CHECKLIST OF ALL OBJECTIVES

OBJECTIVESSTATUSCOMMENTS / RECOMMENDATIONS1. Decentralization of MCH Management System

- |  |   |   |
|--|---|---|
| <p>a. Develop and initiate implementation a plan to decentralise the management of health services to district level. To help planning of decentralization, particularly in areas relating to increasing coordination between services provided by Government of Swaziland facilities and those of non-governmental organizations.</p> <p>b. Develop recommendations/strategies to increase coordination between government and mission health care providers.</p> <p>c. Develop recommendations for a uniform fee structure between Government and Mission Health sectors.</p> <p>d. Develop plan for integrating services at primary level, including vertical programs.</p> <p>e. Review/Revise the MCH organisational structure.</p> | <p>a. A decentralisation plan has been developed; a substantial degree of implementation activities have occurred.</p> <p>b. Effective strategies for increasing coordination between government and mission health care providers have been developed and are presently being implemented.</p> <p>c. Recommendations for a uniform fee structure were developed, approved and implemented in October 1984.</p> <p>d. Strategies for integrating services at the primary level have been developed and incorporated in the "Guidelines for the Future Operation of the Health System" which awaits approval of the Ministry of Health's Decentralisation Task Force.</p> <p>e. A revised organisational structure has been developed and is being employed on an interim basis while awaiting final Cabinet approval.</p> | <p>1 a. Institutionalization of the decentralisation process appears to be progressing more strongly at the regional level than at headquarters. An increased level of commitment is required at the central level, which must also increase the flow of communication with the regional management teams. Without this communication and a more responsive headquarters the enthusiasm of MHT will flag.</p> <p>c. An assessment of the impact of the uniform fee structure and the equity of the special fees was completed in November 1984. A series of recommendations were made for</p> <ol style="list-style-type: none"> <li>(1) Adjusting the fee structure and special service fees</li> <li>(2) Improving the fee collection process, and</li> <li>(3) Allocation of fees.</li> </ol> <p>This report suggested that the Government define its rationale for imposing fees.</p> <p>d. Delays in the implementation of this objective have made it impossible for the project to work with local officials regarding their increased responsibilities. With the project termination, implementation is problematic.</p> <p>e. Assistance will be required at headquarters level to guide unit heads in adjusting to their program development, monitoring and technical assistance role and their delegation of routine operations to the regional management teams.</p> |
|--|---|---|

CHECKLIST.

ANNEX D

2. MOH Personnel Functions

a. Update health manpower assessment and prepare health manpower plan.

b. Develop recommendations for strengthening MOH personnel systems.

c. Institutionalise newly-adopted personnel policies, systems and procedures.

d. Conduct job analyses and revise job descriptions for MOH personnel.

a. A "crash" manpower plan was prepared and accepted by MOH, and submitted to DET.

b. A comprehensive report, "A Review of Personnel Management Policies, Procedures and Practices; Ministry of Health, DOS," detailing recommendations for strengthening MOH personnel systems was prepared by a 3-person consultancy team after reviewing MOH's personnel management functions. An addendum to the report was also prepared containing designs, guidelines etc., that provide the groundwork for several of the recommended activities. The report and addendum was accepted by the MOH.

c. IHAP hired Personnel Management Advisor to provide technical assistance in implementing the Personnel Management report's recommendations.

Accomplishments in institutionalizing personnel policies, systems and procedures include the following:

- strengthening the MOH Personnel Unit, through recruitment and training of Unit Officers, and restructuring job and unit functions.

- developing and establishing the use of a computerized manpower inventory system, a computerized registration system for the Swaziland Nursing Council, procedures for identifying and priority ranking new posts required.

- preparing a revised scheme of service for the nursing cadre.

d. Activity was begun in October 1985 with workshops to conduct analyses of various positions' responsibilities. 32 out of a total 200 to 250 job descriptions (covering about 127 different kinds of MOH posts) have been drafted at the time of the evaluation.

a. An updated and more comprehensive Health Manpower Plan is needed urgently.

c. Efforts to strengthen the Personnel Unit in order for it to carry out the various development functions for personnel concerns have been discouraged by the late filling of newly opened Unit posts, and the fact that the PFO and PO have been acting US and PFO respectively for such of the time, thus severely limiting time available to work on activities.

d. All remaining job descriptions should be completed, reviewed and approved.

- complete sets of the job descriptions should be distributed to MOH MOs and to each responsibility center.

- each MOH employee should receive a copy of his/her description.

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2. continued

- a. Prepare a continuing education/in-service training plan for MOH personnel.

- c. A training policy was drafted and approved by the Training and Personnel Management Committee.

- PMA and Health Education Unit conducted a training needs assessment in the four regions.
- a 2-year training plan was drafted by the PMA and reviewed, revised and approved by the Training and Personnel Management Committee.
- a system for reviewing and ranking candidates for in-service training was drafted, but not implemented.
- efforts to strengthen and institutionalize the role of the MOH Training and Personnel Management Committee.

- e. - the lack of an up-to-date manpower plan seriously hindered the planning for pre-service training. As an urgent priority, the Health Planning Unit should prepare an up-dated manpower plan which covers all categories of posts in the Ministry and which specifies where and how the proposed new manpower will be used.

- new Health Training Officer must assume responsibility for training related activities formerly carried out by the PMA.

- in conducting future training needs assessments, the Training Officer and the Committee must pay more attention to the Mission, Industrial and Private sector's training requirements.

- the new Training Officer should be made a regular member of the MOH Training and Personnel Management Committee.

- the PPO, PO and Training Officer must take more active role in setting agendas and doing advance staff work to ensure meetings are conducted efficiently and along with the US, make sure the Committee meets as frequently as mandated to do.

