

SWAZILAND PRIMARY HEALTH
CARE PROJECT

A MID-TERM EVALUATION

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Swaziland Primary Health Care Project
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ABBREVIATIONS

A.I.D.	Agency for International Development
BCG	Bacillus Calmet Guerin
CCCD	Combatting Childhood Communicable Diseases
CDD	Control of Diarrheal Disease
CE	Continuing Education
CMS	Central Medical Stores
CPR	Contraceptive Prevalence Rate
CSO	Central Statistics Office
CTA	Central Transport Authority
CVS	Central Vaccine Store
DMS	Director of Medical Services
DMOH	District Medical Officer of Health
DPT	Diphtheria, Pertussis, Tetanus Vaccine
DREW	Charles R. Drew Postgraduate Medical School
DT	Diphtheria-Tetanus Toxoid
EPD	Economic Planning Department
EPI	Expanded Programme of Immunizations
FLAS	Family Life Association of Swaziland
FP	Family Planning
GDP	Gross Domestic Product
GNP	Gross National Product
GOS	Government of Swaziland
HA	Health Administrator
HC	Health Clinic of Health Center
HE	Health Education
HIS	Health Information System
HPSU	Health Planning and Statistics Unit
HSU	Health Statistics Unit
IEC	Information, Education and Communication
IMR	Infant Mortality Rate
MCH	Maternal and Child Health
MSH	Management Science for Health
MCH/FP	Maternal and Child Health/Family Planning
MCU	Malaria Control Unit

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Swaziland



— Railroad
 — Road

EXECUTIVE SUMMARY

The Swaziland Primary Health Care Project (PHCP) (No. 645-0220) began in April 1986 and is due to conclude in December 1990. Its purpose is to assist the Ministry of Health (MOH) to improve and expand primary health care services, particularly in MCH/FP. Objectives are to: (1) improve clinic and outreach services; (2) increase worker productivity; and (3) strengthen regional administrative and management capability. Because the Government of Swaziland (GOS) has a commitment to primary health care and was already implementing Regional Health Management Teams (RHMT), the PHCP was designed to build upon and complement existing programs.

The mid-project evaluation was undertaken in September - October 1988 by a five-person team comprised of four short-term outside consultants and a USAID/Washington staff member. Four weeks were used to conduct interviews, review documents, attend meetings, visit clinics and RHMT activities, and make four presentations to the MOH and USAID. This review is the basis for our recommendations about project activities, a revised workplan, and options to modify the project design.

The principal project input is long-term technical assistance (17 person-years) from a MCH physician and specialists in MCH/FP, clinic management, administration, and planning. There were also short-term consultants in health education and laboratory services. Other inputs include academic long-term training (two health educators, one information systems) and short-term courses in African countries other than Swaziland (health administration, health education, etc.) Selected commodities are funded to support MCH/FP clinic services, basic laboratory services, health education, transportation and communications.

The PHCP's initial design, workplan and program activities were broad resulting in a diffuse workload which is still being revised. There appears to be some uncertainty about the PHCP's major objectives and its priorities at the regional and central level. There are unmet expectations for support and commodities in several areas outside of the MCH/FP target population. A clarification of the project's objectives and priority activities should help reduce such misunderstanding.

The evaluation team found that contractor performance by the Management Sciences for Health (MSH) was satisfactory, given start-up delays and shortage of MOH counterparts. Recent visits by a Senior Technical Officer have helped prioritize activities and delineate individual advisor roles. The project should collaborate with the MOH to identify areas where decreased support is appropriate.

The project, in collaboration with the MOH and other donors, has developed effective methods to screen high-risk infants and mothers, implemented a clinic health information system,

established improved supply management for drugs and contraceptives, and increased supervisory competency in management. In collaboration with other MCH/FP-related programs, target area Working Groups have developed several workplans (maternal health, immunization, diarrheal diseases, ARI, and malaria) from which 1 year workplans are prepared. Areas for attention now include strengthening of the referral system and evaluation of project training materials and in-service training. Clinic management is helping to strengthen the clinic linkage to regional planners by generating relevant statistics and monitoring supply needs. An orientation manual has helped staff nurses make a transition from hospital to rural clinic, and a clinic reference manual is widely used.

The MOH is decentralizing administrative and some planning and resource allocation functions to the four Regional Health Management Teams (RHMT). The project has produced guidelines for personnel management, financial management, and drug inventory control, and helped two of the four regions prepare annual budget requests. Establishment of a management information system is a high priority so that RHMTs will make efficient use of transportation, logistics and communication resources.

Training activities involve all levels of the project. Workshops were used widely and achieved a rapid infusion of information about MCH/FP services, problem-solving, and clinic supervision tasks. This in-service input raised nursing morale and confidence. Little evaluation of post-training change has been done, a high priority for the next year. The evaluation team recommends clinic-based learning with planning and training by regional public health nurses and supervisors. Health education has received insufficient attention at the clinic or community level. A short-term health education/curriculum consultant is recommended in early 1989 to help identify target areas, focus training, and monitor results.

The evaluation team has summarized major conclusions and recommendations in Section 7. Detailed information to support the summary is available in section 4 and 5, project inputs and outs.

In conclusion, the project is now progressing in its phase 1 MCH/FP services and clinic management components. Encouraging developments have taken place at regional level and in central administration. If further institutionalization is achieved, the PHCP will make an important contribution in enabling the Government of Swaziland to reach its stated national health goals.

1. INTRODUCTION

This report presents the findings and recommendations from the mid-term evaluation of the Swaziland Primary Health Care Project (PHCP) (USAID Project No. 645-0220). This 5 year project was approved in August 1985 with AID funds of \$5.7 million and a GOS contribution of \$2.3 million and is scheduled for completion in December 1990.

The project is implemented for AID through a contract with the Management Sciences for Health (MSH) of Boston, Massachusetts, a sub-contract with the Charles R. Drew University of Medicine and Science (Drew), and in cooperation with the Ministry of Health of the Kingdom of Swaziland. The project provides long-term technical assistance in health planning and budgeting, administration and decentralization, maternal and child health/child spacing (MCH/CS) and clinic management; short-term consultants participant and in-service training; and limited commodity support for transportation, communication, and MCH/CS services.

The evaluation was carried out by a team of four short-term outside consultants and a AID/Washington staff member between September 19 - October 20, 1988, 24 months after the effective commencement of the project in Swaziland. The first technical advisor arrived in Swaziland in May 1986, but the other members of the team did not arrive until September, 1986. The contract (AID/AFR-C-CO-6021-00) was signed 4/9/86 with an estimated completion date of December 31, 1990.

2. BACKGROUND

2.1 Origin of the Project

In the twenty years since independence, the Government of Swaziland (GOS) has invested heavily to improve and expand health care throughout the country. Of particular concern have been maternal and child mortality and morbidity rates that have remained high for a country with Swaziland's many advantages. These include a homogeneous population with high rates of school attendance; a compact size and good transportation and communications systems; and relatively high per capita gross national product and expenditures on health.

The draft UNICEF situation analysis of status of children and women in Swaziland in 1987 reports an infant mortality rate of 110 per 1000 and notes that half of infant deaths occur before the age of two months.

Primary health care (PHC) has been a major national health focus since 1983 when the GOS issued the National Health Policy with the stated goal of the development of a comprehensive PRIMARY HEALTH CARE system. The policy paper identified primary health care as defined in the WHO Alma-Ata Declaration as the "most effective and least costly strategy" to achieve the Ministry of Health (MOH) objective of improving the health status of the Swazi people. The major elements of the PHC system are:

- .the provision of health education
- .promotion of food supply and nutrition
- .the promotion of clean water supplies and basic sanitation
- .the provision of maternal and child health care, including family planning
- .immunization
- .prevention and control of endemic diseases
- .treatment of common diseases and injuries
- .provision of essential drugs.

To make these services more available to Swaziland's largely rural population, the MOH is integrating health service delivery and decentralizing health service planning and delivery to the regional level. There is an emphasis on community involvement in decision-making, developing additional clinics and outreach sites, using hospitals as referral centers, and increasing health manpower training.

It was within this context of changing and expanding health services that the Primary Health Care Project (PHCP) was designed in 1984/5. Those involved with project design took a "sectoral view" and saw AID financing as "contributing along with other donor and GOS inputs to" the achievement of the national health service targets for 1990. The project was also designed to consolidate and continue activities supported under other AID health assistance projects in health manpower development, health administration and disease control. At that time it was expected that on-going projects in waterborne disease and childhood communicable diseases would end shortly and this project would take on these responsibilities.

2.2 Project Objectives

The resulting project design was very broad with resources directed at eight PHC service areas: prenatal care; attended deliveries; post partum education; immunization; oral

rehydration; growth monitoring; child spacing; and treatment of priority diseases. Five service support areas were specified: training; transportation and communication; laboratory services; health education messages and clinic management. To decentralize health management to the regional level required strengthening of five management and system support areas: coordination of maternal/child health programs; planning, budgeting and financial management; research monitoring and evaluation; health financing and nursing education.

The MOH impact objectives in maternal and child health (MCH) were adopted as the end of project status (EOPS) indicators. Recognizing that the "stated service delivery targets were very ambitious", the project design emphasized the development of a national MCH plan and a workplan which coordinated PHCP activities with those of other donors and other AID projects. An evaluation one year after the arrival of the technical assistance team was planned to determine the adequacy of resources and the feasibility of targets. When AID resource constraints limited the number of long term advisors, the chief of party position was combined with that of a technical advisor.

The project was authorized in August 1985 with total funding of \$7,945 million of which the AID grant was \$5.7 million and estimated GOS contribution was \$2.245 million. A contract was awarded to Management Sciences for Health in April 1986 and the Chief of Party came to Swaziland in May 1986. Shortly thereafter a stop work order was issued until the GOS was able to meet the project requirements for additional MOH positions. This was lifted in August 1986 and remaining team members arrived in September 1986.

2.3 External Factors

Initial project activities were further complicated by changes in USAID, Ministry of Health and project personnel. Very few of those involved with the project design remained to assist in its implementation. Almost none of the MOH technical officers responsible for implementing activities in project areas had been involved in the project design. The availability of MOH counterparts was overestimated. The original technical advisor in health planning and budgeting departed after only one year in the position, and he was replaced in November 1987. The MCH/FP Nurse Practitioner resigned in June 1988 and her replacement arrived in September. In addition, in September 1988 MSH shifted the Chief of Party role to the new Planning/Budgeting advisor.

There appears to have been considerable misunderstanding about the purpose and scope of the project among both MOH and the donor community. Studies to develop baseline data, evaluate targets and focus project activities were not done in the first year as planned. When GOS approval for a baseline health and population survey was not obtained in time to have the activity supported under centrally-funded AID project, the decision was made to support the survey directly with technical assistance from the Centers for Disease Control. The interviewers began the survey in September, 1988. The first PHCP workplan was approved in January 1987. Subsequently, in August 1987, the MOH requested an operational review of the project. Based on that review, a revised workplan was approved by AID and provisionally approved by the MOH in March 1988.

3. EVALUATION METHODS

3.1 Purpose of the Evaluation

In this mid-project formative evaluation from September 19 to October 20, 1988, the evaluation team assessed progress by comparing the level of effort (inputs) and performance (indicators, outputs) against the project's goal, purpose objectives, targets, activities, and indicators. The evaluation team have attempted to clarify the initial project design, objectives, and assumptions as described in the PP lcgframe. After reviewing the indicators intended for monitoring progress the evaluation team identified problems and considered options or solutions which would help attain project objectives. This review is the basis for recommendations to revise the workplan priorities, modify inputs and outputs, and to consider alternative scenarios of project resources and time needed to achieve different levels of output and EOPS.

3.2 Evaluation Scope of Work

The evaluation team was asked to respond to a set of inquiries prepared by the Ministry of Health, MSH team, and AID/Swaziland (Appendix A). These questions were formulated under the following overall objectives of the mid-project evaluation:

- (1) Review the appropriateness, timeliness and quality of inputs of the project and host country; provide a descriptive analysis of project status relative to inputs, identify any problems or short-comings, and make recommendations for overcoming them.
- (2) Review project outputs, quantify progress made toward achieving output indicators, and provide a detailed explanation of these areas where project outputs either have exceeded or are not likely to achieve targets. Recommend strategies for overcoming shortfalls.
- (3) Review the project purpose and assess the extent to which project inputs and outputs are, or are not, leading to the achievements of the purpose and the End of Project Status indicators by the project completion date.

3.3 Evaluation Procedures

These were chosen to meet the information needs described above.

3.3.1 Evaluation schedule

The team leader, AID staff member, and nurse/midwife attended a one day orientation to the project by the staff of Management Sciences for Health. The first two also had a one day briefing by Drew staff before coming to Swaziland. The first week involved orientation meetings with the MSH team, Ministry of Health, AID/Swaziland staff, and key persons in related projects. The second week involved field trips to clinics and hospitals in Shiselweni, Manzini, Lubombo, and Hhohho regions to observe clinic activities. We met all four Regional Health Management Teams and most senior regional supervisory personnel. During the third week, additional interviews were conducted. Findings and a preliminary set of recommendations were discussed with the TA team. An initial report draft was prepared for separate presentation to the MOH and to AID. After review of the draft report we made further revisions to complete the final evaluation report.

In the limited time available the evaluation team could not review all relevant documents or contact all potential informants. The evaluation team scheduled interviews to match team member expertise and responsibilities in the evaluation process. The evaluation team was comprised of a public health physician, a nurse/midwife and specialists in planning/budgeting, training, and health management.

3.3.2 Data Sources

- (a) Documents Reviewed/Places Visited. A thorough review was made of project reports and other documents and relevant documents (Appendix B). Visits were made to clinics and programs chosen as representative of primary health care activities.
- (b) Interviews and Meetings. A large volume of contacts was made by team members, as reflected by Appendix B. Often two or three meetings were made with key persons to obtain additional information. The evaluation team are appreciative of the efforts made by the MOH and TA team to accommodate our requests.

- (c) Feedback. The evaluation team held briefing meetings with the project officer each week. An informal discussion was held with the TA team and Project Officer in the third week to elicit comments and inquiries prior to formal presentations to the MOH and AID. This helped clarify issues and focus final report recommendations.

3.3.3 Limitations

In the process of collecting and analyzing data we identified several topics of interest which lack adequate data. These are important to address during the remainder of the project.

- (1) Assessment of the clinic staff patient care performance (in diagnosis, treatment and referral) and health education;
- (2) Documented evaluation of several project materials - MCH/FP protocols, guidelines, checklists, manuals, activity graphs, workplans;
- (3) Analysis of clinic efficiency: patient flow, staff deployment and tasks, analysis of cost per visit;
- (4) Clinic catchment area population or, alternatively, patient place-of-origin statistics;
- (5) Clinic nurse supervisor performance: lack of evaluation use of various methods used to train staff and assist in planning;
- (6) Follow-up evaluation of training received at workshops or other in-service program;
- (7) Inventories of transportation, communication and housing needs for requesting assistance.

The evaluation was also constrained by having only 3 of the 5 technical advisors in Swaziland when we were there. While three members of the evaluation team met the clinical management advisor (on a 4 month study leave) and former NP/midwife in Boston during a one-day orientation at MSH, we could not obtain the same information they might have provided in the field.

4. PROJECT INPUTS

This section lists project inputs, as called for in the Project Paper (PP) and as contracted for in agreements between AID and the GOS, and AID and MSH. An evaluation as to whether these contractual obligations have been or will be met is also provided.

4.1 USAID Inputs

The Project Paper (pp 19-22) lists AID's inputs to the project. These include long and short-term technical assistance; overseas and in-country training; costs for research, monitoring and evaluation; and a limited amount of commodities. Operations and management of the project were contracted to Management Sciences for Health (MSH). The overseas training component, a portion of short-term technical assistance, and one technical associate position (clinic management) was subcontracted to Drew University, International Institute. Support by AID/Swaziland is coordinated the Project Officer.

4.1.1 Technical Assistance

The PP calls for 197 person months of long-term technical assistance in a team initially comprised of 5 long-term advisors (subsequently re-titled associates). These included 2 technical advisors (MCH physician, FNP/childspacing) for the entire project and 3 administrative/management advisors (health administration/decentralization - 3 years; clinic operations/management - 2 years; and a planning/budgeting advisor - 2 years). While the PP and MSH's contract called for 16 1/2 person-years, one-year extensions have since been made for the planning/budgeting and clinic management advisors, to total 17 2/3 person-years. Therefore two additional person-years have been already approved.

Short-term consultants fully supported by the PHCP include:

Health Education: 1/4 - 2/14/88 (6 weeks)

Laboratory Services: 3/20 - 4/30/88 (6 weeks)

Therefore, to date, the project has consumed 5 months of the available 30 person-months of short-term technical assistance provided by the Sub-contractor, Drew University. Drew is prepared to provide additional technical assistance if requested to do so by the Ministry of Health.

Several other short-term consultants were also used, including:

Health Planning:	8/25	-	9/13/86
Personnel management:	10/4	-	10/2/86
Manpower planning:	10/25	-	12/5/86
Manpower planning:	1/14	-	4/13/87
Workplan priorities:	1/26	-	1/30/87
Cervical cancer review:	7/15	-	7/28/88

The project also hired an administrative assistant to coordinate in-Africa and in-country training and a secretary.

4.1.2 Academic training

The project is financing three participants in long-term training in the U.S. two in health education and one in health information. There are also funds to support 12 participants for long-term (1-2 years) training in African countries in the areas of health administration and health education. Additionally, short-term training in other African countries and in the U.S. was authorized for 49 person-months. While the U.S. long-term training will take about 1 person-year longer than authorized, there have been fewer long-term in-Africa trainees and fewer short-term overseas trainees than anticipated. Pending a review of overall project-supported training needs, it is suggested that overseas short-term traineeships be reduced by 6-8 positions to offset the additional year costs expected for the U.S. trainees, and perhaps a portion of the cost of the two additional person-years of long-term technical assistance. Drew provides a full-time participant training coordinator in the U.S., which appears to be adequate backup staff for the trainee workload.

