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MINISTRY OF HEALTH  
SWAZILAND PRIMARY HEALTH CARE PROJECT

**WORK PLAN**

June 1, 1989 through December 31, 1990

Management Sciences for Health  
Charles R. Drew Postgraduate Medical School  
USAID Project No. 645-0220

2 August 1989

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## INTRODUCTION

The attached is a revised life-of-project work plan and budget for the Swaziland Primary Health Care Project. This final workplan adjusts the Project's focus and outcomes based on the recent Project Paper Amendment signed by the USAID Director and the Principal Secretary of the Department of Economic Planning and Statistics. The workplan reflects numerous discussions between USAID and the Ministry of Health and responds to the findings of the late 1988 Mid Project evaluation and the USAID Program Audit of early 1989.

The Project Paper Amendment calls for the project, during the balance of its existence, to focus at the regional and clinic levels on:

- (1) clinic-based and outreach services;
- (2) decentralization;
- (3) planning, budgeting, financial management and health care financing;
- (4) health information system development.

In carrying out the revised Project scope, USAID and the MOH agreed that extra long-term technical assistance would be required. It was agreed that the work of the Decentralization/Administration Advisor, the Planning and Budgeting Advisor (who is also Chief of Party) and the Clinic Management Advisor should continue until the end of the Project (December 31, 1990).<sup>1</sup>

The Project Paper Amendment also called for a reduction in the scope of the Project. Reductions were made in in-country and third-country training, short-term technical assistance, EPI, CDD and ARI activities<sup>2</sup>. In addition, the work of the MCH Physician would shift more towards maternal health than its focus in the past.

Finally, the Project has been extended to June 30, 1991. Even though all long-term technical assistance will stop on 31 December, 1990, the Project has been extended to accommodate two remaining long term trainees currently working on their degrees in the U.S.. These trainees will not be graduating until June, 1991.

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<sup>1</sup>The Decentralization/Administration advisor would terminate mid September, 1990, the Planning and Budgeting Advisor and the Clinic Management Advisor would terminate December 31, 1990. These dates correspond to the length of time needed for a particular Project emphasis but do not necessarily correspond to the longevity of current Associate incumbents.

At the time of submitting this Work Plan to USAID and the MOH, the Clinic Management Associate has decided not to extend her contract and leave Swaziland the end of December, 1989.

<sup>2</sup>The CCCD Project would fund many activities in this area with the Project providing limited technical assistance with no financial commitment.

## ORIENTATION TO THE WORK PLAN

The Work Plan is broken into three (3) broad areas: (1) clinic-oriented Project activities; (2) management-oriented Project activities; and (3) other activities. These sections are outlined below:

### CLINIC-ORIENTED ACTIVITIES

- . Rural Health Motivators/Community Leadership
- . Maternal Health and Family Planning
- . Health Education
- . Growth Monitoring
- . Clinic Management
- . Laboratory
- . Clinic-based training
- . EPI/CDD/ARI

### MANAGEMENT-ORIENTED ACTIVITIES

- . Transport
- . Decentralization, Systems Development, Health Planning
- . Communications
- . Health Information Systems
- . Financial Management/Health Care Financing

### OTHER PROJECT ACTIVITIES

- . Public Health General

Each component part has a corresponding time line, a budgeted amount <sup>3</sup>, and an indication of which Project Output and indicator (as outlined in the Project Paper) is being addressed by each individual activity. The Project Outputs and Indicators can be found below. Appendix I contains the Project budget representing direct funds available to the Ministry of Health for Project implementation purposes. Funds which are not "direct", local salaries, Associate salaries, MSH Boston support costs, and so on.

## ISSUES RELATED TO IMPLEMENTATION

There are several constraints to implementation which need to be mentioned and which are listed below.

### 1. AVAILABILITY OF COUNTERPARTS

As always the availability of counterparts is an issue. MOH officials are working hard to carry out their necessary functions. However, as one of the objectives of the Project is to transfer skills and knowledge to Swazi nationals it is important that counterpart time be made available to achieve Project activities. In reviewing this Work Plan it is essential that the Ministry of Health consider all Project planned activities in light of Ministry of

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<sup>3</sup>This amount is an estimate of funds available and does not correspond directly with the Contract Budget. For this reason it is to be used only as a general guide to available funds.

Health goals and objectives to assure that Project activities and MOH activities mesh. In this way Project Associates and MOH staff can work together to accomplish both Project as well as MOH objectives.