3. Health Policy Development

- a. Prepare national health policy statement.
- b. Coordinate preparation of health sector component of Fourth National Development Plan.

- a. Completed. Published July 1983. Accepted by Cabinet.
- b. Completed. The Fourth National Development Plan including the health component was adopted by Parliament 12/84.

4. Health Budgeting, Finance and Statistics

- a. Prepare recommendations for rationalizing health sector financing.

- a. Consultant Carl Stevens submitted a report 11/84; discussed by MOH, Ministry of Finance and Treasury.

- a. Recommended increased fees for in-patient hospital services. Personality conflicts affected receptivity of recommendations.

**CHECKLIST**

**ANNEX B**

**4. continued**

- b. Develop/institutionalize procedures for preparing MOH annual plan of operation based on 5 year health plan.
- c. Strengthen/computerize health information system.

- b. Policies and procedures have been developed and NMTs have been trained in budgeting process. Operational plans expected for QOS 1987/8 fiscal year.
- c. Computers installed and functioning, staff trained (under another project), funding.

- b. Follow-up to training may be necessary to ensure institutionalization.

**5. Counterpart Participation and Training**

- a. Recruit Senior Assistant Planning Officer and finance Masters degree training in U.S.

- a. Training of Ms Thenjiwe Masina completed at Tulane in MPH.

- b. Recruit an Assistant Planning Officer after analysing needs of MOH, to finance a Diploma level in management at Arusha or to recommend to USAID to finance a Masters level program.

- b. Mr. Mlophe sent to University of Pittsburgh financed under another AID project.

- a. Unable to return to work at MOH due to illness, but return anticipated 1/88.

- c. Involve counterparts at all levels of planning, implementation and evaluation of project activities. Provide training, support, and assistance for Swazi Counterpart personnel returning from overseas Master Degree training as well as to newly-recruited staff for administrative and personnel units of MOH.

- c. Made an explicit objective after the arrival of the advisory team. Training, support and assistance provided to counterparts when available.

- c. Individual counterparts were not fully available to the advisors throughout the course of the project due to overseas training, termination for marriage and relocation, illness etc. Because most positions will be filled at end of project, several years support will be needed before a strong cadre exists.

**6. Other**

- a. Update rural/primary health care facility assessment and prepare health facility plan.

- a. Assessment was completed and the recommendations accepted by the MOH Policy Committee. These recommendations now serving as guidelines to Planning Unit for determining needs for further construction and equipment.

- b. Develop long range plan for strengthening rural health motivator (RHM) program.

- b. Plan prepared and accepted by MOH and PHU. The coordinator for the RHM program is utilizing plan to forecast training requirements and program management.

- c. Develop recommendations for strengthening ties between traditional/western medicine.

- c. A report was prepared and accepted by the MOH. Subsequently, workshops sponsored by the NEU were held to identify specific areas of cooperation. A Traditional Healer's Association was established to strengthen the ties between the two sectors.

- b. Altho most of the recommendations of the report have been implemented, significant constraints exist in the areas of management/supervision of RHM.

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**CHECKLIST.**

**ANNEX D**

**6. continued**

d. Organise/implement appropriate seminars and workshops at national, district and local levels.

d. Four regional workshops were held to address decentralization and management issues including financial management, supervision, personnel management, drug and medical supply, transportation, and other local and operational problem areas. Based on the results of each workshop, guidelines for future operations were developed and used as a basis for a national decentralization workshop. In addition, various other seminars and workshops were sponsored by the MOH with project funding.

d. Additional training will be required to assure institutionalization of processes developed at earlier workshops.

e. Develop/initiate implementation of plan to strengthen drug and medical supply system.

e. Plan developed and approved by MOH, but implementation was passed to Project Hope in 1984. New medical stores facility built as result of the plan.

e. Problems at MOH headquarters has delayed resolution of logistical support at regional/local levels.

f. Collaborate in development of recommendations for strengthening national nutrition program. Analyse national nutrition survey data and prepare recommendations for policy and program intervention.

f. Project advisors collaborated with CDC technical advisors in design and management of survey. Analysis not completed because of higher priorities in MOH data analysis needs.

BP

CHECKLIST OF USAID/IHAP CONCERNS

ANNEX E

<u>Concerns</u>	<u>Section</u>
1. IHAP team access to decision makers.	IX-A-2
2. Level of commitment received from top MOH management.	IX-A-2
3. Timeliness in MOH's provision of counterparts and counterparts' level of training.	IX-A-2
4. Definition and adequacy of MOH authority responsibility and relationships to implement the Grant.	Ix-A-2
5. Provision of GOS budget submission to take over project activities.	
6. The impact of central ministerial cooperation, or lack thereof, on achieving project outputs, e.g. financial management procedures at regional level, DET, Finance.	(IX-A) (IX-A-3) (IX-A-2) IX-A-3
7. Further actions/inputs required to strengthen and institutionalize decentralization process.	IX-A-3 IX-A-3
8. Unexpected project constraints, which could be/were addressed through project resources.	IX-A-3
9. Whether MOH decisions were communicated to program staff and effectiveness of that communication at ministerial, regional and local levels.	(IX-A) (IX-A-2) (IX-A-2)
10. The adequacy of MOH personnel and ministerial involvement to implement project recommendations, e.g. level of training of staff, and level and degree of intraministerial and interministerial cooperation at various levels.	IX-A-3 IX-A-3
11. To what extent has the MOH internalized the policy changes inaugurated under the project? To what extent have they been (or can they be expected to be) institutionalized?	(IX-A) IX-A-2 (IX-A-2)

ANNEX E continued

Concerns

Section

12. What impact has the project had on health care in Swaziland, particularly on child health?

IX-D, IX-A-2  
IX-A-4