4.1.3 Commodities

Of the commodities listed in the PP Annex 7F 7 vehicles have been purchased and much of the laboratory and clinic equipment and supplies have been ordered.

4.1.4 Research and evaluation

A list of 17 potential studies and surveys for operations research, epidemiologic information, and surveillance (PP, Annex 7H) was initially proposed and budgeted, \$480,000. Only a subset of these warrant implementation (see section 5.1.2). Two external project evaluations are also authorized - this mid-term one and another at the end of the project.

AID has requested that MSH propose a contract amendment to accommodate certain additional costs within the existing

contract budget. These additional costs include the in-country costs of the Family Health Survey and the one-year extensions of the two long-term advisors noted in section 4.1.1, totalling approximately \$500,000. If no additional funds are available to the project as a result of this evaluation, the existing contract budget will need to be revised to reflect project priorities and identify costs that will match the needed \$500,000. However, AID has asked MSH to defer further work on this proposal until after this evaluation is completed, since the evaluation may provide additional rationale for other contract amendments.

4.1.5 Coordination among MCH/FP-related Projects

During the initial project design and implementation phases, there may have been insufficient attention to integrating project resources and activities with those of other donors, NGOs and other USAID-assisted projects. This may have been a product of insufficient communication with other donors in the design stage; inability in the first year to carry out planned design analysis to determine overall project focus, strategy and activities; changes in key personnel; and the delayed and phased arrival of team members.

The relationship between this project and two other related USAID-assisted projects changed between the design and implementation stages. Initially, this project was to serve as an umbrella project for the health sector in primary health care. As such it could consolidate and further support earlier USAID-assisted activities in training, health planning and management and disease control. Subsequently, the decision was made to extend both the Rural Water Borne Disease and the Combatting of Childhood Communicable Diseases (CCCD) Projects. However, the lack of a full-time, Swaziland-based advisor for CCCD resulted in considerable demands on PHCP staff for work in that area, as was the source of some confusion about the relative roles of the two projects. This early expectation that the PHC project could and should assist in all areas of PHC administration, service delivery and logistics support has diffused team efforts and has contributed to misunderstanding in the Ministry of Health. However, many of the -- problem areas have been resolved in the revised PHC Project workplan.

The need for improved planning and coordination among donors, parallel agencies and USAID-assisted projects is well recognized and supported by key individuals in the Ministry of Health, the donor community and other participating agencies. They recognize the importance of the on-going technical collaboration and sharing information and resources at the operational level. The various Ministry, donor and AID coordinating committees such as donor meetings chaired by the

Resident Representative, United Nations Development Program; the Ministry of Health Primary Health Care Coordination Committee; the Ministry of Health MCH/FP Committee; and the Primary Health Care Project Implementation Committee reflect a broad target to coordinate successful multi-donor collaborative activities. The informal USAID HPN Sector meetings also facilitate coordination among the staff of USAID-assisted projects.

With the recently approved MOH/USAID Family Health Services Project and planned new UNFPA MCH/FP project, particular attention needs to be directed to both formal and informal information sharing and planning so that resources used in this critical area are maximized. The importance of child spacing and the prevention of pregnancy in high risk groups for maternal and child health in Swaziland makes this a critical area for coordinated multi-donor support.

Recommendations

- (1) As the project moves into more focused activities in the final years, additional attention needs to be paid to working collaboratively with the MOH and other donors to determine respective roles and tasks so that priority national health needs can be met from the pool of multi-donor resources, and false expectations are not maintained about specific PHCP contributions.
- (2) It would be extremely helpful if such a broad-based group could focus on two critical elements in rural health service delivery: the provision and management of transport at the regional level, and the need for more adequate housing and facilities for nursing staff at certain rural sites. The tradition of community participation i.e. building clinics and nurses' accommodation suggest that PHCP support for building materials may be an appropriate high-priority area.
- (3) Collaborative activities should focus on the strengthening of regional information and management systems, and the improvement and extension of maternal and child health services must be continued. Together with UNICEF, PHCP should continue to provide coordinated support to the MOH in strengthening the ties between the community, RHMs and Public Health Units and clinics. PHCP should also assist the MOH and other agencies in strengthening the linkages between pre-service and in-service training for nurses, nursing assistants, and other categories of health workers. The project should coordinate with the MOH, UNICEF, and SINAN on breastfeeding promotion and education.

4.1.6 Other inputs

Another AID-funded project, CCCD, is implementing immunization, oral rehydration and malaria control activities. This input and other products, such as the Antenatal screening protocol, contribute to achieving MCH/FP service targets. Other donors with PHC-related activities include UNICEF, UNFPA and WHO. While the PHCP cannot attribute all operational success to its own interventions, its involvement in assisting the MOH to coordinate these resources and implement effective methods is a major contribution.

4.2 GOS Inputs

The supportive involvement of key MOH officials (e.g., Principal Secretary, Undersecretary, Senior Health Administrator, Public Health Unit) has created a favorable environment at the central level. In several key areas linkages need to be strengthened in order to make project activities relevant to the priorities of the MOH. Additionally, close, on-going participation by key Swazi counterparts is essential for institutionalization of planning and management capability, a major product desired by the MOH.

The PP indicates that the GOS contribution to the project is 25% of total project costs of which contributions include provision of housing and office space to the technical advisors. While precise expenditure data is beyond the scope of this evaluation, it appears that the GOS has delivered its expected inputs. Alternate financing mechanisms and a policy to retain patient fees need further consideration.

4.3 Contractor Management and Budget Performance

The Technical Assistance team faced several start-up difficulties as described in the Background section. Interviews indicate a weakness in planning and coordinating team activities in the field. This unfocused team effort made monitoring of progress towards project goals difficult. This situation has been partly addressed but, requires additional planning and team building efforts. The MSH Senior Technical Officer has made two project monitoring visits to review, redirect and support the TA team's activities. In addition, a series of short-term consultants (see 4.1.1), have been used to provide special advice and information. Based on the Technical Assistance Team's quarterly progress reports, the revised workplan, and other documents (Appendix C), the evaluation team feels that further improvement is necessary

in order to develop and monitor individual performance targets related to project goals.

The revised workplan is very ambitious in its target outputs and diverse in its scope of activities (see section 5.1.2). Additionally, detailed steps and expenditures required to perform each activity are not fully described. These difficulties have been identified by various parties involved with the project, and need to be resolved.

The budget in the initial life-of-project workplan was not clearly linked to specific activities, and did not fully address and describe all project inputs. As a result, given the "umbrella project" concept, not all project expenditures in support of priority activity areas conformed fully to the workplan budget. This situation has been markedly improved in the revised workplan, but still deserves attention as overall project resources are reassessed as a result of this evaluation.

This situation is further complicated by differences in the in categories and/or line items budgets used by MSH, Drew and USAID, so that the development and use of a common system for tracking and accountability has not been possible. This is quite typical of AID projects, but it presents a particular problem with this project because of the broad range of project inputs. The new COP, together with MSH headquarters staff, have recently devised a financial report and analysis system that will overcome most if not all of the difficulties. Once this system is in effect (retrospective September 1988) project financial management will be greatly improved.

The COP position in many projects is a full-time responsibility. In this project, owing to a reduction in AID funding from that originally envisaged, the COP responsibility was added to one of the full-time advisor positions. The time required for COP administrative/liaison responsibilities to the MOH and USAID, as well as overall project management and monitoring activities, inevitably detracts from time needed to provide expected technical inputs. This task overload adversely affected the previous COP's technical input in decentralization. Even though the COP responsibility was shifted to the Planning/Budgeting advisor, there continues to be a potential overload problem.

Recommendations

-To keep the COP's performance in technical areas at a satisfactory level, a way must be found to reduce his administrative workload. The MSH Senior Technical Officer and the COP need to resolve this issue in the near future. The current Administrative Assistant should have an expanded role,

and additional secretarial support should be provided.

-An intensive strategic planning process, involving the MSH Senior Technical Officer and all team members, is required in order to increase the team's effectiveness in coordinating individual responsibilities in carrying out project activities. On another level of inter-action, assistance in team-building, using MSH resources, should be provided in early 1989.

5. PROJECT OUTPUTS

5.1 Progress Towards Project Outputs

This project's purpose is to improve primary health care in Swaziland using two main strategies:

- improved clinic-based MCH/FP services
- effective decentralization to the regional level.

A series of outputs are shown in the PP logframe, usually with underlying assumptions felt to be necessary for success.

<u>Output</u>	<u>Assumptions</u>	<u>Status</u>
1. Improved outreach and service delivery approaches	1. Government assigns adequate number of workers	Progress
Incentive schemes to increase demand	2. High quality services available	Unclear
	3. Public aware, want services (health education)	
2. More productive health workers	4. Increased in-service training and supervision	Progress
	5. Improved support systems	
	6. Task re-assignments to optimize staff productivity	
3. Health facilities have appropriate equipment and supplies	(e.g. Effective drug inventory system; Effective communications to parent hospitals)	Progress
4. Decentralized system of planning, budgeting, financial management, supervision, and management operating effectively	(e.g. 3-year and Annual Development Plan; tabulation of HIS; financial management)	Gradual progress

<u>Output</u>	<u>Assumptions</u>	<u>Status</u>
5. Increased proportion of GOS recurrent health expenditures for PHC	7. MOH allocates adequate funds. 8. GOS maintains support of PHC and health infrastructure 9. Donor funds available and well-coordinated.	Meeting targets in PP

Based on the above summary, the team concluded that progress has been good in all but two area of outputs. The second part of output 1, stimulating increased demand for health services, has not been sufficiently addressed. This output is incompletely defined, since demand for preventive services has a complex set of factors. As indicated in Section 5.2 below, high-risk groups, principally in the rural areas, will not be reached unless services are expanded. Several key recommendations in the areas of training and health education highlight the approach that should be taken.

The other area of concern is the second part of Output 5, dealing with cost recovery mechanisms ("extra-budgetary support"). Based on team discussions with key MOH officials, it seems clear that the kind of cost recovery mechanisms (e.g. higher fee schedule) proposed in the PP are not realistic for implementation within the GOS financial system during the expected life of this project. Thus the team recommends that this portion of output 5 be deleted. However, since the proposed cost recovery mechanisms were to generate E1,000,000 in extra-budgetary support during the life of project, the MOH and AID need to determine that the overall GOS contribution to the project (25%) will be made available through other resources.

Some of the original project design assumptions are no longer valid. Assumption (1) about an adequate number of rural health workers has not been achieved and many clinics are understaffed. There is a shortage of nursing assistants who might have nursing tasks reassigned to them, freeing up the nurse for outreach programs, including RHM supervision, school education, and home visiting. The assumptions (2-4) underlying more productive workers are true, but additional incentives such as acceptable housing or a salary incentive for rural

service are policy issues warranting further attention. The immediate impact of training, supervision, and a steady flow of supplies on the volume and quality of services seems true, but the long-term outcome is less clear.

Of interest is that neither the decentralization or the system (e.g. supplies) management outputs had specific logframe assumptions. An effective clinic inventory system has had a positive effect, but insufficient communications in some clinics makes timely ordering difficult. A major assumption concerning regionalization is that the central government will progressively relinquish control over transportation management, financial management and budget allocation to reinforce, the RHMT strategy.

The PP gives inadequate attention to demand for PHC, particularly preventive services. An important contributing factor to Swaziland's high infant mortality rate is low clinic utilization even when the child's condition is severe - the "too little, too late" syndrome. A variety of education and social marketing studies have found that education needs to be directed at providers and the public to stimulate their cooperation and interest (assumption 5, 6). But demand also is affected by access, availability and quality of care factors. When it appears difficult to support further clinic expansion, community workers such as the RHM or traditional healers can facilitate community clinic linkages. Assumptions 10 and 11 about factors enhancing demand for services seem reasonable, though untested as yet. A positive patient-health worker visit experience presumably encourages subsequent utilization. Health education is an important strategy to raise community awareness about available services. Promotion of "non-urgent" preventive care may be a gradual, long-term process.

Financial (7-10) and infrastructure (1) assumptions are critical rural MCH/FP service sustainability issues (assumptions 7-10). Pressure continues on the MOH to provide an increasing volume of curative services, and hospital-based activities consume the majority of MOH recurrent expenditures. A variety of innovative health financing mechanisms are receiving attention. The project's pending user cost/fee schedule study may clarify the current fee/cost gap. Even if an increase in current fee schedule was authorized, current revenue policy does not allow patient fees to be retained by the MOH. A significant amount of MCH/FP service activity is provided by donors, and careful coordination and planning is necessary to maximize their impact.

One important assumption that was implicitly made in the PP, though not formally stated, was that the clinic supervisor and nurse would be available for coordinating RHM activities and

increasing community participation in MCH/FP. These activities are time-consuming and often require significant logistical resources which may not be available at the peripheral clinic unit.

While the logframe outputs lack clear definition or measurability, the project has accomplished progress in the first four. There has been improvement in MCH/FP services (see Section 5.2 below); training and supervision; and effective decentralization. For example, two of the four RHMTs have prepared recurrent budgets, but need strengthening of planning and financial management components in conjunction with a more effective health information system (see Section 5.3).

5.1.1 Mid-term Progress Towards EOPs Indicators

There is a consensus that the original project's design, complexity and scope of outputs resulted in a large and inoperable project workplan (see Background). One of the mid-term evaluation goals is to reassess this document and "streamline" the activities and relevant inputs to match the priorities.

The logframe EOPs indicators and output indicators were selected to be consistent with the MOH objectives in primary health care. Because delivery and support inputs came from several sources - MOH, this project, and other MCH/FP-related or PHC-related programs, (e.g. UNICEF, CCCD, FLAS, SINAN, etc) it is impossible to attribute changes in the EOPs indicators to this project alone.

The EOPS indicators include MCH/FP coverage rates and several quality of care measurements for selected conditions for the eight activities the MOH originally directed this project to strengthen. These are:

<u>Activity</u>	<u>EOPS Indicators</u>
1. Antenatal care	90% of pregnancies
2. Postnatal education	90% of maternity deliveries
3. Trained birth attendants	70% of births
4. Child spacing	12% using contraceptives
5. Infant immunization	70% by 12 months
6. ORT	Effective use in 50% of serious diarrheas
7. Regular growth monitoring in preschoolers	90% of under fives
8. Priority diseases	Appropriate management of
(a) under fives	malaria, lower resp. infections,
(b) 15-49 yr old women	Syphilis, anemia, toxemia.

Activities 1-5 and 7 above are important targets and reflect future outputs produced by an effective, well-supported primary health care system. This project's activities and resources are not capable of achieving all of the long-term targets (EOPS indicators). However, progress is occurring, particularly in immunization (5), availability of ORS (6), high-risk clinic screening (7) and in-service training and supplies to support treatment of target conditions (8).

These outcome measures are similar to those used by AID Child Survival as Tier II indicators of coverage rates. While such measures can identify successful programs, they do not provide day-to-day operational indicators to plan program activities. Additionally, this project cannot be estimated in local areas until catchment area population statistics are available.

The decentralization component does not have adequate process indicators specified in the original project design as reflected in the PP's logframe (see 5.1). These are needed as tracking measures to guide program operation decision-making.

Well-tested process indicator examples are available, such as the list of service delivery and support activities developed by PRICOR. This valuable resource includes all eight MCH/FP service areas, their process indicators, and recommended measurement methods.¹ The TA team is now refining a set of MCH/FP process indicators to evaluate training and as a baseline to test clinic operations research. Use of process indicators will make an important contribution to other PHC projects, such as the CCCD, whose 3-year plans for diarrheal diseases, immunization and malaria do not include such indicators. By refining use of selected process indicators at the clinic and regional levels, this project has the opportunity to make a major contribution to MCH/FP programs worldwide.

¹ Primary Health Care Thesaurus. Vol.1. A list of Service and Support Activities. PRICOR. Center for Human Services. Bethesda MD. 1988.

5.2 Project Activities

5.2.1 MCH/Family Planning Services

This has five elements: maternal care, expanded program in immunization, growth monitoring, family planning, and rural health motivators and community development. The project, in collaboration with the MOH and other donors, has made considerable achievements in the areas of maternal and child health, the majority of which are sustainable. The quality of outputs in the areas of high risk screening, the assessment and management of STDs, the development and implementation of a health information system (HIS) for MCH/FP activities at the clinic level, analysis of maternal/perinatal mortality in Swaziland, the development of a supply system for family planning commodities, and clinic management are particularly notable. It is clear from the many site visits that the project is responsible for extensive skill development and increasing the self-esteem, confidence and motivation levels of the clinic nurses and supervisors. The absorptive capacity and enthusiasm of the nurses regarding project outputs appears to be consistently high.

The improvement of service delivery at the clinic level is a considerable achievement, however the maternal and child mortality and morbidity rates remain unacceptably high for a country with Swaziland's infrastructure, resources and commitment to primary health care. Of particular concern is the extremely high mortality rate for infants during their first year of life and pregnancy related mortality and morbidity. A large percentage of the mortality and morbidity could be prevented if mothers and infants at risk were reached with a limited number of low cost, appropriate technologies and services. Of particular importance are high risk screening and referral and breastfeeding promotion. This is an area where the PHC project has the potential to make an enormous contribution to Swaziland by directing the majority of its resources to strengthening the service delivery mechanisms that will enable the clinic nurses to reach important target populations in the rural areas.

Building upon the solid accomplishments the project and the MOH have made in training, clinic management and high risk screening for mothers and children, the project now needs to develop a clear, cohesive strategy to direct technical assistance, commodity support and training efforts (including on-the-job supervision) towards reaching these critical populations, where the majority of mortality and morbidity occurs.

In collaboration with the MOH and other donors, the project should move into a second phase. While continuing to strengthen the service delivery skills of the nurses, clinic staff and supervisors, increased emphasis should be placed on: community leadership development, strengthening the role of the RHMs and their working relationship with the clinic nurses, collaboration with traditional healers to identify and refer high risk cases, and health education in the community.