## 2. CONTINUITY OF PROJECT ASSOCIATES

The Project has seen a relatively large turn-over in Associates. Obviously such turn over makes Project continuity difficult. At the end of December, 1989 Dr. M. Price, Clinic Management Associate, will not be extending her current contract with Drew for work on this Project. Every effort will be made to have a smooth transition of Margaret Price out of the Project and to maintain momentum of her Project activities which must continue during 1990. An assessment of Dr. Price's activities which are to be carried over into 1990 has been made. Provisions have been made in the Work Plan to carry on the critical areas of her work in order to achieve Project objectives. The Project Work Plan reflects areas where technical assistance is still needed in the area of Clinic Management and where assistance will be forthcoming either in the form of short or long term consultants.

## 3. AVAILABILITY OF PROJECT FUNDS

The Project funds, as noted in the work plan, should be adequate to meet all Project objectives. In general, however, funds have been shifted away from central MOH activities to a clinic or regional focus. Training is a good example. With few exceptions, training will be regional or clinic-based as opposed to national or hotel-based. A per person cap on training per-diem has been in effect since September, 1988 and this cap will remain as a maximum allowable per person amount per day. In the future, clinic-based training of nurses will be a major Project priority with activity planned in all four (4) regions.

## 4. SUSTAINABILITY

Although the budget is effective June 1, 1989, the Project has only 17 months remaining until Project activities, with the exception of 2 long term trainees in the U.S., will cease. During this period of time it is critical the Project strive to build sustainable systems, skills and processes within the Ministry of Health. This will be done in several ways including more intense counterpart contact, reductions in funding where funding levels are not sustainable by MOH budgets, training to improve skill levels in critical areas such as HIS implementation, nurses clinical skills, and so on. In addition, attention needs to be placed on assessments of efforts to achieve targets.

## 5. PROJECT MONITORING

It is important that the Project be closely monitored and evaluated to assure that it is going in the proper direction. Several monitoring methods are or should be established.

Internal Project monitoring Internal monitoring needs to be done on a financial and programmatic basis. Monthly financial and narrative reports will be prepared for the Ministry beginning August, 1989. Quarterly reports, emphasizing Project

accomplishments will be distributed to the Ministry and USAID as usual.

external evaluation In October, 1990 the final USAID Project evaluation will take place. This evaluation will measure Project progress against this work plan and budget. Funds for this evaluation have been held aside by USAID and so will not be reflected in the attached Project budget.

In addition to this, the Chief of Party will continue to maintain a close working relationship with the Under Secretary, meeting regularly to discuss Project implementation issues. Each Project Associate, in turn, will meet and work regularly with his/her counterparts.

#### CONTRACTED END OF PROJECT STATUS INDICATORS

The Project Paper Amendment stated that the Project's goal is: "To improve the health status of Swazi children under five years of age and women of child-bearing age" with its purpose being "To improve and expand the primary health care system in Swaziland". In order to measure achievement in these areas END OF PROJECT STATUS (EOPS) statements were developed to focus Project activities. Project outputs and indicators were later developed to measure progress and achievement of these EOPS. The outputs and indicators are found below.

##### Project Outputs

##### Project Indicators

- |   |  |
|---|--|
| 1. Improved Service delivery delivery and outreach approaches developed and | a. Establish 49 new outreach sites, including provision of of basic furnishings and equipment  |
|   | b. Proportion of rural clinics from which nurses make regular home visits increased by 40% during project life                             |
|   | c. Proportion of clinics offering priority PHC services to women and under-5 children is at least 78%                                      |
|   | d. Proportion of clinics at which staff use project-related manuals and protocols to effectively diagnose and treat patients is $\leq$ 50% |
|   | e. Proportion of all clinics with functioning community health committees increased by 40% during life of the project                      |

f. PHC Lab services strengthened and at least 50% of clinics and health centers are performing critical PHC lab tests

2. Improved skills and motivation of health workers, brought about by improved conditions of service, improved transport and communications, and improved supervision and management support

a. in-country, in-service training strengthened, emphasizing competency-based training methods, evaluation and follow-up

b. at least 80% of clinic nursing staff trained in priority PHC service areas, as well as in basic clinic management skills

c. Appropriate service delivery tasks reassigned to NAs and RHMs so that nurses' skills and time are more effectively used.

d. Improved conditions of service for rural clinic staff, including provision of limited furnishings for nurse's accommodations.

e. Studies of MOH communications and transport systems completed and follow-up initiated with available Project resources.

f. At least 80% of rural clinics receiving monthly supervisory visits from regional nursing supervisors.