5.2.1.1 Maternal Care

The major outputs in the area of MCH have included the implementation of antenatal cards, high risk screening and protocols, the identification and management of STDs, MCH workshops, the support of research on breastfeeding practices by SINAN, an analysis of the extent of cervical cancer in Swaziland with recommendations for action, a regional analysis of maternal/perinatal mortality in Swaziland and the implementation of a HIS for MCH/FP activities at the clinic level. The quality of outputs in this critical area appear to have been consistently high.

Findings

-The HIS for MCH activities is well established at the clinic level.

-High risk screening mechanisms are in place, however, the infrastructure support to effectively deal with high risk cases, once they are identified, is inadequate in most areas.

-Many clinics visited did not have basic equipment to conduct high risk screening (ie; BP cuffs) or to attend deliveries (ie; delivery instruments).

-Nursing assistants in many of the clinics appear to be assuming responsibilities identical to those of RNs, without the appropriate training, due to the shortage of staff.

Recommendations:

-Mechanisms to support/strengthen the back-up and referral system for high risk MCH cases need to be developed on a regional basis. This should be a project priority.

-The institutionalization of regional review committees to investigate all maternal and neonatal deaths should be a project focus. Lessons can be learned and practices contributing to preventable deaths can be modified effectively through this mechanism. It is important that the senior public health matrons and supervisors, as well as a physician are represented on each committee.

-Responsibility for conducting the MCH/Perinatal Mortality Meetings should be assumed by the MOH, with minimal support from the project, in order to institutionalize this capability. Meetings could be held regionally every 6 months, with a national meeting once a year.

-Nursing assistants should be included in all future MCH training activities.

-The provision of material support necessary for high risk screening activities and conducting deliveries in the clinics should be a project priority.

5.2.1.2 Expanded Program in Immunization (EPI)

According to the draft UNICEF situational analysis, immunization coverage increased from 14% to 60% between 1982 and 1986. The project has contributed to the on-going MOH efforts to increase immunization coverage. Major project outputs in the area of EPI have included support in developing the Immunization Program, the development of training materials for EPI, the revision of the EPI component of the Clinic Manual, back-up support to the EPI program in planning, management and operations during the absence of the Combatting Chronic Childhood Diseases (CCCD) Project Technical Officer, the distribution and inventory of sterilization equipment, and regional workshops.

Findings

-EPI activities appear well-established at the clinic level.

-The HIS for EPI activities at the clinic level are well-established.

-The cold chain appears to be functioning adequately at the clinic level.

-Mechanisms for identifying and reaching unimmunized children in the community are inadequate. Little follow-up appears to be conducted.

Recommendations

-The project, in collaboration with CCCD, should focus on developing mechanisms for reaching unimmunized children in the community (ie: RHMs, school programs, community based campaigns)

-The practice of using disposable vs re-usable syringes/needles varies from clinic to clinic. Clear policy guidelines in this area should be established by the MOH with support from the project and CCCD.

5.2.1.3 Oral Rehydration Therapy/Control of Diarrheal Diseases (ORT/CDD)

This continues to be an important area of infant and child morbidity and mortality, despite the fact that an estimated 60% of child care providers have learned how and now use ORT (UNICEF). Early supplementation of infant diets (lack of exclusive breastfeeding in the first 6 months); contaminated water supply, inadequate sanitation and hygiene and delays in providing ORT to sick children are the principal causes for the continued high morbidity and mortality.

Project outputs in the areas of ORT/CDD have included the implementation of "ORT Corners" in designated clinics in each region, workshops for clinic nurses in ORT, the development of training material for ORT, the production of an ORT manual and a manual for Directors of Diarrhea Training Centers.

Findings

-ORT packets are widely available in the clinics.

-The KAP of nurses in ORT/CDD appears excellent at the clinic level.

-There appears to be a clear emphasis on breastfeeding for control of diarrheal disease on the part of the nurses, however skills in the area of managing breastfeeding problems need strengthening.

-Several of the hospital nurses interviewed appeared to question the value of ORT.

Recommendations

-In-service education on ORT for the hospital nurses should be considered in collaboration with CCCD.

-The project should increase its support of breastfeeding promotion activities in coordination with SINAN. 64% of all hospital deaths in infants under the age of 4 months in Swaziland are due to diarrheal disease (UNICEF). Since exclusive breastfeeding in the first 4 months of life would prevent the vast majority of these deaths (and the need for ORT), as well as prevent the number and severity of ARI cases (the 2nd leading cause of infant death), this should be a project priority.

5.2.1.4 Growth Monitoring

Approximately 1/3 of Swazi children fail to grow as well as they should during the first 3 years of life, resulting in a high prevalence of chronic malnutrition or nutritional stunting. Attendance at growth monitoring programs rose from 25% to 40% between 1983 and 1987 (UNICEF).

Project outputs in the area of growth monitoring include collaboration with UNICEF in the production of a Growth Monitoring Training Manual, regional workshops, and assisting the MOH to develop Growth Monitoring policies.

Findings

-The KAP of clinic nurses in the area of growth monitoring appears to be excellent.

-Mothers with growth charts in hand were observed in most clinics visited.

Recommendations

-The project should focus on developing mechanisms to promote RHMs involvement in growth monitoring activities in the community in collaboration with UNICEF. RHMs could be provided with scales, arm circumference bands and teaching materials. This strategy could increase the credibility and stature of RHMs in their communities and be a focal point for expanding the involvement of RHMs in other critical MCH activities such as high risk screening and referral, breastfeeding and weaning counseling and education, family planning counseling and referrals for immunizations.

5.2.1.5 Family Planning

The GOS has identified the lack of family planning as one of the main contributors to poor maternal/child health in Swaziland. The problem is exacerbated by low contraceptive prevalence rates combined with decreased rates of exclusive breastfeeding (an important factor in the delay of post partum fertility).

Family planning outputs have included the development and implementation of a family planning commodity and supply system, the implementation of family planning protocols, the development of a plan for childspacing activities for 1987-1988 in addition to a 3 year plan, family planning skill development in the clinic setting, workshops, the compilation of family planning service statistics, pre-service and in-service curriculum development and the provision of family

planning health education materials and tools to the clinics.

Findings

-Clinic nurses appear to have a positive attitude towards family planning. Their sensitivity to social issues involving the promotion of family planning in the community and the implications for women is impressive.

-All clinic nurses questioned expressed the need for additional in-service in family planning skills.

-The HIS for family planning services are well-established at the clinic level.

-Two family planning trainers for each region have been trained.

-Infrastructure support for the family planning trainers to conduct their activities in the regions is weak. A number of the supervisors stated that the trainers are losing the skills learned in the workshops because they have been unable to put them to use in the clinic setting due to logistical problems (ie; lack of transport).

-Community activities to reach target populations for family planning promotion appear to be minimal.

Recommendations

-The development of infrastructure support mechanisms to enable the family planning trainers to implement their program activities needs to be explored by the project in collaboration with FLAS and UNFPA.

-The project should continue to provide family planning skill development for nurses at the clinic level in collaboration with the family planning training coordinator, the family planning trainers, FLAS and UNFPA.

-Mechanisms for the expansion of community based family planning promotion activities should be developed by the project in collaboration with FLAS, UNFPA and the MOH.

5.2.1.6 Rural Health Motivators (RHM) and Community Development

Since independence the COS has sought to improve access to health services for rural populations. With the help of local communities and donor groups the MOH has expanded the

number of clinics and service delivery sites through outreach (community sites served by mobile units) and the Rural Health Motivator (RHM) program. The goal of the RHM program is to augment clinic services through the use of trained community workers. UNICEF has provided the major donor support for the RHM program. In addition to outreach sites and the RHM program, clinic nurses are expected to visit homesteads.

The project has provided some assistance for the equipping of clinics and community shelters for outreach activities and in assessing clinic renovation needs (PHC Technical Report: A Proposal for the Rehabilitation of 11 Rural Clinics in Swaziland 1987). The project has provided modest support for the RHM program through its support of several workshops in Community Leadership in collaboration with UNICEF and the sponsoring of a 2 week study tour for 12 RHM tutors and 4 Regional Public Health Matrons in Kenya. There is strong national leadership for the RHM program.

The project paper, and subsequent reviews of PHC have identified the lack of adequate housing in certain rural sites as a major constraint to the posting and retention of clinic staff. In its provisional acceptance of the revised PHC project workplan, the MOH cited the clinic rehabilitation report and requested that budget allocations be made to strengthen the physical infrastructure of rural clinics by upgrading and renovating staff housing. The MOH has asked for help with the cost of materials only with the local communities providing the labor.

Findings

-UNICEF training materials for RHMs are excellent.

-Support for RHMs by the nurses at the clinic level appears high.

-The support mechanisms for the supervision and effective utilization of RHMs in the community are inadequate. The clinic nurses have a key role in establishing and maintaining a working relationship with the RHMs to extend services to the local level.

-RHMs are an important cadre of outreach workers. However, there appear to be several key problems that need to be overcome: rapid turnover, uneven effectiveness, in part due to problems with the selection process, the lack of a consistent policy concerning their role, and lack of supplies, transport, consistent supervision and support in the community. UNICEF is currently planning a major evaluation of the RHM program in early 1989.

Recommendations

-If the necessary resources can be found, in collaboration with the MOH, the project should provide materials necessary for the renovation of staff housing at the 11 priority clinics. Such support should be contingent on the Ministry developing a budget line item for clinic renovation and staff housing in the next GOS budget cycle, to ensure sustainability of this critical effort to improve work conditions in the rural areas. Procedures for community participation similar to those used in the Rural Water-Borne Disease Project should be developed.

-In collaboration with UNICEF and the MOH, the project should continue to promote linkages between clinics and RHMs. Efforts should be concentrated on mechanisms which increase the effectiveness of RHMs in the community to reach critical target populations.

-The project should continue modest support of workshops and other activities which promote the development and involvement of community leaders.

-On-the-job training for clinic staff should continue to emphasize the importance of home visiting and other methods of facilitating community development and client follow-up.

5.2.1.7 Cyclical Planning in MCH Programs

The Public Health Unit, project-related programs (e.g., CCCD), and donors have established a cyclical planning strategy to guide and manage selected conditions (immunizable diseases, diarrheal disease, malaria, acute respiratory infection and growth monitoring).

The current planning process includes the appointment of a Working Group comprised of local experts and representatives from the appropriate organizations to devise a 3-year workplan which includes targets, indicators, and monitoring procedures. The Working Group then prepares a detailed 1-year workplan from the 3-year document. This includes priorities, new initiatives, activities to achieve targets, time tables and specific task responsibilities. These tasks are displayed on GANTT charts.

Using this planning sequence the project has assisted in the production of several 3-year plans for maternal health, diarrheal diseases, malaria, ARI, and immunization. Another 3-year plan for Growth Monitoring is scheduled for early 1989. Each of these long-term guides is being used as the basis to produce a series of 1-year workplans. This cyclical planning

process has encouraged donors to work together with the MOH. This process now needs to be extended and linked with similar planning at the regional level by the RHMTs. This has been included in program workplans as an annual Regional Review, beginning with CCCD and EPI, because of the implementation by clinic supervisors. This includes an evaluation of outreach and community involvement and the scope of health education.

5.2.2 Clinic Management

This is a critical area in assuring quality of care, sustainability and consumer use of services. Project outputs in the area of clinic management are impressive and appear to have resulted in significantly improved clinic operations and supervisory skills. The outputs include informal needs assessments, supply management guidelines, the training of community health committees in clinic management, workshops and in-service, the implementation of a drug management program, working with regional teams to expand outreach sites, and the development and implementation of a Supervisory Check List, Orientation Manual and Clinic Reference Manual.

Findings

-Clinic management activities in the project appear to have resulted in significantly improved skill development and problem-solving abilities on the part of the supervisors (Appendix H).

-The Clinic Orientation Manual is being utilized at the clinics and appears to be useful in assisting new staff in adjusting to working in the clinic setting. This is an important tool in addressing the problem of high turnover and frequent rotation of staff from clinic to clinic and hospital to clinic.

-The Clinic Reference Manual is being used extensively by the nurses in the clinics (all copies inspected were worn from use). All nurses questioned stated the manual was extremely helpful in their clinical practice. The Manual is also being used in pre-service nursing education at the Institute of Health Sciences. Many nurses stated more copies of the Clinic Reference Manual were needed.

-The Drug Management Program, included in-service training in drug management at the clinic and regional levels, reduced the number of drugs used in the clinic to 21, and provided of drug charts for all clinics. The program appears to have had a positive impact on drug use in the clinics. All nurses questioned stated the new system was a significant

improvement, problems with drug supplies were now minimal, and they were now able to distribute necessary drugs more effectively and efficiently.

-The Supervisory Checklist is being used by the supervisors; however; many of the supervisors stated it was too long and needs revision.

-The infrastructure support system for the supervisors in the regions to carry out their responsibilities is inadequate. Several of the RHMTs expressed anger that the supervisors were unable to implement the new skills learned in the workshops due to logistical problems (i.e., lack of transport), therefore increasing their frustration level.

Recommendations

-The Supervisory Checklist should be revised by the MOH with support from the project.

-Additional copies of the Clinic Reference Manual should be printed and distributed to appropriate health personnel.

-The project should collaborate with the RHMTs and other donors to address the problem of inadequate logistical support for the supervisors. The provision of a limited number of vehicles for the clinic supervisors in the regions, should be considered, with strict covenants regarding use/management/maintenance plans.

5.2.2.1 Laboratory Services

This continues to be a high-priority area for the MOH, as indicated in their 1989/1991 Health Sectoral Development Program Plan. Considerable MOH resources for the rehabilitation of the Central Public Health Laboratories are included in the MOH, 3-Year Capital Rolling Plan. In 1987 a consultant from Drew University conducted an extensive evaluation of the laboratory services at the Central and regional level. The project appears to have spent a considerable amount of time on assessing and upgrading the provision of basic laboratory services at the Central, regional and clinic levels. Workshops for laboratory assistants have been conducted, 4 laboratory personnel were sent on a study tour of the Blood Banking Program in Zimbabwe, and equipment and basic laboratory reagents and supplies have been provided.

Findings

-The level of resources that would be required to implement even a small section of the recommendations outlined in the report are not available within the current project, except at the expense of other important project activities.

-The majority of nurses questioned at the clinics stated that transportation for getting lab tests to the nearest laboratory facility was essentially nonexistent. Vehicles are usually flagged down to take the specimens.

-The nurses at the clinic level appear to have adequate knowledge regarding important tests for high risk MCH screening/FP.

Recommendations

-Given the magnitude of technical assistance and material resources that would be required to make a measurable/sustainable impact on the upgrading of laboratory services at both the Central and regional levels, further project inputs into laboratory services, except at the clinic level, are neither desirable nor appropriate. The project should continue to provide technical assistance and the minimal material support necessary to conduct only tests critical to high risk MCH screening (i.e., STD tests, hemoglobin, pregnancy tests).

-Consideration should be given to contracting private labs to provide basic laboratory services. This may be a more cost-effective solution at the present time.

5.2.3 Regionalization

The MOH has transferred decentralized decision-making for administrative and planning functions to all four Regional Health Management Teams (RHMT). This is intended to encourage greater local input in health services management and is expected to increase productivity. Because it involves training and supervision, logistics and supplies, and communications and referral, regionalization is critical for sustaining improved clinic services.

The project strategy is to phase in administrative, planning and system management skills by regular RHMT in-service sessions and workshop exercises. A core set of planning and financial management skills is required. During evaluation team visits, RHMTs described budgeting and management capability, particularly transportation and personnel services, as their high-priority training needs.

Decentralization is a gradual process and cuts across all the projects's EOPS indicators. As decentralization becomes institutionalized, it should make support to peripheral clinics increasingly efficient, and should impact positively on health service delivery.

Findings

- The Decentralization Task Force has been working effectively to assess RHMT progress and provide guidance and support.
- RHMTs are holding regular meetings; two of the four are progressing especially well in planning capability.
- A series of appropriate guidelines in personnel management, financial management, and drug management have been produced; the personnel management guidelines have been partially implemented.
- The Administration/Decentralization Advisor has had frequent contact with all four Regional Health Management Teams and the new RHA.
- Two critical logistical needs, transportation and communication, are not met at the regional level.

Recommendations

- Project staff, together with the Regional Health Administrator, should establish annual workplans with each RHMT, identifying priority activities and the resource requirements necessary to implement the plan.
- A set of process indicators need to be revised and introduced at each RHMT to assess progress in planning and support activities. These should include easily observed graphic (e.g., Gantt chart) as well as periodic written activity reports.
- Feedback to clinics should be developed to encourage timely, high-quality reports.
- The Senior Health Administrator and project advisors should devise strategies to tie RHMT budget information more directly to the central MOH recurrent budget process. Senior MOH officials should consider developing and implementing policy changes that will shift both the authority and responsibility for budgets and financial management from MOH headquarters to the RHMTs.

5.2.3.1 Transportation and Communication

The project paper identified transportation and communication as one of the four critical areas for project financing resources of activities which would directly "support the capacity of service providers to perform more effectively". AID support in these areas was contingent upon the Ministry of Health conducting feasibility studies, developing management and operating procedures and making arrangements for maintenance and the support of recurrent costs.

Findings

As was noted in the WHO Primary Health Care Review and many of the evaluation team meetings with MOH officials at the national, regional and local level, the absence of adequate reliable transportation and communication continues to be a major constraint in the improvement and expansion of maternal and child health services in many rural areas.

Recently, a limited number of vehicles have been assigned directly to the Regional Health Management Teams to assist in the management, delivery and supervision of public health services.

-In addition to the five vehicles that support the Project team, the project has provided two vehicles to the Ministry of Health to meet high-priority needs. A project advisor is a member of the MOH working group which is studying communication requirements at the clinic level. They have identified approximately 25 clinics by 1990 will not have telephone or radio links to a higher-level care facility. A short-term consultancy is just beginning to assess needs, feasibility, equipment options, costs and maintenance and management requirements of an expanded MOH communications network. A similar transportation study is planned for the near future.

Recommendations

If the two planned studies confirm the need for additional support in transport and communications, the Ministry of Health agrees that these two areas are high-priority, project activities and makes the requisite decisions and allocations for management, maintenance and operation of this equipment:

-Consideration should be given to augmenting project resources to support the purchaser of a limited number of vehicles for use at the regional level, and communications equipment for clinics with special needs.

-Such equipment should only be provided where need's assessments have demonstrated its importance for MCH service delivery and where procedures for management and use have been developed.

-The provision of the equipment must be accompanied by training for all those concerned with the management, operation and maintenance of this equipment.

-Because of the potential important contribution of such assistance, a specific and accelerated timetable should be developed for decisions on the purchase and distribution of such equipment within the next twelve months.

5.2.4 Systems Management

In the following sections, Health Planning and Budgeting, Resource Allocation, and HIS/Monitoring are key activities to be institutionalized. They also are major factors in sustaining clinic service delivery, as well as the broader regional health activities. To achieve institutionalization, proposed recommendations and strategies need to consider how requisite skills and knowledge can be transferred by PHC project staff and consultants to relevant Swazi colleagues. This will include the use of both appropriate technology and culturally relevant operational guidelines.

The project should increase management capacity from the "bottom up", expecting that RHMT competency will impact upon central level performance.

5.2.4.1 Health Planning and Budgeting

Planning and budgeting is required for the implementation of the programs supporting the national/project target service areas. Project emphasis should be at the regional level and below. RHMT sub-committees for planning, budgeting and monitoring plans will facilitate joint planning between the regions and MOH headquarters, and will facilitate "bottom-up" planning.

Findings

- MOH health planning has been deficient due to shortage of experienced Swazi staff and high turnover in key positions.
- The MOH budget has historically been developed using a straight-line extrapolation based on historical trends. Current regional plans and budgets are not incorporated into the overall MOH budgetary process.

- The project has trained 2 persons to use LOTUS spreadsheets for preparing budgets; and planning and budgeting functions as the central level have been strengthened in some specific areas through the PHC project staff efforts.
- Project advisors personnel participated in developing the MOH 3-years plans for MCH/FP, ORT/CDD and ARI.
- The MOH Financial Controller's office has been receptive to these planning inputs, and project manuals on budgeting and personnel management have been developed and implemented.

Recommendations

- Focus planning and budgeting assistance on the RHMTs and the Regionalization Task Force as a high priority capability. The Administration/Decentralization Advisor and the Planning/Budgeting Advisor should jointly plan and monitor their activities with the RHMT's.
- Redefine "counterpart" in the planning/budgeting area to cover a wider range of Swazi colleagues with whom the appropriate PHC project staff members may collaborate.
- The proposed user fee study should be carried out with the collaboration of central and regional MOH colleagues to facilitate skills transfer and enhance use of findings.
- The Planning/Budgeting Advisor, together with appropriate MOH officers, should collect and analyze resource use and unit cost information to encourage central MOH to re-evaluate its resource needs and financing options.

5.2.4.2 Resource Allocation

The lack of successful long-term experiences with alternative financing schemes in developing countries illustrates the difficulty of achieving major breakthroughs in this area. Yet financing and its corollary, resource allocation, are critical to maintenance of health services delivery at the periphery. The project should focus on improving resource allocation, and should slowly build a basis for future consideration of alternative financing schemes.

Findings

- Little data exist on MOH service unit costs or the effect of different facility size, location, and workload on efficient resource allocation.
- Previous health financing alternative analyses have not been fully understood by the MOH; interviews indicated reluctance to introduce health financing alternatives at the present time.
- Fees are collected at clinics and passed on to the general treasury. may act as a disincentive for the MOH to raise user charges.
- There are, additional community activities in support of MOH health service delivery. Most commonly this involves community participation in the construction of clinics, staff housing and outreach shelters.

Recommendations

- The Project Paper incorporates a covenant regarding GOS commitment to investigate and experiment with various forms of financing of health services outside normal GOS budgetary resources, with a view to increasing by E1,000,000 by the end of the project the amount of extra-budgetary funds spent by the MOH on health services". The evaluation team recommends that this covenant be deleted, since the current political climate appears to preclude the consideration of such alternative financing schemes during the remaining life of the project.

5.2.4.3 Health Information System (HIS)

The Health Information System being developed under this project combines two equal sub-systems: one which monitors health status indicators and health service indicators and another which tracks the resource flow to service and support activities. In Swaziland the term "Health Information System" (HIS) is used for both health statistics or the more comprehensive term, Management Information System (MIS), which includes resource allocation. HIS at the regional or central level in this report is synonymous with MIS.

The MOH has identified the health information system (HIS) as a top priority to support primary health care delivery. Information systems are inherent in many of the activity areas

listed and are important for proper management at the clinic and regional levels. The project should upgrade the existing HIS and broaden that system to encompass a variety of management information needs.

Findings

- Parts of an HIS exist at central and regional levels. Clinics have basic financial accounts periodically and submit forms such as Monthly Activity Forms. Analysis of this information is incomplete and statistics forwarded to central headquarters has had little impact on regional planning.
- Skills in basic HIS analysis are needed for clinic managers, while skill in comparative HIS analyses are needed by RHMTs.
- PHC Project staff are assisting RHMTs in analyzing their HIS forms and their use for planning. All clinics visited display basic HIS data on large wall graphs, including immunization and prenatal visits.
- CCCD has begun to collect data on certain diseases from the clinics and to provide feedback feed trends back to the regions.
- A national Family Health Survey funded by the PHC Project is currently underway with collaboration from CCCD. Survey results should provide important baseline data for the health information system.
- Owing to the overall workload of the Planning/Budgeting Advisor, including his COP responsibilities, development and implementation of the Health Information System is proceeding more slowly than planned.

Recommendations

- Project advisors should reinforce the MIS concept and the value of analyzing both types of information in allocating health resources effectively.
- Project HIS activities should focus on the information needs of RHMTs and clinic supervisors.
- Regional results of the Family Health Survey should be used by each RHMT in regional planning and resource allocation.

5.2.5 Training and Health Education

The project has provided assistance to the MOH in both pre-service and in-service training in Swaziland, and in short- and long-term participant training in other countries. Training was one of the major components of the national PHC Plan. The National Health Policy identifies "the availability of appropriate health manpower as a critical factor in implementing primary health care services".

5.2.5.1 Pre-Service Training/Nursing Education

Findings

-Project advisors have developed a close and effective working relationship with both Nazarene Nursing College (NNC) in Manzini and the Institute of Health Sciences (IHS) in Mbabane. The project also provided a bus to IHS to facilitate practical field experience for the nursing students. Project staff have also collaborated with Project HOPE in the area of pre-service training.

-The faculties of both nursing schools agree that there is an on-going need to integrate further primary health care into the core curriculum. The lack of coordination of pre-service and in-service training is also a concern.

-There appears to have been limited interaction by project advisors with the School for Nursing Assistants in Siteki. Plans are currently being made to expand the curriculum to include midwifery training for nursing assistants.

Recommendations

-Efforts to strengthen the linkages and coordination between pre-service and in-service education should be continued.

-Project staff should inform nursing school faculty of training activities in the field and exchange resources among the IHS; NNC; and Siteki programs.

-Primary health care and health education promotion should be further integrated into the core curriculum of all pre-service training institutions.

5.2.5.2 In-Service Training

The project has sponsored a large number of workshops in areas such as clinic management, health education, maternal and child health, and management and supervision. The project

has also worked with other donors on the training of trainers for family planning and community leadership.

Findings

-Clinic staff who have participated in the workshops expressed a high level of satisfaction with the training. The nurses stated that prior to the inception of the project, they had not received any in-service training for 15 to 20 years. This was of particular concern because of the many recent changes in practice and technology in primary health care.

-An important additional benefit of the training is that it has increased the self-confidence and self-esteem of the nurses. Self-esteem is critical for increased leadership skill and problem-solving capabilities. The groundwork has been laid for more task-specific, skill-oriented training in the future.

-The workshops appear to have accomplished an important goal in raising consciousness and providing much needed recognition and attention to the clinic based providers. There is evidence that this has resulted in a positive change in nursing practice at the clinic level.

-An important outcome of the workshops was the development of the Clinic Nurses Orientation Manual. The manual is being used in all the clinics visited by the evaluation team, and the nurses indicated that it is very helpful.

-There have been a number of shortcomings in the way training was designed, scheduled, evaluated and reported. Training was carried out without formal needs assessments or the development of written criteria for the selection of participants. Record keeping has been minimal. The reports of the training workshops are inconsistent; some describe in detail the format and content, whereas others provide almost no information.

-From the reports, it appears that most of the training has been experiential, with limited structure and little emphasis on measurable learning objectives (skill/competency based)

-Recent assessments of training by project staff have identified problems in the length, location and cost of the training workshops. Project staff now are seeking more appropriate, cost-effective ways to provide training. Project staff are also working with the MOH on implementing new procedures to coordinate training efforts.

-At the project level, there has been insufficient coordination of training efforts. However, there are several

good examples of coordination among projects and donors in placing and implementing in-service training courses that achieved mutual objectives.

Recommendations

-Providing appropriate education in primary health care should continue to be a focus of the project. The link between in-service and pre-service training is essential in order to institutionalize primary health care strategies in MCH.

-Guidelines should be established for all future training activities. These should include:

- a) Formal needs assessment
- b) Overall training goals
- c) Behavioral objectives
- d) Methodology
- e) Skill assessment
- f) Evaluation
- g) Follow-up

-Evaluation and follow-up of all training activities is critical for both participants and supervisors. Follow-up activities should test for competency and retention of knowledge gained.

-All training should be competency-based. Skills to be mastered should be clearly defined and measurable.

-The hotel-based workshop format should be replaced by more individualized, clinic-based training.

-Training should be a joint effort between MOH headquarters and the regions. The regions are aware of their needs but the central level should provide coordination of resources and ensure consistency in training, since nurses often rotate from region to region.

-Attendance records should be monitored at both the national and regional levels to ensure that training opportunities are made available equitably.

5.2.5.3 Participant Training

The project has supported the following long-term training: 6 participants to Lesotho for training in laboratory technology; 2 participants to Botswana for training in health administration; 2 participants to Nigeria for training in health education; 2 participants to the United States for training in health education and mass communications; and 1 participant to the United States for training in health information systems.

The project has provided short-term out-of-country training to: 12 RHM trainers in Kenya (2 weeks); 2 matrons to a 1-month MEDEX course in the United States; 1 MD to a 6 week Child Survival Course at Boston University in the United States; 1 Nursing Principal to Boston University for 1 month, 2 participants for a 1 week HIS course in Boston and 4 health planners to Zimbabwe for 3 weeks.

Findings

-No records of the training curriculum for these participants were available. Thus it is difficult to assess the overall effectiveness of this training.

-Short-term participants interviewed by the evaluation team reported favorable experiences.

Recommendations

-Because of budgetary constraints, priority should be given to skill-based, in-country training. The emphasis on training should be on skill building, rather than general observation. This can best be accomplished in-country.

-Study tour commitments already made should be honored. Any further study tour activities should be curtailed.

-Long-term training currently in progress should be continued and supported as should other third-country training for which firm commitments have already been made. (This includes the two additional participants for health education training in Nigeria, although candidates have not yet been selected.) The project should not support any additional long-term training.

-Out of country short-term training courses should be carefully evaluated as to their appropriateness and cost-benefit. Such training should be limited to high-priority activities for which no in-country alternative exists.

-The 8-week course in the U.K. proposed for administrators should be considered as to its appropriateness and potential impact on the health care system.

5.2.5.4 Health Education

Improvements in maternal and child health are dependent on families recognizing health risks, utilizing health resources and changing behavior. The draft GOS and UNICEF report on the situation of women and children in Swaziland makes the important points that:

-infant mortality could be reduced appreciably by changes in a limited number of health care practices; and

-education, promotion and social mobilization could alter these behaviors.

The report also points out, efforts to change health behavior in Swaziland have been "remarkably successful." It attributes important changes in the utilization of immunization, growth monitoring and ORT to the "impact of well-designed and executed community education programs". Health education is one of the major tools for increasing public awareness and encompasses a range of activities at the national, regional, clinic and community levels. Another important tool is involving communities and their leadership in decisions about health needs, priorities and resources.

Project activities in this area have been limited. While the project design and the MOH policy statement both identify health education as an integral part of primary health care, this has not been given priority.

An inventory of in-country health education resources was completed by a short-term consultant in February 1988. A survey of the impact of health education was carried out earlier this year but the data have not yet been analyzed. There has been one workshop, "Health Education: Alternative Methods and Strategy" for clinic nurses. Those who participated are actively engaged in outreach/health education work (i.e., home visits, small group talks, use of graphs and charts), using techniques such as songs and puppet shows, which they learned in the workshop. The majority of the nurses interviewed acknowledged the importance of health education in all aspects of their work with clients and expressed a desire to expand their knowledge base and practice in health education.

The project has supported long-term training in health education in Nigeria(2) and in the United States(2). Two additional participants are expected to complete the Nigeria course.

Health education in the schools is not an area of project activity. This overlooks the great potential that the school-age child has as a health advocate/promoter in his own family. The high enrollment of children in schools in Swaziland makes this an important channel of information into Swazi homesteads. Another reason to consider this health education

avenue is the proximity of schools to clinics. Many clinic nurses have been assigned responsibilities for school health but they are limited in their effectiveness by lack of skills, materials and time. UNICEF and other donor agencies have excellent school health materials which could be used in an expanded effort.

Recommendations

-The importance of health education in primary health care must be emphasized and should be a unifying focal point for the entire project team. Team members should look for opportunities to work with the MOH at all levels to expand health education outreach activities.

-Together with key MOH headquarters staff and the RHMTs, the team should develop a strategy for implementing health education activities throughout the system.

-A workplan for integrating health education/community outreach should be developed. The major focus in all future in-service training should be on teaching all providers (nurses, nursing assistants, health inspectors, supervisors, etc.) basic tools and techniques for promoting PHC through education. This would include the use of group talks, charts/posters, songs, plays and visual aids.

-Resources should be allocated for short-term technical assistance and in-service training in health education. An estimated 6 months of short-term technical assistance is needed to help the MOH and project staff design and implement the community health education strategy. Appendix O contains a brief description of the tasks to be carried out under this technical assistance.

-Project staff must work with the MOH, UNICEF and other agencies in identifying important health messages (breastfeeding, better weaning foods and other nutritional behavior and environmental sanitation), and seeing that new ways of getting these messages to key decision-makers, leaders and childcare providers are developed and implemented.

-Health education in the schools, an important sub-component of health education, needs to be addressed.

- In collaboration with UNICEF and CCD emphasis should be given to further training of the clinic nurses assigned to school health - especially in health education methods, tools and techniques.

-Materials developed by UNICEF and CCCD should be provided to the school health nurses and their activities should be reinforced by appropriate followup and continuing education by clinic supervisors.

Collaboration should be sought between the Ministries of Education and Health in order to introduce health education (re. primary health care) into the curriculum.

6. OPTIONS FOR OVERALL PROJECT RESOURCES

The scope of work directs the evaluation team to reassess technical and management inputs in relationship to progress towards outputs (5.1). The evaluation team did not reach a consensus about extension of the project. Four scenarios were devised and are shown below. Scenarios A and B assume that the project will end in December 1990 as planned. Scenarios C and D include extensions of six months or three years. Each scenario is based on different assumptions about the extent to which project outputs 1-4 (section 5.1) have been met, the availability of resources, and sustainability by the GOS. The scenarios reflect a cumulative set of resources for A to D.

The evaluation team considered technical assistance, project achievement, and sustainability issues as background for preparing the set of project scenarios.

1. Technical assistance input

Technical assistance has contributed to significant accomplishments in attaining objectives to improve MCH/FP services and more productive health workers. Less progress has been achieved in decentralization/regionalization partly because it is a new development in which transfer of central decision-making will take time. The initial technical assistance distribution and COP time requirements resulted in the regionalization component receiving about one third of total long-term technical assistance input. The evaluation team recommends increased technical assistance in this area after the project's third year. This redistribution of technical assistance input should be considered when reviewing project scenarios.

2. Progress towards project objectives and goal

The evaluation team had difficulty in reaching a consensus because they differed in the interpretation of key terms - "outreach", "demand", "expand" - used in the Project Paper. One interpretation is that these terms were to be applied to clinic catchment areas, and that this project should not be expected to achieve the MOH's long-term goal of improved health status. An alternative interpretation is that the EOPS indicators and health status impact are appropriate project objectives, which deserve a re-focus of present MCH/FP service delivery and outreach approaches to reach currently less accessible population subgroups, where there are high rates

of preventable disease and death. This latter interpretation will not be achievable within the current project resources and time-frame, giving a rationale for extension scenarios in time and resources. In addition, support and resources from the GOS and other donors will be important.

3. Input sustainability by GOS

AID and other large donors such as UNICEF, the United Nations Development Program, and the World Bank have recently considered factors which affect the sustainability of health project activities and benefits after donor project funding ends. In a recent AID review of experience with health projects,² critical program components for sustainability were:

- Financing
- Host country policy
- Appropriate program design with respect to breadth of objectives
- Program management
- Community participation in planning and implementation

These components tend to interact. A sustainable program must have trained and motivated counterparts a functioning management information system, and a system to monitor progress. Community involvement would seem important if a greater proportion of action service costs for expanded PHC was to be met by patient charges. In view of the present GOS fee schedule policy which precludes raising fees, any planned expansion of rural PHC services would warrant additional discussion with the GOS.

Scenario A

This proposal involves obtaining additional resources to support a third TA (planner/budget - Chief of Party) to the EOP in addition to the two TAs (Maternal/FP; child health) originally budgeted. It includes funds to offset the current \$500,000 shortfall caused by an increase in long-term technical assistance (2 extra years) and several unbudgeted expenditures. Because there has been more technical advisor input in the clinic service/management component, the decentralization objectives are likely to remain less complete. If this scenario does not receive support, there will be a need to reallocate existing funds by cutting back in training, research and commodities.