3. A decentralized system of planning, budgeting, personnel, management, supervision and financial management in place and operating effectively at MOH headquarters and in the regions, in accordance with approved regional workplans.

a. RHMT's and Regional Health Advisory Councils operating effectively in all 4 regions

b. Decentralized planning, budgeting, personnel, admin, and financial management systems developed and operating in all four (4) regions.

- c. Health information systems developed and assisting both the central MOH and regions in reinforcing the decentralization process.
  
- 4. An increased proportion of GOS recurrent expenditures for health devoted to PHC; and mechanisms developed for at least pilot efforts to provide extra-budgetary support for PHC programs.
  - a. MOH recurrent expenditures for PHC services increased from 15.3% in 1985/86 to 20.3% by 1990/91.
  
  - b. Financial studies carried out (user fee, unit cost, financial management) both to strengthen MOH financial mgmt and to enhance extra-budgetary support mechanisms.
  
  - c. Pilot mechanisms developed in limited number of specific service areas (e.g., lab services at the clinic level) to provide potential for extra-budgetary support.

PRIMARY HEALTH CARE PROJECT - REVISED LIFE-OF-PROJECT WORK PLAN  
 BASED ON THE NEGOTIATIONS BETWEEN THE MOH AND USAID  
 AND IN LINE WITH THE REVISED PROJECT PAPER AMENDMENT

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INTRODUCTION TO THE WORKPLAN  
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This draft work plan is an outgrowth of the mid-project evaluation carried out late 1988. In addition, the results of the USAID Program Audit conducted in early 1989 heavily influenced this document. Both of these activities resulted in the Project Paper Amendment (May, 1989) which was signed by the USAID Director and approved by E. Rheebe, Principal Secretary, Department of Economic Planning and Statistics on the 5th of May, 1989.

1. clinic-based and outreach services
2. decentralization
3. planning, budgeting, financial management and health care financing
4. health information systems

The focus is on institutional strengthening at the regional and clinic levels particularly strengthening and expanding services.

Priorities for the remaining 17 months of the Project fall into four (4) areas:

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CLINIC ORIENTED PROJECT ACTIVITIES

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RURAL HEALTH MOTIVATORS/COMMUNITY LEADERSHIP

The Rural Health Motivators (RHM) Program and clinic outreach services are two means of increasing access to health care for the rural population. If the ambitious national goals for health are to be met, these programmes must be aided and expanded.

- (2) Support in carrying out RHM support activities as agreed with the MOH and UNICEF based on the findings and recommendations of the RHM Programme evaluation (to be known in October 1989).

Focus and priorities at this time should be:

- (1) Training of clinic nurses in the supervision/support of RHMs.

- (3) Strengthening of Clinic (Community) Health Committees (a clinic-based activity).
- (4) Carrying out RHM support activities as agreed with the Ministry of Health and the UNICEF based on the findings

ACT!act!	RD!seq!	RURAL HEALTH MOTIVATORS PROGRAMME	funds !	1989 !	1989 !	1989 !	1990 !	1990 !	1990 !	1990 !	1991 !	1991 !	USAID !	EXPLANATORY NOTES
			(€)	QRT.2	QRT.3	QRT.4	QRT.1	QRT.2	QRT.3	QRT.4	QRT.1	QRT.2	INDIC !	
1 ! 1	!	! Training and support of clinic nurses !	4,000 !	!	!	!	!	!	!	!	!	!	!IB	! Training of clinic nurses in RHM supervision and
!	!	! for supervision of RHMs and community !	!	!	!	!	!	!	!	!	!	!	!IE	! support is included under clinic-based training.
!	!	! participation. !	!	!	!	!	!	!	!	!	!	!	!	!
2 ! 2	!	! Training/support for Clinic !	11,000 !	!	!	!	!	!	!	!	!	!	!IB	! primarily the link between clinic and RHM's
!	!	! (community) Health Committees !	!	!	!	!	!	!	!	!	!	!	!IE	!
!	!	!	!	!	!	!	!	!	!	!	!	!	!	!

15,000

MATERNAL HEALTH/FAMILY PLANNING

Less than one-third of all clinic nurses who are expected to provide family planning care have been trained to do so. There is a critical shortage of family planning-related equipment in many clinics and the health information system is currently not operating effectively enough to provide management and supervisory information.

Focus and priorities at this time are:

- (1) Improve the availability of necessary FP-related equipment;
- (2) Improve clinic supervision related to FP and assure that all clinic nurses have adequate knowledge to provide necessary child spacing services;
- (3) Development and implementation of a comprehensive maternal health and family planning plan for Swaziland (PHC Project activities should be based on this plan);
- (4) Develop and implement an FP Health Information System
- (5) Assure that nursing supervisors receive the skills necessary to supervise and arrange in-service education in MH and FP activities.
- (6) Improving the operation of under-utilized rural maternities and the improvement in skills of the hundreds of traditional birth attendants in Swaziland;
- (7) Improving clinical supervision related to maternal care MDH and Mission facilities;
- (8) Improving the amount and quality of antenatal & post partum care in clinics including provision of post partum exams;
- (9) Improving clinic nurse's ability to provide appropriate health education to mothers;
- (10) Provision of in-service training as necessary for clinic nurses to carry out these services and educate mothers;

ACT/seq!	Funds	1987	1989	1989	1990	1990	1990	1990	1991	1991	USAID	INDIC	EXPLANATORY NOTES
NO.!(E)	!(E)	QRT.2	QRT.3	QRT.4	QRT.1	QRT.2	QRT.3	QRT.4	QRT.1	QRT.2	!	!	!
! !MATERNAL CARE AND FAMILY PLANNING	!	!	!	!	!!	!	!	!	!	!	!	!	!Meeting of Regional/Central MDH
1 ! 3 !Completion of 3 year Plan	!	!	!xxxxxxx!	!	!	!	!	!	!	!	!	!	!
2 ! 4 !Printing of Plan	!	500 !	!	!xxxxxx!	!!	!	!	!	!	!	!	!	!Printing of MH/FP Plan
3 ! 5 !Training of clinic nurses in High Risk	!	2,500 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!
! !Approach to ANC	!	!	!	!	!	!	!	!	!	!	!	!	!
4 ! 6 !Integrate MH/FP programme	!	1,199 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!Collaborate with D. Kraushaar and other funding
! !into regional HIS's	!	!	!	!	!	!	!	!	!	!	!	!	!agencies in development of MDH/FP data collection sys.
5 ! 7 !Increase number of functioning rural	!	20,000 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!At least one rural maternity/region to be
! !maternities nationally	!	!	!	!	!	!	!	!	!	!	!	!	!reactivated by addressing staffing, equipment,
6 ! 8 !Provide training to health care providers	!	10,000 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!
! !in maternities that do high volume	!	!	!	!	!!	!	!	!	!	!	!	!	!
! !deliveries (including use of labor graph,	!	!	!	!	!	!	!	!	!	!	!	!	!
! !breast feeding techniques, PP hlth ed)	!	!	!	!	!	!	!	!	!	!	!	!	!
7 ! 9 !Training of clinic nurses in post	!	30,000 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!
! !partum care/family planning	!	!	!	!	!!	!	!	!	!	!	!	!	!
! ! - Regional training	!	!	!	!	!!	!	!	!	!	!	!	!	!
8 ! 10 !Equip clinics with materials	!	7,000 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!It will be necessary to supply curtains, barriers,
! !necessary to provide privacy	!	!	!	!	!!	!	!	!	!	!	!	!	!dividers in some clinics to achieve privacy for pelvics!
9 ! 11 !training materials in family planning	!	!	!	!	!	!	!	!	!	!	!	!	!flipcharts on FP methods for all facilities
! !promotion and education	!	10,000 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!providing FP services
10 ! 12 !Promotion of breastfeeding through	!	10,000 !	!	!xxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!nurse midwife's membership on SINAN
! !collaboration with SINAN and growth	!	!	!	!	!	!	!	!	!	!	!	!	!executive board - poss secretarial support
! !monitoring committee TA to SINAN's training!	!	!	!	!	!!	!	!	!	!	!	!	!	!
! !activities	!	!	!	!	!	!	!	!	!	!	!	!	!
! ! - breast pump acquisition	!	!	!	!	!!	!	!	!	!	!	!	!	!all maternities need hand-operated pumps
! !	!	!	!	!	!	!	!	!	!	!	!	!	!

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HEALTH EDUCATION

Nurses don't have the skills nor means of developing programmes to influence the knowledge, attitudes or practices of the Swazi population. The critical shortage is messages and methods targeted at maternal health and family planning. An unmet need also exists relating to the TB programme and hypertension which are major health problems in this country.