²AID Program Evaluation Discussion Paper No.23 Development Assistance and Health Programs: Issues of Sustainability. AID Washington, DC 20523 (PN-AAL-097) Oct. 1987.

Scenario B

This estimate retains a fourth long-term TA (decentralization/administration) to the end of the project in order to provide additional support to the regionalization/systems component, to increase potential for institutionalization. Since 4 positions are recommended to EOP but 5 TA's are currently involved, the contractor should work with the MOH to decide which of two positions (clinic management; child health should be continued after the project third year. Additionally, a set of high priority MOH commodity requirements are recommended. These include radio equipment at 25 clinics, 2 vehicles per region to facilitate clinic supervision (total:8), and building material to help renovate 11 clinic facilities. If this scenario does not receive support, outputs 3 and 4 are unlikely to be fully attained or institutionalized. If this scenario does not receive support, the decentralization and management objectives are unlikely to be fully attained or institutionalized. The proposed commodity resources were cited as areas for budget reallocation by the MOH in their provisional acceptance of the revised workplan.

Scenario C

This scenario is similar to B except for a six month extension to offset the delayed start-up of the project until 9/86. The same four long-term technical advisors are retained to the EOP. This scenario assumes that a modest extension of the project, combined with the increased central MOH support of decentralization, will enhance RHMT institutionalization.

Scenario D

This scenario assumes that both the MOH and AID agree that the project goal of decreasing MCH morbidity and mortality and the project purpose are still valid and important. It also assumes that both are prepared to commit resources, along with those of other donors, to reach high-risk population with high impact low-cost interventions. This scenario would require continuing resources for training (in-country and limited third country), commodities, and technical assistance. The long-term technical assistance would consist of an additional 108 person-months. Short-term technical assistance would be approximately 9 person-months. Resources should also be included for modest studies (2-3 per year). Consideration should also be given as to whether a followup Family Health Survey should be carried out in the 7th project year.

These scenario profiles are summarized below.

END OF PROJECT	ASSUMPTION RE OUTPUTS(3) AND INSTITUTIONALIZATION	RESOURCE REQUIREMENTS		
		Technical Assistance No. TAs(1)	Total P-M(2)	Other
A 12/90	1-2 met 3-4 Incomplete; Some institutionalization	3	84	To offset current shortfall
B 12/90	1-4 met; Moderate institutionalization	4	108	Radios for 25 clinics; 8 vehicles; renovation of eleven clinics
C 6/91	1-4 met; Improved institutionalization	4	132	Same
D 12/93	Output 1 has not been met: there is inadequate access to high-risk population subgroups; 2-4 met; improved institutionalization	3	240	Adequate logistics support

- (1) Number of Technical Advisors at End of Project
(2) Estimate of person-months of long-term technical advisors from 12/88 to proposed End of Project.
(3) Outputs are described in the Project Paper.

- 1) Improved outreach and service delivery approaches and incentive schemes to increase the demand for health services implemented.
- 2) More productive health workers.
- 3) Health facilities supplied with necessary MCH/FP equipments, ORS, supplies, vaccines, drugs, and contraceptives on a steady, reliable basis.
- 4) Decentralized system of planning, budgeting, financial management, supervision, and management.
- 5) Increased proportion of GOS recurrent expenditures for health devoted to primary health care.

7. SUMMARY OF MAJOR CONCLUSIONS AND RECOMMENDATIONS

The Primary Health Care Project and other donors are effectively collaborating with the Ministry of Health to improve and expand primary health care and to develop management capabilities and systems to sustain and support these gains. The project's initial phase has made contributions in several areas: improved outreach and service delivery approaches; more productive health workers; a reliable, steady supply system; and regionalization of planning, budgeting, and system management. Staff workers have more confidence in their skills and are able to rely on regular supplies and assistance from experienced supervisors. At the regional level, all four Regional Health Management Teams (RHMT) have been supported with guidelines and technical advice from the project. Annual workplans and identification of regional health priorities have helped to budget resources more appropriately. An effective information system is beginning to evolve. The remaining project time should refine and help institutionalize these capabilities and make the improved clinic services more accessible.

The project's initial design, workplan, and activities were broad and created a heavy project staff workload, as well as unrealistic MOH expectations of material support in several areas (see Sections 2.1 and 2.2).

1. The project workplan and strategic planning process should be re-focused principally on the clinic service/outreach and decentralization components. Other priority areas include planning/budgeting and the health information system. The roles of project advisors should be redefined as necessary to focus on these areas.
2. Efforts should be continued to reduce the scope of activities, with corresponding reductions in advisor time and other project resources. A streamlined workplan is a high priority.
3. The Contractor, in collaboration with the MOH and AID, should identify areas for decreased support to ensure that project resources are used efficiently, that they have the desired impact on PHC services, and that sustainability is likely.

Areas to consider for reduction in support include: out-of-country training, short-term technical assistance except in support of priority areas; laboratory services and equipment except for those necessary for high-risk screening at the clinic level; and disease control programs where other donors or other AID-assisted

projects have mandates and the necessary resources.

In view of the re-focusing and priorities recommended above and emphasized in other recommendations which follow, the MOH and AID should review the availability of project resources to provide limited, high-impact commodity support in the following areas:

4. -- Clinic supplies for high-risk screening and deliveries.
- Building materials for community renovation of priority clinics and associated staff housing.
- Based on the outcome of the planned studies of transport and communication needs, provide limited vehicular and communication equipment to support MCH/FP activities at the clinic level, contingent on appropriate MOH management decisions to support sustainability.

Project management and advisor priorities have contributed to a fragmented set of activities with insufficient team collaboration. Cooperative team functioning is critical to maximize this project's objectives. (4.3)

5. An intensive strategic planning and team-building process, involving the MSH Senior Technical Officer and all team members, is required in order to increase the team's effectiveness in coordinating individual responsibilities and carrying out project activities.

The advisor/counterpart linkage is quite strong in several areas but needs strengthening in others. Increased joint decision-making is needed to make activities relevant and to facilitate institutionalization of technical skills. (4.2)

6. The MOH Undersecretary and the project Chief of Party should periodically review participation of counterparts in critical areas and jointly address any difficulties.

Monitoring of project progress to date has not fully involved all three key parties -- the MOH, the Contractor, and AID. In particular, project financial information has not been available, although a system is now being installed that will identify and control resources more effectively. Reactivation of the Project Steering Committee has been proposed but has not yet been accomplished. (4.3)

7. The Contractor should continue efforts to refine and improve the project's financial management system and use it as a basis for making joint resource allocation

decisions.

8. The Undersecretary and the COP should hold scheduled, periodic briefing meetings to assess project progress and problems.
9. The proposed reactivation of the joint MOH/Contractor/AID Project Steering Committee should be implemented as soon as possible.

The MOH has stated that the majority of the very high levels of maternal and infant mortality could be prevented through simple, low-cost interventions and health education via community-based programs which "directly target infant, young child, and maternal mortality and morbidity in underserved rural areas. Specifically, considerable epidemiological information implicates the adverse effect of early discontinuation of breastfeeding on infant mortality. (5.2.1)

10. The project should assist the MOH in developing simple mechanisms, using available data where possible, to identify high-risk groups which can be targeted for intervention.
11. The project should assist the MOH to devise strategies to improve community health education; strengthen referral mechanisms between communities, clinics, and health centers and hospitals; identify areas of cooperation with traditional healers; develop community leadership; and improve outreach activities.
12. The project should support breastfeeding promotion activities in collaboration with SINAN and UNICEF.

The quality of clinical procedures and clinic management introduced thus far in the project have favorably affected the level of clinic functioning. These areas deserve further evaluation and refinement,. (5.2.2)

13. Evaluation and follow-up of on-the-job training sessions should be instituted to maximize the effectiveness of the guidelines for supervisors and clinic staff.

The implementation phase of the project has gone well at the clinic and regional levels with an increasing capacity to manage clinic and regional support systems. It is essential to transfer the problem-solving and decision-making capacity to Swazi personnel during the remainder of the project. Similarly, a variety of manuals and guidelines have been devised for RHMT programs, but are being implemented at different speeds. (5.2.3)

14. A management needs assessment and priority-setting process is needed for each RHMT because of variable levels of experience.
15. The Senior Health Administrator, together with the Administration/Decentralization Advisor and the Planning/Budgeting Advisor, should provide increased technical and management input to expand the planning and management capabilities of the RHMTs so that all four RHMTs achieve an agreed-upon and sustainable level of functioning by the end of the project.

The project's initial training focus on workshops has had benefits in reaching a large group of health personnel, stimulating their efforts and transferring appropriate clinical and management skills. Insufficient evaluation and follow-up work has been done. There needs to be a greater linkage with pre-service training institutions to ensure that current needs and field experience are reflected in pre-service curricula. (5.2.5)

16. Future training emphasis should be on on-the-job training and small, regional workshops. Efforts to develop stronger pre-service and in-service links for PHC should continue with a focus on the institutionalization of in-service training capabilities.

A fundamental component of primary health care, health education, has not received sufficient attention. (5.2.5)

17. Health education in primary health care must be emphasized and should be a unifying focal point for the entire project team. Team members should work with the MOH at all levels to expand health education outreach activities.
18. A short-term consultant should assist the MOH and project staff to design and implement a community health education strategy.

The evaluation team has prepared four alternative project options for consideration by the GOS and AID (Section 6). Each makes different assumptions about the project's progress toward objectives, strategies, and the availability of project resources. None of the proposed scenarios can be implemented without additional resources.

19. In reviewing the four options, the GOS and AID should consider the extent to which the project purpose and outputs will be achieved and relevant sustainability factors.

10 AUGUST 1988

ATTACHMENT 1

STATEMENT OF WORK FOR MID-PROJECT EVALUATION

SWAZILAND PRIMARY HEALTH CARE PROJECT
(645-0220)

I. BACKGROUND

A. Project Rationale

The GOS, with assistance from AID and other donors, has invested heavily in improving and expanding primary health care (PHC) services throughout the Kingdom during the past decade. Although there has been vast improvement in the training and placement of rural health personnel and accessibility to clinic facilities, and although the Government has adopted a health policy which emphasizes preventive health care, there has only been moderate improvement in maternal and child mortality and morbidity since 1975.

The approach taken in the design of this project was to identify with the Ministry of Health a limited number of key areas within primary health care which, if given priority attention, would make a substantial impact on maternal and child mortality and morbidity in Swaziland. Based on an analysis of health problems and the health care system in Swaziland, the MOH and USAID concluded that a major effort in eight target service areas would have the most impact on the maternal and child health problems identified.

Project Goal and Purpose. The goal of the PHC Project is to improve the health status of Swazi children under five years of age and women of childbearing age. The project purpose is to improve and expand the PHC delivery system. To achieve this goal and purpose the project focuses on the eight target service areas, as well as key support systems, in order to strengthen PHC service delivery and obtain a corresponding improvement in maternal and child health status.

End of Project Status Indicators. In each of the eight service areas a target service level was established for the end of the project, i.e., the end of project status (EOPS) indicators to be achieved by 1990. These EOPS indicators are as follows:

1. To provide better, earlier, and more frequent pre-natal care to 90% of pregnant women.
2. To increase to 70% the number of births attended by health personnel or trained attendants.
3. To provide post-partum education for 90% of mothers who deliver in a maternity.
4. To immunize fully 70% of all children under one year of age.

5. To make ORT available to 90% of children under five years of age and have ORT effectively used in 50% of the incidents of diarrhea in this age group.
6. To perform growth monitoring routinely for 90% of all children under five years of age that identifies children with problems and leads to improved diagnostics, treatment and nutritional repair, plus effective education of mothers.
7. To increase to 12% the proportion of women of reproductive age who are continuing users of child-spacing techniques.
8. To provide to children and women of childbearing age appropriate and timely treatment against major parasitic, infectious and lower respiratory diseases.

Project Outputs. The Project Paper identified detailed outputs related to each of the eight target service areas, and summarized them into five more general outputs, as follows:

1. Improved outreach and service delivery approaches, and improved incentive schemes to increase demand for health services.
2. More productive health providers, brought about by improved training, reassignment of work responsibilities, improved conditions of service, improved transportation and communications, and improved supervision and management support.
3. Health facilities supplied with necessary MCH, JS equipment, ORS supplies, vaccines, drugs, and contraceptives on a steady, reliable basis.
4. A decentralized system of planning, budgeting, financial management, supervision, and management in place and operating effectively.
5. Improved cost recovery mechanisms developed and implemented, and an increased proportion of GOS recurrent expenditures devoted to primary health care.

Project Inputs. AID inputs under the project evolved from an analysis of what is required to achieve the eight service targets by the end of 1990, activities currently underway or planned in these areas, and the assistance gaps which remain. They are designed to supplement resources provided by the GOS and other donors and other AID projects in these service areas. Assistance is given both to strengthen service delivery and to improve management and support systems. The project provides long- and short-term technical assistance, overseas and in-country training, funding for operations research and other monitoring, studies, and evaluations, and a limited amount of commodities. The total project cost is \$7,945,000, of which the AID contribution is \$3,760,000. The GOS contribution of \$4,185,000 represents 52% of the total cost. The project was authorized in August 1985 and the Project Assistance Completion Date (PACD) is December 1990.

* A sixth project output initially incorporated in the Project Paper, concerning the development and implementation of a GOS population policy, was deleted by mutual agreement between the GOS and USAID/Swaziland.

B. Project Activities

The project supports activities of three different types: (1) those directly related to improving service delivery, (2) those related to supporting health service providers, and (3) those related to improving management and support systems. These are summarized as follows:

1. Activities directly related to primary health care services:

- pre-natal care
- attended deliveries
- post-partum education
- immunizations
- oral rehydration
- growth monitoring
- child spacing
- treatment of priority diseases

2. Activities which directly support service providers:

- training
- transportation and communication
- laboratory services
- health education messages
- clinic management

3. Activities providing management and systems support:

- decentralization
- coordination of maternal/child health programs
- planning, budgeting and financial management
- research, monitoring and evaluation
- health financing
- nursing education

II. EVALUATION SCOPE OF WORK

ARTICLE I. Title

Swaziland Primary Health Care Project
(645-0220)
Mid-Project Evaluation

ARTICLE II. Objectives

1. Review the appropriateness, timeliness and quality of inputs of the Project and the host country. Provide a descriptive analysis of the project status relative to the inputs and identify any problems or shortcomings and make recommendations for overcoming them.

2. Review project outputs, quantify progress made towards achieving output indicators, and provide a detailed explanation of those areas where project outputs have exceeded or are not likely to achieve targets. Recommend strategies for overcoming snottfalls.
3. Review the project purpose and assess the extent to which project inputs and outputs are, or are not, leading to the achievement of the purpose and the EOPS indicators by the project assistance completion date (PACD).

ARTICLE III. Scope of Work

The Contractor will perform a mid-project evaluation beginning in mid-September and extending through mid-October 1988. The evaluation team will be composed of five full-time members, with background and expertise consistent with the focus of the evaluation. One of these team members will be an AID Direct Hire HPN Officer. (See "Qualifications of Evaluation Team Members" below.) In addition, although an MOH official cannot be made available on a full-time basis, the evaluation team will benefit from the participation of one or more MOH officials to the extent that performance of their other duties will allow.

Prior to arrival in Swaziland the team leader will meet with Management Sciences for Health (MSH) staff in Boston, Massachusetts to review the Project Contractor's home office support and operations for this project. The team leader will also meet with staff of the Project Subcontractor, The Charles R. Drew University, in Silver Spring, Maryland to review its home office support and operations. In Swaziland the team will meet with GOS officials, representatives of other relevant organizations and agencies, the MSH long-term TA team, and USAID officers.

The evaluation team will begin its work in Swaziland on September 19, 1988. The team will coordinate its work through the Regional Health and Population Development Officer, who is the Project Officer for this project. In carrying out its tasks the evaluation team will review Project and GOS reports, workplans, and documents, as well as other relevant materials; meet with GOS officials, representatives of other organizations and agencies, the long-term TA team, and USAID officers; and make selected site visits together with MOH and TA team members.

In addition to the participation of the USAID Project Officer (12 days), the team will draw on assistance as needed from the USAID Financial Management Office (5-7 days) in analyzing the overall AID Project budget and the GOS contribution to the Project. The USAID Evaluation Officer will also be involved in all major steps of the evaluation process (3-5 days). Other USAID officers will be available as needed.

The evaluation team will present a full draft report (20 copies) and an oral briefing to GOS and USAID officials not later than 10 October 1988. GOS and USAID officials will provide comments on the report not later than 13 October. If required, the Team Leader will remain in Swaziland for up to one additional week to incorporate any necessary changes in the draft and submit a final evaluation report (20 copies) prior to his/her departure.

In working to achieve its objectives, the evaluation team should focus on the following specific topics:

Objective 1. Review the appropriateness, timeliness and quality of inputs of the Project and the host country. Provide a descriptive analysis of Project status relative to the inputs, identify any problems or shortcomings, and make recommendations for overcoming them.

1.1. Are the level and quality of AID Project inputs adequate to achieve the project's outputs and EOPS during the remaining life of project? In particular, are the Project contractor and subcontractor carrying out their contractual responsibilities satisfactorily, both in-country and at their home offices? Has the quality of technical assistance, including management of the long-term TA team and coordination among team members, been satisfactory? Does each team member each have a manageable workload? Are the currently envisioned levels of long-term TA sufficient to achieve the Project outputs and EOPS? Is USAID/Swaziland performing its Project management role satisfactorily and being responsive to Project needs?

1.2. Is the absorptive capacity of the MOH -- the availability, timeliness, and quality of MOH inputs -- adequate to achieve the Project's outputs and EOPS during the remaining life of project? Is the GOS meeting its obligations under the Grant Agreement and Project Paper, especially the provision of appropriate counterparts? Has the GOS succeeded in increasing the percentage of its budget spent on primary health care? Should the formula for calculating PHC expenditures be revised? Does the GOS capital budget adequately support the national PHC Program, and thus the Project?

1.3. Is the mix of Project inputs appropriate, especially the balance between inputs directed toward strengthening human resources (technical assistance and training) and those directed toward capital improvements (rehabilitation of clinic facilities, improved communications and transport)?