FOCUS AND PRIORITIES AT THIS TIME ARE:

- (1) Training four (4) health educators long-term in Nigeria to take up posts as regional health educators as well as the training of two long-term health educators in the U.S. to assist the Central Health Education Unit.
- (2) Setting up and equipping regional health education units (CCCO funded.)
- (3) Developing health education methods with the newly returned health educators focusing on maternal health and family planning, TB and hypertension
- (4) Developing skills of clinic nurses to provide basic health education to their clients (see clinic-based training)
- (5) Completing analysis, write up and dissemination of findings from the Health Education Survey carried out in 1988

ACT!act! NO.!seq!	HEALTH EDUCATION PROGRAMME	!funds !(E)	! 1989 ! QRT.2	! 1989 ! QRT.3	! 1989 ! QRT.4	!! 1990 !! QRT.1	! 1990 ! QRT.2	! 1990 ! QRT.3	! 1990 ! QRT.4	! 1991 ! QRT.1	! 1991 ! QRT.2	!USAID ! !INDIC !	EXPLANATORY NOTES
1 !13	!Training 4 health educators long-term ! in Nigeria	!Drew !	!	!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!2 in Oct '89 and 2 in Oct. 1990
2 !14	!Training 2 BA, Health Education In USA	!Drew !	!	!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!1 returning in June, 1991
3 !15	!Setting up regional health ! education units	!CCCO + ! 2,700 !	!	!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!	!4-month consultancy
4 !16	!Develop health education methods ! focusing on TB, hypertension, ! maternal care and family planning	!consult +! ! 3,000 !	!	!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!2A	!Committee/organization to be developed to work with !consultant, and to provide continuity and !sustainability
5 !17	!Develop skills of clinic nurses to ! provide basic health education in their ! clinics/communities (clinic-based training)	! 2,680 !	!	!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!2A	!
6 !18	!Complete, analyse, write up, print and ! disseminate findings of health ! education impact survey	! 4,000 !	!	!xxxxxxx!	!!	!	!	!	!	!	!	!	!Sub-contract with UNISWA for analysis
7 !19	!Regional seminars to disseminate ! information	! 1,000 !	!	!xxxxxxx!	!!	!	!	!	!	!	!	!	!

note:

13,380

setting up regional health education units using a DREW consultant is contingent upon the work plans of the returning health educators trained in Nigeria as well as the time of the returned health educator

from the U.S.. Their participation and leadership in this function is critical to its success. Two educators will return from Nigeria in 1989 and two in 1990. Depending on their return dates, implementation can begin. Securing their participation from the Health Education Unit is necessary.

GROWTH MONITORING

Growth monitoring is not implemented consistently in Swaziland nor is there a national GM plan which guides implementation of this activity. Growth monitoring is a key PHC effort designed to assess growth patterns of children, identify health problems before they lead to morbidity or mortality and offer an opportunity for health education talks with mothers.

The Project's work in the growth monitoring area will be consistent with our focus on ARI, CDD and EPI. Work in this area will be primarily during implementation of clinic-based training where skills in growth monitoring will be stressed during clinic and preventive sessions.

ACT. NO.	DESCRIPTION	!funds !	! 1989 !	! 1989 !	! 1989 !	!! 1990 !	! 1990 !	! 1990 !	! 1990 !	! 1991 !	! 1991 !	!USIAD !	EXPLANATORY NOTES
	GRONIE MONITORING & NUTRITION PROGRAMME	!(E)	! QRT.2 !	! QRT.3 !	! QRT.4 !	!! QRT.1 !	! QRT.2 !	! QRT.3 !	! QRT.4 !	! QRT.1 !	! QRT.2 !	!INDIC !	
1 !20	!Develop on-site training and followup	! 5,000 !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!health personnel at clinic and for	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	!Activities will be approached region-by-region
	!weighing, measuring and recording the	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	!starting with Shiselweni with remaining regions
	!under-five population receiving the	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	!addressed in 1990
	!the services	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
2 !21	!Increase the KAP of the health personnel	! 10,000 !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!and matters about the Child Health Cards	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!as guides to health assessment of	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!under-five clients	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
3 !22	!On-site training of health personnel in	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!breastfeeding, weaning practices, feeding	! 5,000 !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!practices of sick children and nutritional	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!management of pregnancy and lactation.	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
4 !23	!Include growth monitoring in the	! 700 !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !
	!regional Health Information Systems	! !	! !	! !	! !	!! !	! !	! !	! !	! !	! !	! !	! !

20,700

12

## CLINIC MANAGEMENT

The clinic represents the front line of preventive, promotive and curative health services in Swaziland. It reflects the total MOH policy towards health and the community on the one hand, and the community's response to these policies on the other.

Clinic staff are faced with the impact of traditional beliefs and practices, limited knowledge and negative attitudes which can impede their efforts. In many instances, the staff are also faced with such environmental constraints as poor housing, lack of potable water, lack of basic sanitation, absence of means of communication, inadequate or non-functioning equipment and lack of essential supplies. Many staff also lack the skills required for them to perform their basic functions.