Objective 2. Review project outputs, quantify progress made towards achieving output indicators, and provide a detailed explanation of those areas where project outputs either have exceeded or are not likely to achieve targets. Recommend strategies for overcoming shortfalls.

2.1. Are the activities described in the Project Paper being carried out? What has been the impact of these activities in relation to Project outputs and EOPS? Have activities, especially training, been adequately followed up to assess their appropriateness and effectiveness? Is there an adequate mechanism to insure that improved in-service training curricula are reflected in the corresponding pre-service curricula, and vice-versa? Are there general areas of activity (e.g., cost recovery mechanisms, drug supply system) where Project outputs may not be fully achieved? If so, how should the situation be resolved? (The evaluation team should review the results of the recent inputs/outputs/EOPS matrix analysis which has been carried out jointly by the TA team and USAID.)

2.2 Which activities described in the revised workplan would contribute most to achieving the Project purpose within the remaining life of the Project? Are critical PHC Program functions being institutionalized through the Project so that they will be sustained after the Project ends?

2.3 Do the MOH and the TA team coordinate Project activities adequately, both with those of other donors (e.g., UNICEF, WHO, UNFPA) and with other USAID projects (e.g., Combatting Communicable Childhood Diseases, Rural Water Borne Disease Control, and Family Health Services)?

2.4 Is there adequate communication and coordination between MOH headquarters and field personnel concerning the timing, content and objectives of PHC activities? What has the PHC Project done to facilitate such coordination and communication? To what degree do personnel at the MOH headquarters and at the regional and clinic levels share a common concept of, and support for, such project activities as planning, budgeting, training, decentralization, alternative financing, etc.? Should the mechanisms for regular communication among MOH counterparts and Project team members be expanded and improved?

Objective 3. Review the project purpose and assess the extent to which project inputs and outputs are, or are not, leading to the achievement of the purpose and the EOPS indicators by the project assistance completion date (PACD).

3.1 Are the initial logical framework assumptions still valid? If not, what modifications should be made, and what implications do these changes have for the Project?

3.2 Has the GOS Primary Health Care Program in Swaziland improved since the PHC Project began? Does the MOH have the ability to track and measure changes in the utilization of PHC services? To what extent can any improvement be traced to PHC Project activities?

3.3 Is the scope of the PHC Project realistic in terms of both its national framework and its comprehensive range of activities? How does the revised workplan fit with the original Project design? Are the outputs and EOPS achievable and realistic within the remaining life of the project, or should they be revised? Which indicators should be used to evaluate the progress made toward achieving the Project purpose?

3.4 Are Swazis aware of which PHC services are available to them, and as the use of these services increased? What additional activities should be undertaken to increase demand for services? Have Project efforts thus far to extend PHC services beyond static health facilities (e.g., mobile outreach clinics, strengthening the Rural Health Motivator program) been successful? Should these efforts be expanded to help achieve Project outputs and EOPS?

3.5 Do MOH personnel understand and support the objectives of the Project? Do MOH personnel understand and support the revised workplan? Are Project activities generally consistent with the priorities of MOH personnel? Do other key GOS ministries (e.g., Ministry of Finance, Department of Economic Planning and Statistics) understand and support the goals of the PHC Project?

3.6 Are the Project purpose and emphases supportive of current GOS health policies, plans, and priorities? Are there any new developments in PHC services that should be incorporated into Project activities and outputs (e.g., the findings and recommendations of the joint UNICEF/USAID-supported Weaning Improvement Project)?

ARTICLE IV. Qualifications of Evaluation Team Members

The Primary Health Care Project covers a wide range of activities related to primary health care. It is essential that each evaluation team member, while focusing on one or more specialized aspects of the Project, be able to relate his or her area(s) to the overall Project as an integrated whole.

1. Team Leader (Public Health Physician): M.D. degree and Master of Public Health or equivalent degree required. Extensive and increasingly responsible experience in comprehensive health care program development, implementation, and assessment required, including in a developing country setting (preferably sub-Saharan Africa). Previous health project/program evaluation experience required, including AID project evaluation. Excellent analytical and writing skills required. Experience in developing and implementing inservice training programs for health workers in a developing country setting highly desirable. Experience with health care operations research desirable.
2. Health Information/Financial Management Specialist: An advanced degree in public health or related field required, with emphasis in health information systems and/or financial management. Extensive experience required in the development, implementation, and assessment of health information and financial management systems, including in a developing country setting (preferably sub-Saharan Africa). Excellent analytical and writing skills required. Previous health project/program evaluation experience highly desirable. Experience in health care operations research desirable.
3. Nurse/Midwife: Master's degree required in nursing, with emphasis in maternal and child health (MCH), midwifery, and/or family planning. Extensive experience required in comprehensive MCH program development, implementation, and assessment, including in a developing country setting (preferably sub-Saharan Africa). Experience in curriculum development and teaching in MCH and related areas required. Excellent analytical and writing skills required. Experience in health care operations research desirable.

4. Health Training Specialist: An advanced degree required in education, with emphasis in manpower planning and development, and preferably including curriculum development and assessment. Specialization in the health field especially desirable. Extensive experience required in manpower development, curriculum development training, and the assessment of short-term training programs, preferably in the health field. Relevant experience in a developing country required. Excellent analytical and writing skills required.
5. Health Management Specialist (AID Direct Hire HPN Officer): Relevant academic qualifications and extensive field experience in developing, implementing, and evaluating AID HPN programs and projects, preferably including sub-Saharan Africa. Excellent analytical and writing skills required.

ARTICLE V. Reports

1. The Evaluation Team will provide a full draft report (20 copies) and make an oral presentation (summary findings, conclusions, and recommendations) to GOS and USAID/Swaziland officials not later than 10 October 1988.
2. GOS and USAID will provide comments on the draft report to the team no later than 13 October 1988.
3. The Team Leader will remain in Swaziland for up to one additional week to incorporate any necessary changes to the draft report and submit a final report (20 copies) prior to his/her departure.
4. The format of the final report will be consistent with the AID Project Evaluation Summary format.

ARTICLE VI. Relationships and Responsibilities

1. The evaluation team will coordinate its work through the USAID/Swaziland Regional Health and Population Development Officer.
2. The Team Leader will have overall responsibility for conducting the evaluation and assuring that its objectives are met in accordance with the evaluation schedule provided in Article VII below, and as described more fully in Article III above.

ARTICLE VII. Terms of Performance

Beginning on or about 13 September 1988, the team leader will conduct site visits to the home offices of the Project Contractor, Management Sciences for Health, in Boston, Massachusetts and the Project Subcontractor, The Charles R. Drew University, in Silver Spring, Maryland. Work will commence in Swaziland on or about September 19, 1988 for the entire full-time evaluation team. All work is expected to be completed by 21 October 1988 with the submission of the final evaluation report.

ARTICLE VIII. Work Days Ordered

Note: A six-day work week is authorized in Swaziland.

1. Team Leader (Public Health Physician): 33 work days plus travel (including up to six work days to finalize the report).
2. Health Information/Financial Management Specialist: 23 work days plus travel.
3. Nurse/Midwife: 23 work days plus travel.
4. Health Training Specialist: 17 work days plus travel.
5. Health Management Specialist: [AID Direct Hire HPN Officer]

ARTICLE IX. Miscellaneous

1. Duty Post: Swaziland
2. Language: English
3. Access to classified information: None
4. Logistical support: USAID/Swaziland will make available all pertinent documents and files related to the Swaziland Primary Health Care Project. Limited office space will be provided for evaluation team use. The Contractor is expected to arrange for all secretarial and clerical assistance as well as transport for the evaluation team, as reflected in the Illustrative Budget (Attachment 2). USAID/Swaziland will assist in making appointments with GOS and other officials, and hotel and rental car reservations if requested.

APPENDIX B - LIST OF PERSONS CONTACTED

REGIONAL FIELD PERSONNEL SWAZILAND

Elizabeth Nxumalo	Siphofaneni Clinic
Elizabeth Mndzebele	Siphofaneni Clinic
Prisca S. Khumalo	Nursing Sister & MH FP Coordinator
Gcina R. Dlamini	Res. Health Inspector
A.D. Zwane	Senior Matron, G.S.H.
T. Nxumalo	Region Matron
E. Dhangwenya	S/N Sithobela
E. Nyoni	N/S Siteki P.H.U.
A.M. Mndzebele	Health Inspector, Sithobela
A. Hobbs	SMO, Good Shepherd Hospital
S. Motha	R.H.A., Lubombo
Philemon Dlamini	PH, Inspector, Lubuli
Moses Shongwe	S/H/A, Lubombo
Dudu P. Makhanya	Dwaleni Clinic
Agnes Dlamini	Zombondze Clinic
Precious Nkambule	Zombondze Clinic
Catherine N. Dube	Zombondze Clinic
Emminah Madonsela	Pharmacist
Assunato Simelane	School Health Nurse
Rachel Mavuso	Mental Health Nurse
Catherine N. Dube	Public Health Matron
Agatha Mgunwa	Hlatikulu Hospital
Pauline Mdiniso	Nursing Sister Nhlanguano Clinic
Virginia T. Tembe	Matron, Hlatikulu Hospital
Edmund Dlamini	Regional Health Administrator
Hazel Tembe	Assistant Nurse
Khanvisile Nkabindze	Staff Nurse
Dumisile Dlamini	Staff Nurse
Dudu Masilela	S/N Basic Management, Health Educ.
Happiness Maziya	N/Assistant
Thobile Madolo	S/N
Elizabeth D. Dhangwenya	S/N Basic Management, Health Educ.
Margaret Vilane	Assistant Nurse
Elizabeth T. Mndzebele	King Sobhuza II Health Centre
Prisca Khumalo	Family Planning Coordinator, King Sobhuza II Health Center
Mavis Khumalo	Family Planning
Vera Abler	Med. Surgery Nazarene Nursing College
C. Mkhonta	Regional Health Administrator, Shiselweni
E. Mdluli	Regional Health Administrator, Manzini
G. Matsebula	Regional PH Matron, Hhohho
T. Khumalo	Regional PH Matron, Lubombo
P.P. Mthembu	Senior Health Educator
L.L. Mtetwa	Senior Health Inspector
R. Maziya	Medical Technologist
Hilda Mdluli	EPI Coordinator
Thandie Mndzebele	CDD Coordinator
Elizabeth Mndzebele	PH Matron also coordinator for RFM

Sister Mary Magwaza	Clinic Supervisor
Sibongile Dladla	Nursing Assistant
Zandile Mathenjwa	Staff Nurse
Thandi Mango	Nursing Assistant
Thandi Nxumalo	Staff Nurse
Gladys Nhleko	Nursing Assistant
Sophie Matola	Staff Nurse
Nelly Vilakati	Staff Nurse
Ntombi Mndzebele	Nursing Sister
Fikile Gule	Nursing Sister
Mr. Dennis Khumalo	
Dr. Jack Hickel	
Mr. Alsen Kunene	
Constance Ngozo	Matron
Vena Dlamini	Sister
Joyce Vilakati	Sister
Mary Magagula	Sister
Hope Msibi	Sister
Alson Kunene	Hospital Administrator
Vena Mabuza	Nursing Sister

MINISTRY OF HEALTH/SWAZILAND

Trusty Masuku	Training Officer, MOH
Dr.Q. Dlaminkhubu	Chief Nursing Officer
Louisa B. Dlamini	Deputy CNO
Nester T. Shongwe	Principal Institute Health
Isabel T. Zwane	Tutor, Com. Health, Inst. Health Sciences
Bertha Vilakati	Nursing Tutor
Ephraim Hlophe	Under Secretary
Pitnera Mthembu	Senior Health Educator, Health Ed Center
C.S. Mkhonza	Principal Secretary
Dr. J.J. Mbambo	Director of Health SVS (Acting)
Dr. Qhing Qhing Dlamini	Deputy Director of Health
Ngwebendze Nhlalatsi	Senior Health Administrator
Paul Thompson	Financial Controller
C.V. Kunene	Principal Accountant
Dr. T. Shilubane	Medical Officer, PHU
T. Khumalo	Personnel Officer
T. Masuku	Training Officer
A.J.Dlamini	Senior PH Matron
Dr Frances Friedman	The Hon. Minister
Mr. Chris Mkhonza	Principal Secretary
Mr. Ephraim Hlophe	Under Secretary
Dr. M.P. Makhubu	Chief Nursing Officer
Dr. John Mbambo	Director of Health Services
Mr. Mduduzi Hlophe	Health Planner)
Mr. Ngwebendze Nhlalatsi	Senior Health Administrator
Mrs Abigail Dlamini	Sr. Public Health Matron
Mrs Nester Shongwe	Principal, IHS
Ms Kara Hanson	Sr. Assist., Hlth Plan.

Ms Gillian Holmes
Mr. Sipho Hlophe

Sr. Assist., Hlth Plan.
Principal Personnel Officer

Donor Agencies

Larry Brown
Faye Richardson

Technical Officer, CCCD Project
Nazarene Nursing College
Raleigh Fitkin Memorial
Hospital
Project Hope
Nazarene Nursing College
Raleigh Fitkin Memorial
Hospital

Tom Kenyon
Agatha Lowe

Nurse Educator, Project HOPE
WHO Representative
UNICEF

Arline Duvall
Dr. Q. Qhobela
R. Phillips
K. Dlamini
M. Mkhabela
A.W. Hoadley

FLAS
Red Cross
Rural Water Borne Disease Control
Project/RWSB
NGO Coordinator
IPPF
Save the Children Fund
Assistant Representative
Deputy Resident Representative Louisa

S. Dlamini
B. Pekeche
W. Msibi
Rodney Phillips
Bernard Hausner

USAID/SWAZILAND

Roger D. Carlson
Allan Foose
Mary Pat Selvaggio
Allan Reed
Columbus Spaine
Max Gonson

Mission Director, USAID/Swaziland
Regional Health & Population Officer,
USAID/Swaziland
Assistant Regional Health &
Population Officer, USAID/Swaziland
Program and Project Development
Officer, USAID/Swaziland
Deputy Controller, USAID/Swaziland
Financial Analyst, USAID/Swaziland

MSH/DREW TEAM/SWAZILAND

Al Neill
D. Kraushaar
J. McDermott
Dr. Margaret Price
Dr. Ned Wallace
Dr. R. LeBow
R. Connor
Dr. R. King
Ms. Mary Kroeger
Ray Maseko
Nosisa Mohammed

Admin., Management Sciences for
Health
Planner, Management Sciences for Health
MCH/PF, Management Sciences for Health
Clinic Mgr., Management Sciences for
Health
MCH, Management Sciences for Health
Senior Technical Officer, MSH
President, MSH
Drew University
Family Nurse Practitioner
Admin Assistant
Snr Program Assistant

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Midwife/childspacing Associate, PHU project
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by Mavis Nxumalo
PHC Project Evaluation
Primary Health Care Project approach during the first 90 days
and tasks for work plan development (Albert R. Neill) June
30, 1986
Implementation of Decentralization 90 day Day Programme:
July - September, 1986 - Musa Mdladla, Albert R. Neill
Quarterly Status Report No. 4 for Period 1 January - 31
March, 1987 (Charles R. Drew)
Quarterly Report - (Jeanne McDermott)
Clinic Management (A.R. Neill) October 8, 1987
Quarterly Status Report No. 3 for the Period 1 October - 31
December, 1986 (Charles R. Drew)
Quarterly Status Report No. 5 for the period 1 April - 30
June, 1987 (Charles R. Drew)
Revised life of project workplan December 1987 (R. Drew)

APPENDIX D

Table D-10. Preliminary Health Facility Data, 1983

Health Facility	Sector	Urban/ Rural	No. of Beds	Total Admissions	Average Stay (days)	Out- patients	
Hospitals							
Mbabane	Gov't	Urban	328 ^a	10,059	12.0	166,882	
Hlatikulu	Gov't	Rural	189	4,788		38,097	
Pigg's Peak	Gov't	Rural	66	2,761		38,002	
Mankayane	Gov't	Rural	43	1,848	7.7	27,327	
RFM	Mission	Urban	300 ^a	10,527 ^b	5.6	51,830	
Good Shepherd	Mission	Rural	120	4,315		22,465	
Havelock	Industry	Rural	68	1,606	10.4	6,202	
Specialty Hospitals							
Tuberculosis	Gov't	Urban	120				
Mental	Gov't	Urban	200				
Health Centers							
Nhlangano	Gov't	Rural	17	3,002	3.0	30,205	
Sithobela	Gov't	Rural	16	456	2.9	9,787	
Ngonini	Gov't	Rural	-	-	-	-	
Ekhuzweni	Mission	Rural	27	1,523	5.4	11,500	
Mbabane Clinic	Private	Urban	25	1,412	3.7	4,490	
Tshaneni	Industry	Rural	20	-	-	-	
Uombo Ranches	Industry	Rural	31 ^a	1,751	3.5	72,862	
Rocklands	Industry	Rural	14	-	-	-	
Bhunya Hill	Industry	Rural	12	-	-	-	
Simunye	Industry	Rural	8	502	2.1	62,498	
Health Facility	Sector	Rural/ Urban	Out- patients	ANC	CW		
Public Health Units							
Mbabane	Gov't	Urban	1,618	10,191	6,343		
Pigg's Peak	Gov't	Rural	-	2,606	3,071		
Hlatikulu	Gov't	Rural	1,114	4,666	3,798		
Mankayane	Gov't	Rural	-	2,188	4,380		
KS II	Gov't	Urban	1,180	5,709	7,465		
Good Shepherd ^c	Mission	Rural	1,923	3,321	12,383		
Health Facility	Sector	Rural/ Urban	Outpatient Visits	ANC	CW	Number	Number Reporting
Clinics							
	Gov't	Urban	-	-	-	0	-
	Gov't	Rural	378,367	37,709	84,564	35	33
	Mission	Urban	-	-	-	1	0
	Mission	Rural	184,323	18,834	35,742	27	26
	Private	Urban	9,143	252	1,409	15	1
	Private	Rural	14,560	1,303	3,407	23	4
	Industry	-	119,564	2,758	3,813	17	7
	Other	Urban	-	-	-	2	2
	Other	Rural	-	-	-	3	0

^aIncludes bassinets.^bIncludes boarders.^cIncludes outreach.