As a team, V.Joret, M.Kroeger and M.Price will maintain a clinic focus. Since training remains a priority, training done in this area will primarily be clinic-based, and in-service including development of skills of Regional Trainers. For this clinic-level work funds have been allocated here as well as in the clinic-level training sections of the work plan. Focus and priorities at this time are:

- (1) Management skills including those related to inventory management, work scheduling, supervision, managing drug and vaccine supply among others at the clinic level
- (2) Nursing skills in community outreach, health education, problem solving, and basic outreach services to be implemented at the clinic level

- (3) Ongoing work on improving the referral system
- (4) Evaluation of the referral system trial, drug management program and regional supervisory methods
- (5) Training of regional trainers to carry out clinic-based training
- (6) Development of appropriate clinic-focused manuals
- (7) Provide limited funds for upgrading nursing housing in the regions

ACT NO.	CLINIC MANAGEMENT PROGRAMME	!funds !(E)	! 1987 ! QRT.2	! 1989 ! QRT.3	! 1989 ! QRT.4	! 1990 ! QRT.1	! 1990 ! QRT.2	! 1990 ! QRT.3	! 1990 ! QRT.4	! 1991 ! QRT.1	! 1991 ! QRT.2	!USAID ! !INDIC !	EXPLANATORY NOTES
1 !24	!Provide clinic-based training to clinic nurses in basic management skills including supervision, patient flow, drug mgmt., community profiles and outreach	! 2,000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!add'l funds available (see clinic-based training)
2 !25	!Establish with H Ed unit regional H Ed units	! 2,000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!38
3 !	!Upgrade clinic nurses accommodations	! 44000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!
3 !26	!Finalize and evaluate nursing orientation manuals and procedures	! 500 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!2C, 1D!
4 !27	!Implementation and evaluation of: - referral system pilot - drug management program - methods used for clinic supervision	! 16,000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!2C, 1D!
5 !28	!Training regional trainers in clinic-based training including development of manuals for clinic management.	! 3,000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!2A, 2B! to be implemented as part of the clinic-based training! to be done in all regions starting with Shiselweni
7 !29	!Generator maintenance and repair training	! 4,000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!2D
9 !30	!Complete analysis and write up of H.Ed.survey!	! 3300 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!
10 !31	!complete TOI manuals for clinic management	! 500 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!
11 !32	!Expand use of clinic supervisory checklist	! 932 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!
12 !33	!Trainers manual for drug management	! 2000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!
13 !34	!Development of nursing incentives	! 1000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!
14 !35	!Develop nursing "scheme of service"	! 1000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!
15 !36	!Build community support around clinics"	! 1000 !	! !	! !	! !	! !	! !	! !	! !	! !	! !	! !	!

LABORATORY

Many clinics do not either have access to laboratory facilities allowing them to carry out critical laboratory tests or adequate facilities and trained staff to do such tests themselves. Inadequate transport makes the sending of lab specimens (and the return of results) impossible. There is also a shortage of equipment necessary to see that these lab tests are done routinely and as close to the client encounter as possible. Critical lab tests include hemoglobin testing, VDRL and pregnancy tests. Equipment required for this are hemoglobinometer, VDRL kits with reagents, (for selected sites) rotator/shakers, pregnancy test kits with reagent, uristicks, spatulae and slides.

Focus and priorities at this time are:

- (1) Ensure that adequate trained nursing staff are on site to carry out priority tests;
- (2) Equipping appropriate clinic labs with the necessary equipment for critical tests (not including reagents & supplies);
- (3) Improving laboratory supervision and quality control procedures; (consultant)
- (4) Enhancing current clinic focused lab management information system methods (consultant)

NOTE: The lab section has a definite focus on clinics and not on central or regional labs. If a clinic has no capacity for lab service provision, a decision would be made to use a higher-level lab. In this instance, assistance could be given to that higher-level lab. In those cases, only critical tests would be supported.