Source: Health Planning Unit.

SWAZILAND PRIMARY HEALTH CARE PROJECT

memorandum . . .

Mbabane
4 October 1988

To: Evaluation Team
From: Al Neill

PROJECT DELIVERABLES¹

<u>Deliverable</u>	<u>Reference²</u>
<u>TECHNICAL</u>	
1. Antenatal Card and Protocols	4/4
2. 1987 SEPI (Swaziland Expanded Programme for Immunization) Plan of Action - Staff Development and Training, March 1987	4/5
3. Expanded Programme for Immunization, Instruction Manual for Refrigerators, July 1987	5/5
4. Director's Guide, Diarrhea Training Unit, Draft, June 1987	5/6
5. Proposed Actions for Childspacing for 1987-88, 21 April 1987	5/7
6. Report of Field Visits to Health Facilities in Hhohho Region (focus on Family Planning and Post-natal Care), 25-27 May and 8 June 1987	5/9
7. Immunization Statistics Packet, including national targets, coverage for the years 1983-86, monitoring forms for clinics, and histograms for national coverage and individual clinics	5/15
8. Report of the Proceedings of the National Maternal and Perinatal Mortality Meeting of Swaziland, 2 September 1987	6/3
9. Training Manuals for Steam Sterilization and RCW Refrigerators	6/4

¹Deliverables as referenced in the Quarterly Reports, excluding training workshops and administration.

²Refers to reference numbers contained in Quarterly Reports, i.e. Quarterly Report No./Reference for the given quarter).

10.	Assessment of Laboratory Services, August 1987	6/7
11.	A Proposal for Evaluating the Impact of Health Education, September 1987	6/10
12.	Draft EPI Manual	7/5
13.	Measles Outbreak Documentation	7/6
14.	Draft ORT Manual	7/7
15.	Report of Regional Field Visits for the distribution of FP Protocols, October 30 1988	7/8
16.	A Report of the Current State of Medical Laboratory Equipment used by the Swaziland Government in its Medical Laboratories, Med-Mer, Swaziland	7/10
17.	Health Education Consultancy Report, Mary Ashley	8/3
18.	Breastfeeding Practices Survey Report (SINAN)	8/6
19.	Equipment List for National and Regional Diarrhea Treatment Centres	8/7
20.	Research on Home Mixed SSS and One Year Review of Diarrhea Treatment Centre	8/8
21.	Clinic Reference Manual	8/11
22.	Final Report submitted by Jeanne McDermott, Nurse Midwife/Childspacing Associate, 30 May 1988	9/1
23.	Report on Maternal and Perinatal Mortality, based on two meetings - 2 September 1987 and 2 March 1988	9/2
24.	Insert for ANC Card	9/3
25.	Report on Syphilis Seroactivity of Pregnant Women in Swaziland, 1986	9/4
26.	Guidelines for Operation of ORT Corners in Clinics	9/5
27.	Family Planning KAP among Women of Childbearing Age in a Peri-urban Area of Swaziland, May 23 1988	9/6
28.	ARI Guidelines, drafted for use in workshops	9/7
29.	Study Tour to Zimbabwe for Laboratory Personnel to Investigate Blood Banking Programme	9/9
30.	Clinic Laboratory Management Information Systems Manual, 1st. Edition, Richard Haynes, April 1988	9/10
31.	Procurement Lists for Clinic Equipment	9/12

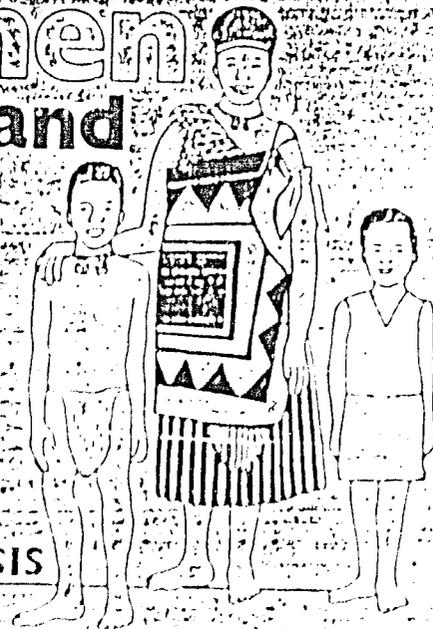
MANAGEMENT

1. Memo - Implementation of Decentralization - 90 day Programme, 30 June 1986 1/5
2. Health Planning Consultancy, Lucy Gilson, 25 August - 13 September 1986 2/5
3. Clinic Management Programme (formulated in one-day conference with health providers), 15 Oct 88 3/3
4. Manpower Planning Consultancy, David R. Alt, 25 October - 5 December, 1986 3/4
5. Personnel Management Consultancy, David R. Alt, 4-24 October, 1986 3/6
6. Referral Forms and Procedures for Trial Application in the Manzini Region, March 1987 4/6
7. Operations Research Study on Drugs Supplies Management, Hhohho-North Sub-Region, February 1987 4/7
8. Community Health Nursing Standards, Draft, March 87 4/8
9. "Your Regional Health Management Team, Hhohho Region, A Brief Explanation of Decentralization, Your Role, and the Role of the RHMT," March 1987 4/9
10. Health Manpower Requirements - FY 1988-89 to FY 1992-93 (Five Year Manpower Plan), and Manpower Planning Consultancy Report, David R. Alt. 15 Jan-2 March 1987 4/10
11. Research Study, Transport Management, Hhohho-North Sub-Region, 2 July 1987 5/11
12. Draft Specifications for Studies of Mbabane Government Hospital: (1) Patient Length-of-Stay, (2) Out-patient Services, 14 May 1987 5/12
13. Regional Personnel Management Policies and Procedures Manual, April 1987 5/13
14. Personnel Management Consultancy, David R. Alt, 3 March - 13 April 1987 5/14
15. Handing-Over-Notes, M. Joseph Bastian, Health Planning and Budgeting Associate, 5 October 1987 6/2
16. Supervisory Checklist for Clinics 6/11
17. Kenya Study Tour Report for the Training of Rural Health Motivators and Community Based Programmes, 7-19 November 1987 7/9
18. Government and Mission Clinics in Swaziland: A Summary of Clinics' Utilization, 1983-86, Social Science Research Unit, UNISWA, March 1988 7/12

19. Requisition Forms for Drug Management	7/13
20. Field Training for RHM Tutors and Regional Health Matrons, Kisumu, Kenya	8/9
21. Clinic Orientation Manual	8/12
22. RHMT Team Building Consultancy Services (EDA)	8/13
23. Regional Personnel References: (1) Regional Personnel Manual, (2) General Orders, GOS. (3) Job Descriptions, MOH, (4) binder with personnel management references (Employment Act, Pensions Act, etc.), (5) MOH Five Year Manpower Plan	8/14
24. Report of Field Visit to Botswana to study the Health Information System	8/16
25. Review of Swaziland Health Information System	8/17
26. Review of MOH Computerized Manpower Information System, David R. Alt, May 1988. Regional Personnel Management Consultancy, Parts I and II, David R. Alt, 22 April - 23 July 1988	9/14
27. Memo from Undersecretary - Coordination of Work shops	9/15
28. Revised Regional Budgeting Manual	9/16
29. Hhohho Region Plan for Health Information System	9/19
30. Review of Malawi Health Information System	9/20

REVIEW DRAFT

Children & Women in Swaziland



A SITUATION ANALYSIS

GOVERNMENT OF THE KINGDOM OF SWAZILAND
UNICEF UNITED NATIONS CHILDREN'S FUND

1987



EXECUTIVE SUMMARY

The analysis of the situation of children and women in Swaziland highlighted six points of central importance for UNICEF programming:

- o The poor health status of children under five and the extremely high mortality rates in early infancy.
- o The importance of tradition in Swazi society and the need for greater recognition of and more sensitive attention to traditional beliefs and practices in the development and implementation of health education activities.
- o The significant fact that infant and child mortality could be reduced appreciably by changes in a limited number of health care practices and the likelihood that education, promotion and social mobilization could alter these behaviours.
- o The need for more research on the situation of women and implications for child welfare: particularly the effects of women's health status, tasks and time, information and skills, and access to resources on child care practices.
- o The existence of "at risk" groups who require special consideration in programme planning and implementation: particularly rural homesteads with limited or no access to off-farm income, health care facilities or potable water and households living in substandard urban squatter settlements.
- o The decline in living standards and an increase in the child population at risk as a consequence of rapid population growth and Swaziland's economic and political vulnerability.

Health conditions in Swaziland are poor and well below those of other countries with similar levels of socio-economic development. The infant mortality rate (110/1000) is higher than would be expected for a compact country with a relatively high per capita GNP (\$870 in 1983), reasonable communications and access to health services (80 percent within 5 kilometers) and high per capita expenditure on health services.

Early infant mortality is disproportionately high with nearly 50 percent of infant deaths occurring before the age of two months and nearly 70 percent of all under five deaths occurring before six months.

Available data, largely hospital based, draw attention to four major causes of infant mortality: perinatal conditions (29 percent), malnutrition (11 percent), diarrhoea (23 percent) and acute respiratory infections (15 percent). For children aged one to five malnutrition is responsible for approximately 40 percent and diarrhoea for 15 percent of deaths. The morbidity data reflect a similar pattern with diarrhoea, malnutrition and acute respiratory infections being the major causes of poor child health and growth.

Reflecting the significant increase in immunisation coverage since 1980 infant mortality attributable to immunisable diseases is low (3 percent), but child morbidity from these diseases remains relatively high (13 percent of hospital outpatients, 1983-84).

Malnutrition is widespread with 30 percent of under-fives nutritionally stunted and, although the prevalence of acute malnutrition is low (1 percent), it is associated with extremely high case fatality rates.

A large proportion of infant and young child mortality and morbidity appears to be avoidable. The major factor underlying poor chances of child survival is the early and widespread introduction of breastmilk substitutes which predisposes young infants to constant infections and the onset of a debilitating infection (especially diarrhoeal-malnutrition cycle).

Inappropriate practices related to breastfeeding are widespread in Swaziland. Exclusive breastfeeding for more than six weeks is uncommon, even in rural areas. Thus, with the early introduction of non-breast milk and solids young infants are exposed to infections and undernutrition. An indicator of the severity of this problem is that 50 percent of infant hospital deaths attributable to diarrhoea and malnutrition occur among infants less than four months of age. These data underline the importance of the promotion of exclusive breastfeeding and improved young child feeding practices as an essential component of Swaziland's child survival strategy.

Other child care practices contribute to the cycle of infection and malnutrition and infection. They include: use of high-bulk low energy weaning foods; inadequate childhood diets; low utilization of modern health services even when the child's condition is severe (the "too little too late" syndrome); persistence of hazardous traditional practices such as "vaccinations", smoke inhalations and enemas for diarrhoea; and the failure to use adequate hygiene and sanitation. Other factors placing survival at risk and stretching existing childbirth resources are the high fertility rate of Swazi women, early pregnancies, inadequate antenatal care (especially tetanus toxoid immunisation) and the high prevalence of STDs.

Experience over the past five years, however, has demonstrated the impact of well designed and executed community education programmes in promoting beneficial child health care practices. For example, immunisation coverage increased from 14 percent to 60 percent over the 1982 - 1986 period; 60 percent of childminders learned and now use oral rehydration therapy; a significant proportion of traditional healers reportedly modified hazardous health practices such as the giving of purges and enemas to children with diarrhoea; over 70 percent of pregnant women make at least a first attendance at antenatal clinics; and the proportion of infants regularly attending growth monitoring sessions increased from 25 percent to 40 percent between 1983 and 1987.

This experience points to the potential of education, promotion and social mobilization in bringing about improved practices and health status. However, a number of lessons have been learned. For example, insufficient attention has been paid to the importance of older women and grandmothers ("gogos") as child caretakers and as major influences on mothers' behaviour and decisionmaking regarding child care. The consequences of leaving the young, and inexperienced, to care for the very young has been ignored. Inadequate attention has been given to understanding traditional practices and ways in which linkages between the traditional and modern health sectors could be forged to improve health communications and service delivery. And further, the full potential for education and social mobilization of chiefs, community leaders, churches, youth and social organizations is yet to be fully exploited in a comprehensive and integrated manner.

Although the direction is clear, the specifics are not. Effective programming requires an intimacy of detailed knowledge and a clarity of proven relationships which are not currently available. Community based information concerning young child mortality and morbidity is lacking. So too is an up-to-date picture of the dynamics of the rural homestead, especially regarding income, food and poverty. Given the rapid urbanization of the Swazi nation, there is need for a similar portrait of the urban and peri-urban household. However, perhaps the most urgent of all is a better understanding of women, mothering and child care practices - particularly the implications of women's health, tasks and time, information and skills, and access to resources for child care.

In other countries in the region, poor child nutrition and health largely reflect inadequate access to incomes and inadequate household food security. There is little evidence that these are the major determinants of the poor health and foreshortened lives of Swazi children. The rural Swazi homestead is characterized by its diversity of income sources, dependence on off-farm wage employment (mainly involving males), and relatively limited levels of food production for home consumption. Overall household food security is

indicated by the relatively low proportion of cash income spent on food, no significant evidence of adult undernutrition and the experience of the Rural Area Development Programme which resulted in increased productivity, rather than increased production in order to release male labour for off-farm employment.

This is not to say that inadequate resource utilization rather than absolute deprivation is a universal phenomenon. Indeed, there are a significant number of high risk groups. Despite dated information it is understood that approximately 30 percent of Swazis are living below the poverty datum line, 30 percent have inadequate access to health services, 76 percent drink unpotable water, 10 percent live in squalid urban conditions and 20 percent have no access to off-farm income sources. Geographically, many of these characteristics are displayed by households in the southern Lowveld areas of the country renowned for its poor communications, lack of social services and an unfavourable agricultural climate.

Growing vulnerability of household incomes and food security is also indicated by the country's deteriorating economic and political conditions. Following a period of rapid economic growth until the early 1980s, Swaziland has experienced a downturn in economic fortunes. Recent years have evidenced low to negative rates of economic growth, high inflation (14 percent pa.), a dramatic depreciation in the value of the Lilaneni (52 percent), a decline in export earnings, an increasing debt burden, stagnation in government revenues and a burgeoning unemployment problem fuelled by rapid population growth. Underlying these economic difficulties are a number of structural weaknesses related to Swaziland's dependence on South Africa, foreign markets and investment, sugar earnings and the continuing economic and political uncertainty as to the future of the southern Africa region.

MINISTRY OF HEALTH SECTORAL DEVELOPMENT PROGRAMME

1989/90 - 1991/92

INTRODUCTION

The Ministry of Health is committed to the World Health Organization goal of achieving HEALTH FOR ALL BY THE YEAR 2000.

The Ministry's principal objective, as stated in the National Health Policy Document 1983, is:-

"to improve the health status of the Swazi people by providing preventive, promotive, rehabilitative, and curative health services which are relevant and accessible to all."

In line with its goal and objective, the Ministry of Health will continue to strive to reorientate health care delivery in Swaziland away from its predominantly urban/curative base towards greater preventive and promotive health care activities in the rural areas.

Despite heavy investment in the curative infrastructure during the last twenty years, the general health status of the Swazi people remains poor - especially when correlated with other widely accepted measures of development such as GNP per capita. The infant mortality rate at over 110 per 1000 live births is one of the highest in the southern African region, and it is estimated that one in five Swazi children die before reaching their fifth birthday. The vast majority of these deaths are caused by poor nutrition, diarrhoea, respiratory infections and communicable diseases - all of which can be prevented through health education, immunisation and simple interventions such as oral rehydration therapy.

Vital community based programmes which directly target infant, young child, and maternal mortality and morbidity in underserved rural areas will consequently receive high priority during the next plan cycle. Primary health care, focusing on preventive, promotive and early curative interventions at clinic level, is accepted as the most efficient and cost-effective means of improving the health status of the population.

Many of the key primary health care programmes such as the Expanded Programme on Immunisation, Control of Diarrhoeal Diseases, Acute Respiratory Infections, Maternal Health including Family Planning, and Manpower Development currently receive substantial recurrent financial and technical assistance from donor agencies such as UNICEF, World Health Organization, UNFPA, Save the Children, USAID and International Planned Parenthood Federation.

The Ministry of Health's commitment to primary health care is reflected in its prioritization of infrastructure projects submitted for inclusion in the Three Year Capital Rolling Plan (1989/90 - 1991/92). These projects such as Rural Clinics Federation, Staff Housing at Rural Clinics, and Water and Sanitation, which strengthen the operational base from which preventive and promotive primary health care services are delivered, are seen as key components of the Ministry's capital programme.

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PLAN PRIORITIES

Whilst it is recognised that the vast majority of Swaziland's health problems are rooted in limited resources and uneven distribution of wealth and income, which lie outside the domain of the Ministry of Health, the Ministry will nevertheless continue its efforts to improve access to health services and promote healthier behaviour amongst the population. Long components of the Ministry of Health's policy over the next three years are as follows :-

-Commitment to a Primary Health Care Strategy as the least costly and most effective means of promoting good health and preventing disease.

-Equitable geographic, financial and cultural access to all health services.

-Health education and community mobilisation to encourage individuals and communities to take interdependent responsibility for their own health needs.

-Implementation of a Health Manpower and Training Plan, prioritising investment in the human capital of nurses, nursing assistants and rural health motivators.

-Gradual localisation of senior managerial posts and intensive recruitment and training of national medical officers.

-Improved coordination of non-governmental and donor health inputs and greater inter-sectoral collaboration with other government ministries.

-Decentralisation of health service management and programme planning to grass roots level.