ACT NO.	LABORATORY PROGRAMME	funds (£)	1989 QRT.2	1989 QRT.3	1989 QRT.4	1990 QRT.1	1990 QRT.2	1990 QRT.3	1990 QRT.4	1991 QRT.1	1991 QRT.2	INDIC	EXPLANATORY NOTES
1	!37 !Ensure that adequately trained nursing staff are on-site to carry out priority testing (training & materials)	! 3,800 !	!	!	!	!	!	!	!	!	!	!	!
2	!38 !Equip appropriate clinics & health centers with necessary equipment for critical lab tests	! 232,826 !	!	!	!	!	!	!	!	!	!	!	!50% of clinics and health centers will perform critical PHC lab tests themselves
3	!39 !Improve laboratory supervision and quality control procedures	!consult !	!	!	!	!	!	!	!	!	!	!	!4 week consultancy
4	!40 !Enhance current clinic focused lab management information system	!consult !	!	!	!	!	!	!	!	!	!	!	!2 week consultancy. System already in place. Requires assessment and modification if necessary
5	!41 !Establish an inventory management system to ensure adequate supplies and reagents	!consult !	!	!	!	!	!	!	!	!	!	!	!1 week consultancy
6	!42 !Develop standards and standard protocols	!consult !	!	!	!	!	!	!	!	!	!	!	!2 week consultancy if added to quality control consultancy.

CLINIC-BASED TRAINING

The PHC Project has focused on training as a major activity during the past 3.5 years. In the future, consistent with the narrowed focus of the Project, training will for the most part be CARRIED OUT IN CLINICS, focussing on problems of clinic nurses in their actual clinic settings. Such training will be jointly planned, monitored, implemented, evaluated and followed-up by the Project team together with the regional Clinic Supervisors, Regional Public Health Matrons and trainers who have been trained by the Project.

Dr. Joret, as Project Technical Director, Dr. Price and Me Kroeger will form a "clinic training team" to plan with the regions to carry out this training in an appropriate and timely manner. This team will also jointly decide on the most appropriate allocation of these training funds to the various topics outlined in this Work Plan. Although no funds are allocated to each region, an equitable distribution of these training resources will be assured for each region.

Training to be carried out using these funds below is to focus on several critical areas:

1. strengthening clinic (community) health committees
2. maternal health and family planning
3. clinic health education
4. clinic management
5. growth monitoring/EPI
6. clinical skills in ARI, CDD and other priority diseases
7. clinic-based high priority lab tests
8. health information system

ACT!	NO.!	CLINIC-BASED TRAINING	!funds !	! 1989 !	! 1989 !	! 1989 !	!! 1990 !	! 1990 !	! 1990 !	! 1990 !	! 1991 !	! 1991 !	!USAID !	EXPLANATORY NOTES
			!(E)	! QRT.2 !	! QRT.3 !	! QRT.4 !	!! QRT.1 !	! QRT.2 !	! QRT.3 !	! QRT.4 !	! QRT.1 !	! QRT.2 !	!INDIC !	
1	43	!training activities for ! ! all four regions	! 166,655 !	!	!	!	!!	!	!	!	!	!	!2A ! !2B !	
			166,655											

15

EXPANDED PROGRAMME ON IMMUNIZATIONS (EPI)

Measles, polio and other vaccine-preventable diseases still have a relatively high incidence rate in Swaziland and the infant mortality rate, given Swaziland's relatively high per capita income, is unusually high. Although other major donors (UNICEF, WHO, CCCO) are the primary actors in this arena, there are still areas where the PHC Project can assist.

Focus and priorities at this time are to develop the skills of nurses in their respective clinical settings to be able to carry out an effective EPI programme in line with the 3-year plan of action. Clinic-level training will remain the primary focus of this Project in EPI for the duration of the Project.

CONTROL OF DIARRHEAL DISEASE

Diarrheal disease is a leading cause of morbidity and mortality among Swazi children. As with EPI there are other donors who are providing the bulk of financial and technical assistance in this area; however, the PHC Project can make a contribution to this effort.

Focus and priorities at this time are to develop the skills of nurses in their respective clinical settings to be able to carry out an effective CDD programme in line with the 3-year plan of action. Clinic-level training will remain the primary focus of this Project in CDD for the duration of the Project.

ACUTE RESPIRATORY INFECTIONS

Acute Respiratory Infections are a common cause of morbidity in Swazi children. ARI has not been a major programmatic thrust as have CDD and EPI, yet the problem is great however such of the ARI activities will be funded by the CCCO Project. Future work in this area will mirror that of the EPI and CDD activities discussed above. Our primary thrust will be at the clinic level and in-service, in-clinic training in ARI management.