PREVENTIVE AND PROMOTIVE SERVICES

Preventive and promotive health interventions are designed to prevent diseases and illnesses before they develop, reducing the need for, and cost of, curative services. The strategy is usually two fold :-

1) promotion of healthy behaviour and attitudinal change in individuals through health education and community mobilisation, and

2) active case detection and preventive interventions through immunisation and early treatment of debilitating illnesses.

Grass roots community involvement, acknowledging the right of every individual to input into decisions affecting his/her health status, is the only acceptable strategy for achieving this.

"HEALTH FOR ALL BY THE YEAR 2000".

The main preventive and promotive health programmes are:

- Water and sanitation
- Expanded programs on immunisation
- Growth monitoring and promotion
- Control of diarrhoeal diseases
- Adult respiratory infections
- Maternal health and family planning
- Communicable Disease Control
- AIDS
- Health Education

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The recurrent costs of these programmes are financed primarily through donor agencies, but the Ministry of Health is committed to increasing its share of the recurrent budget devoted to preventive activities by 1% per annum. Over the medium-term the Ministry of Health intends to take over the entire recurrent cost financing of these preventive programmes, to accommodate gradual withdrawal of support from donors.

Although many of these programmes require minimal capital investment, the Ministry consistently prioritises all projects designed to strengthen the primary health care infrastructure. In this context, the distinction between investing in curative as opposed to preventive medicine becomes blurred, especially as most preventive activities are conducted from rural clinics, which are classified as curative facilities.

Water and Sanitation

Diseases caused by unsafe water and inadequate environmental sanitation are leading causes of morbidity and mortality in Swaziland. Only c.30% of the rural population have access to potable water, and less than one third own and use a pit latrine.

Over the next three years, the health inspectorate, in close collaboration with the Rural Water Supply Board, aims:-

- to motivate communities to construct 2000 pit latrines and protect 10 springs per annum.
- to raise the level of community knowledge about the health hazards of unclean water and poor sanitation.

This project will henceforth be largely funded by Government due to the completion of the USAID-sponsored Rural Waterborne Disease Control Project.

Expanded Programme on Immunisation

Government policy on immunisation has recently been revised and updated in "The Swaziland Expanded Programme on Immunisation (EPI) Three year Implementation Plan."

Some of the key objectives of the programme for 1992 are:-

- To reduce measles morbidity to less than 1500 per annum.
- To reduce pertussis morbidity to less than 150 cases p.a.
- To reduce T.B. in children under five by 50%.
- To reduce polio morbidity to less than 5 cases per year.
- To maintain diphtheria morbidity at zero cases per year.
- To reduce neonatal tetanus by 50%.

Promotion of Young Child Feeding and Growth Monitoring

The broad goal of the nutrition/growth monitoring programme is to reduce the prevalence of chronic malnutrition and stunting in children under five years, and to promote breastfeeding and improved young child feeding practices.

Specific targets for 1992 include:-

- Increasing the proportion of infants attending growth monitoring sessions on a regular monthly basis from 41% to 80%.
- Increasing the proportion of mothers exclusively breastfeeding up to the age of four months from 8% to 50%.
- Achieving a 50% adoption rate among mothers of improved child feeding practices, especially after diarrhoeal and respiratory infections, as developed and disseminated by the Project for Promotion of Improved Young Child Feeding.

Control of Diarrhoeal Diseases

The main cause of morbidity and mortality in children under five years is the malnutrition-diarrhoea-respiratory infection complex. The Control of Diarrhoeal Diseases Programme aims to reduce the number of infants dying unnecessarily through diarrhoeal dehydration by:-

- Increasing access to oral rehydration therapy for children under five years to 90% by 1992.

- Establishing ART, DCC, training and treatment units in all regional hospitals.
- Encouraging exclusive breastfeeding and improved care of diarrhoea.

Acute Respiratory Infections

Respiratory tract infections are one of the most common causes of outpatient attendance at clinics for infants and young children. It is estimated that acute respiratory infections contribute to half-year underweight and growth retardation of infants living in Swaziland. Upper respiratory infections caused by poor ventilation in households, overcrowding and poor ventilation tend to precede bacterial-induced lower respiratory tract infections such as pneumonia which are major child killers.

Between 1989 and 1992, the Ministry of Health aims to reduce mortality and morbidity due to ARIs in children under five years by 40% by:-

- Training 5% of health care workers in the appropriate management of ARIs.
- Distributing essential equipment equivalent to 5% of rural health facilities.
- Providing equipment and supplies to treat ARIs to all clinics and outpatient departments.

Maternal Health and Family Planning

Swaziland's unacceptably high rate of maternal mortality and morbidity is correlated with a high incidence of anaemia and high risk pregnancies. These are attributed to factors such as low education and contraceptive needs of women, inadequate use of pregnancy warning signs, poor, outdated health education materials, lack of community mobilisation, and low contraceptive coverage and underutilisation of existing services.

The Ministry of Health aims to improve the health status of women over the next five years by slowly changing old traditions and cultural barriers of access to maternal health and family planning services. Specifically, the Ministry seeks to:-

- Increase to 80% the number of pregnant women receiving education and some financial ante-natal care.
- Increase to 70% the number of women attended by trained attendants.
- Increase professional care to 50% of women delivering at a delivery.
- Increase to 20% the number of women aged 15-19 who are using safe means of contraceptive techniques.

Rural Health Motivators

Rural health motivators are complex phenomena, related to socio-economic and cultural factors. The Ministry of Health is currently conducting a study to determine the various factors which influence rural health behaviour. Health education and extension programmes will be developed to address these factors and to improve rural health services. The study will also determine the various factors which influence rural health behaviour and to determine the various factors which influence rural health behaviour.

The Ministry of Health aims to improve rural health services by:-

- Training 10% of health workers in the management of rural health services.
- Distributing essential equipment equivalent to 5% of rural health facilities.
- Providing equipment and supplies to treat rural health services.
- Training 10% of health workers in the management of rural health services.
- Distributing essential equipment equivalent to 5% of rural health facilities.
- Providing equipment and supplies to treat rural health services.

Best Available Document

Mental health care services will be further strengthened through:

7) Construction of a 24 bed Mental care sub unit in Shiselweni on the Nhlangoeni Health Centre site to complete the decentralisation of the Mental Health Care System.

Rural Clinic Services

Rural clinics form the backbone of the primary health infrastructure. They are the static base from which all PHC programmes operate and provide first line curative and emergency interventions to the rural population.

Over the past decade, clinic buildings have been allowed to decline into an appalling state of disrepair. Over 50% of clinics currently lack basic facilities such as potable water, sanitation, electricity, communications, burglar proofing, security, fencing, waiting areas for patients, staff housing, furniture and equipment. The result of this cumulative deterioration is a virtual breakdown in the efficiency of primary health care delivery in the rural areas.

In an attempt to address this problem, the Ministry of Health is proposing a major programme of clinic renovation over the next three years, covering Mission as well as Government clinics. The emphasis will be primarily on renovating existing clinics, with new construction confined to extreme hardship areas where Government commitment has already been given, or through community based/ donor supported initiatives. Recent policy has advocated piloting outreach clinics in communities requesting a clinic to ensure that the facility is appropriately located before full scale investment is incurred.

Between 1988/89 and 1991/2 the Ministry of Health will consequently be seeking to:

1) Renovate 217 rural clinics with the assistance of the Rural Clinics Maintenance Unit based in the Ministry of Works and Communications.

2) Construct 17 staff houses at clinics for nursing staff who are currently forced to share rooms or sleep on clinic floors.

3) Construct a new clinic at Mhono, which by objective health criteria is one of the most deprived communities in Swaziland.

4) Construct a clinic and additional staff housing at Mbuluzi in support of the grant made by the Canadian High Commission.

5) Construct a replacement clinic at Mbuluzi.

6) Repair generators and install new generators in clinics lacking a viable electrical supply.

7) Encourage communities to use donor support and raise their own funds to construct clinics in their areas to relieve the financial burden on Government.

HEALTH SUPPORT SERVICES

Over the next three years the Ministry of Health aims to improve the delivery of vital health support services which facilitate curative and preventive interventions at all levels.

Best Available Document

Laboratory Services

One of the most important components of the Ministry of Health capital project inventory for inclusion in the Three Year Rolling Plan is the project to rehabilitate and extend the Central Public Health Laboratories. Refurbishment of the building which currently houses the bilharzia, malaria control, and T.S. Centre, and construction of a purpose built laboratory (blood bank complex) should enable the separate units to once again carry out their designated function effectively.

Advanced diagnostic equipment will be installed in the new laboratories to facilitate faster detection and containment of communicable diseases of public health concern, especially AIDS.

Drugs and Medical Supplies Services

During the next three years, the Ministry of Health hopes to speed up the procurement and distribution of essential drugs, vaccines and medical supplies by constructing drug stores in each of the four administrative regions. The satellite depots will ease the logistical problems of the current overly centralised system by cutting down on overstocking at Central Medical Stores and reducing transportation costs and unnecessary drug expiry at peripheral clinics.

Health Administration

The Ministry hopes to improve community participation in health service delivery by strengthening the decision making and implementative capacity of community health committees and the Regional Health Management Teams. A framework of clearer policy, guidance and tighter programme coordination within which to base these decisions will ensure a more optimal distribution of appropriate health services, especially in the rural areas.

The Ministry will also strive to improve the coordination of donor and non-governmental financial and technical assistance, and initiate opportunities for greater cooperation between the modern and traditional health sectors. In this manner, the relevance and integration of services will be improved.

Communicable Disease Control

The Communicable Disease Control Programme's goal is to control malaria, bilharzia and T.B. and reduce mortality and morbidity associated with these diseases.

The Malaria unit's principal objective is:-

- To reduce mortality and morbidity from malaria by vector control, residual spraying of homesteads, active case detection, presumptive treatment of all individuals with fever with chloroquine and continuous monitoring of anti-malarial drug efficacy through regular in-vivo testing.
- Ministry of Health policy now advocates the phasing out of chemoprophylaxis on farm estates except for pregnant women and high risk cases in malaria endemic areas.

The Bilharzia unit's principal objective is:-

- To reduce the prevalence of urinary schistosomiasis among school children and adults in the middleveld and Lubombo plateau through health education, tighter screening and snail control. Schistosomiasis injections will be phased out over the next three years due to their inefficacy.

The T.B. unit's principal objective is:-

- To reduce morbidity and mortality from T.B. by upgrading sputum examination facilities at hospital laboratories, introducing a more effective chemotherapeutic regime for smear positive patients, and strengthening community-based treatment and monitoring programmes.

All three units will be rehoused in the upgraded Central Public Health Laboratory Complex in offices and laboratories more conducive to their work.

AIDS Prevention and Control

Acquired Immune Deficiency Syndrome (AIDS) is caused by a virus known as Human Immunodeficiency Virus (HIV), which attacks the body's natural defence system. There is at present no vaccine or cure for those people who are already infected by the AIDS virus.

The Ministry of Health's objective is to prevent and control the spread of HIV infection and AIDS in Swaziland, primarily, through health education.

Over the next year, training will be conducted for all cadres of health workers, including traditional healers, as well as community leaders and special risk groups. AIDS prevention and control will be managed within the context of a comprehensive national Sexually Transmitted Infections (STI) Programme, promoting safer sex attitudes and practices in the community.

By 1992, the Ministry will have developed adequate clinical capabilities in the national health service to facilitate early detection, diagnosis, prompt management, and appropriate counselling of persons with HIV infection and AIDS.

The Ministry of Health will continue to work closely with the World Health Organisation to the development of clinical aspects of AIDS.

Health Education

The goal of the Health Education Programme is to attain a level of educational and general knowledge amongst the Swazi people which is potentially prevent and reduce the incidence of major public health problems, especially those related to maternal and child health, water and sanitation, communicable diseases and nutritional deficiencies.

Over the next three years, health educators will continue to support all preventive and promotive programmes by :-

- developing effective and acceptable mass media messages,
- promoting community involvement in the planning, development and utilisation of primary health care facilities by encouraging chiefs and other community members to form community health committees.

CURATIVE SERVICES

As mentioned above, the division between curative and preventive services is often blurred because timely curative interventions with low-tech medicines such as oral rehydration therapy effectively prevent young children with diarrhoea from becoming susceptible to respiratory infections and more acute forms of malnutrition. Moreover most preventive services are delivered from hospital outpatient departments and rural clinics, which are classified as curative facilities.

Nevertheless, the Ministry of Health is committed to providing a comprehensive range of inpatient services at curative facilities to minimise the debilitating effects of illnesses after they occur.

Hospital Services

Hospitals act as referral centres for clinics and tertiary rural health centres, and provide technical and clinical support for all outlying health units.

Over the next three years, the Ministry of Health intends to ease the workload on the National Referral Hospital at Mbabane and improve the distribution of inpatient beds and medical personnel by :-

- 1) Rehabilitating and extending Mzimba Hospital with the aid of a DME million loan from the West German Government.
- 2) Rehabilitating and extending Mankoyane Hospital.
- 3) Constructing a small operating theatre and maternity ward at Simons's Health Centre.
- 4) Completing construction of the 12 bed health centre at Mchanganeni, which started in 1982 with an investment of a.m.
- 5) Rehabilitating and extending King Sobhuza II Health Centre.

Special attention will be paid to improving staff coordination between the government and division sectors. Over the next five years, integration has been strengthened through the introduction of a common job structure, a common salary scale, a system for training and a common internal promotion system. Further internal and working arrangements of decentralisation, staff transfers, return of the health authorities and Government policy will be decided by the Ministry of Health in consultation with the relevant sectors. The Ministry of Health will also be involved in the development of a health care system.

- 6) Rehabilitating and extending King Sobhuza II Health Centre with the support of the World Bank in the underdeveloped level.

CLINIC REPORT - JULY , 1988

APPENDIX B

DATE	CLINIC VISITED	SIGNIFICANT ACHIEVEMENT OR CHANGES	AREA OF WEAKNESS OR PROBLEMS	WHAT IS BEING DONE	MEETING WITH STAFF OR COMMUNITY	WHAT IS REQUIRED	OTHER COMMENTS
	MANGWENI	<p>The health services are well done and records are proper done except the clinic schedule.</p> <p>Attendance is very good - on Mondays they see about 60-80 patient CWF figures has risen due to food suppliments-in June 163 - July 489 Nurses have problems with RHMs they don't go to the clinic to assist as per the clinic schedule. Very few goes there for gardening only.</p> <p>Malaria still a problem in June they treated 20 cases</p>	<p>Cleanliness of the clinic equipments and proper care of government property should be reinforced Clinic surrounding are untidy.</p>	<p>Staff Nurse arranged sewing classes for those interested they are about 10-15 and they pay E25.00 tuition fee per month.</p> <p>They have a good garden and the Health community bought seeds, manure and insecticide for spraying.</p>	<p>One nurse attends the health committee meetings monthly.</p>	<p>They need to dig a rubbish pit to bury all the dirt used vials, disposable syringes + needles pit latrines needs maintenance, some has no doors and some has no toilet sits.</p> <p>S/N expressed a need for a N/A in order to utilize all the clinic services effectively.</p> <p>Still no furniture for the new nurses houses. - Replacement of the doors which were spoiled by ants.</p>	<p>No way of sending UDRL specimen to the lab. We have tried to ask Mkhuzweni H.C for assistance only to find that the nation of the HC was away & sister incharge was busy in the theatre on the day of our visit</p>

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	MANGWENI (CONTINUED)	+ July 42 Fortunately there is a Health Assistant stationed there who take slides from suspect.					
	NTFONJENI	Had problems in keeping records but showing signs of improvement after the visit by MCH FP Coordinator and FP Storeman through invitation by us.		Drains have been fixed. Nurses told us that the Health committee is busy collecting money so that they can build a maternity section.	Health committee is not functioning well. We have tried several times to attend their meetings but failed because it was not conducted at the scheduled time.	Still require proper maintenance of the Ind nurses house which is still unoccupied. FWD have seen the building. It also needs furniture N/A is needed to make their work load lighter. A telephone is also needed.	

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	HEREFORDS	<p>The standard of Health Education has gone very high. We were invited to attend the H.E. competition on the 30/8 whereby four groups of participants (mother) displayed their knowledge which they have acquired through H.E. We were very much impressed about their knowledge through the role plays and Health messages given.</p> <p>The Chairman of the Health Committee and the participants requested the RHMT members to please come and watch the same competition when ever possible and they would very much love to have their speeches broadcasted through SBS or STBC so that other clinics may do the same.</p>	<p>The records are not up to date. There is a relief nurse at the moment and she was shown how to keep records</p>	<p>There is a close relationship between the RHMs Community Health Committee and clinic staff with full support from Ebuhleni Royal residence. They accumulated E1,500 in order to have clean water supply in their area and E6,000.00 was donated by donor urgencies. The chairman of the CHC gladly reported that they have started using clean water from the taps as from the 29th August,88.</p>	<p>A very good relationship between health committee and clinic staff also good relationship with RHMs.</p>	<p>They need fence, and treated poles in order to start a garden They need accommodation for the groundsman see plan They need additional S/N because the Health committee occasionally goes around the homestead with the present S/N to see if toilets gabbage pits are dug.</p> <p>They need an extention cord for the new electric Hoover machine.</p>	<p>Health committee bought an electric Hoover worth E216.00 for the clini</p>

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	BULANDZENI	Health services are done well clinic schedule done monthly community Health Committee helped a lot during the clinic burglary which occurred on the 23.06.88.	Needs to improve in taking work as a priority not social business.	The health committee meets regularly once a month to discuss on matters concerning the clinic like building a maternity wing, installing a telephone.	Clinic staff meets with community health committee every month.	They need burglar proofs on store room door and to the window to prevent burglars.	
	PEAK NAZARENE	Good co-operation with the staff special care given to underweights and malnourished children although records are not properly kept. Patients attendance improving. O.P.D. cases were 360 in June and 787 in July still very few client for F.P.	Drugs stock management needs improvement CHW has greatly improved in June they were 127 and in July 182.	Intergration of services is good	Meetings with staff are done but not with the community	Formation of a Health Committee Improvement of water supply (RFMH is aware of this) Staff houses are needed. Also inside toilets since this is an Urban area.	