ACT/act: NO. :seq	EPI PROGRAMME	!funds !(£)	! 1989 ! QRT.2	! 1989 ! QRT.3	! 1989 ! QRT.4	! 1990 ! QRT.1	! 1990 ! QRT.2	! 1990 ! QRT.3	! 1990 ! QRT.4	! 1991 ! QRT.1	! 1991 ! QRT.2	!USAID !INDIC	EXPLANATORY NOTES
1 :44	!On-site training and follow-up of !health personnel for correct !implementation of national EPI !guidelines	! 0	!	! ! ! ! !	! ! ! ! !	! ! ! ! !	! ! ! ! !	! ! ! ! !	! ! ! ! !	!	!	!2A	
2 :45	!Integrate the EPI program into the !regional Health Information Systems	! 0	!	! ! ! ! !	! ! ! ! !	! ! ! ! !	! ! ! ! !	! ! ! ! !	! ! ! ! !	!	!	!3C	

CONTROL OF DIARRHEAL DISEASES

3 :46	!Revise and evaluate existing protocol !and implement in clinic-level training	! 0	!	!	!	!	!	!	!	!	!	!	!1C	
4 :47	!Adapt the current procedures for manage- !ment of children with diarrhea to !clinical level	! 0	!	!	!	!	!	!	!	!	!	!	!2A	
5 :48	!Assist in the follow up of trainees !of the National ORI Training Centre in !their respective clinic settings.	! 0	!	!	!	!	!	!	!	!	!	!	!2A	
6 :49	!Develop on-site CDD training program !for clinic nurses and nursing assistants !integrated with the other PHC activities	! 0	!	!	!	!	!	!	!	!	!	!	!2B	!Activities 8), 9) and 10) will be done !region-by-region beginning in Shiselweni Region
7 :50	!Integrate the CDD program in the !regional Health Information Systems	! 0	!	!	!	!	!	!	!	!	!	!	!3C	
8 :51	!estab ORI corners during clinic training	! 0	!	!	!	!	!	!	!	!	!	!	!1C	

ACUTE RESPIRATORY INFECTIONS

9 :52	!field test, analysis and use !Guidelines for Clinic and Home !Management of ARI Problems of !Children" during clinic-level training	! 0	!	!	!	!	!	!	!	!	!	!	!2A	
10 :53	!Plan, implement and follow-up the !on-site training of health personnel !for ARI at clinic level !using the ARI Guidelines	! 0	!	!	!	!	!	!	!	!	!	!	!2A	!Activities 5) and 6) will be carried out !region-by-region beginning in Shiselweni Region.
11 :54	!Integrate the ARI programme in the !regional Health Information Systems	! 0	!	!	!	!	!	!	!	!	!	!	!3C	

END OF CLINIC ORIENTED PROJECT ACTIVITIES

MANAGEMENT ORIENTED PROJECT ACTIVITIES

TRANSPORT

Lack of transportation adversely affects the delivery of health services. Supervision of clinics, consultations, reporting and feedback of health information, delivery of drugs and supplies, transport of laboratory specimens and reporting back, patient referrals, and outreach clinics all depend on reliable transport. Repeatedly, the providers of these essential primary services in Swaziland have complained that they cannot do what is expected of them without adequate transport.

The availability of vehicles is largely a function of their management. Therefore, Project assistance will be in the form of a Transport Management Study which will include an assessment of existing policies and procedures, a complete computerized vehicle inventory, a critical examination of every transport problem and constraint, and feasibility studies of innovations such as mini-workshops for routine servicing and minor repairs and a loan fund for employee-owned motorbikes. The use of log books and vehicle service/maintenance records will also be studied and implemented on a trial basis.

Focus and priorities at this time are:

- (1) Conduct Transport Management Study;
- (2) Based on the study recommendations, implement a few selected management systems and procedures within time and budgetary constraints;
- (3) Train approximately 20 health staff to qualify for government vehicle operator's licenses, as an inexpensive, but effective and timely way to help alleviate the problem of transport availability;

COMMUNICATIONS

Telecommunications within the MOH at all levels continues to be a problem. Most recently the Telecommunications Department has indicated that telephones will be installed in many facilities in the future, however, not all facilities will be served.

Focus and priorities at this time are:

- (1) Carry out the communications needs assessment with a contractor to determine the extent of the problem and possible solutions to the communication problem;
- (2) Assist in implementation of selected recommendations if funding and time allows.

ACT !	NO !	TRANSPORT PROGRAMME	funds !	1989 !	1989 !	1989 !!	1990 !	1990 !	1990 !	1990 !	1991 !	1991 !	USAID !	EXPLANATORY NOTES
NO !	NO !		(E) !	QRT.2 !	QRT.3 !	QRT.4 !!	QRT.1 !	QRT.2 !	QRT.3 !	QRT.4 !	QRT.1 !	QRT.2 !	INDIC !	
!	!	!TRANSPORT	!	!	!	!!	!	!	!	!	!	!	!	!
1	!	!Transport Management Study	!	37,400 !	!	xxxxxxxxx!xxx	!	!	!	!	!	!	!2E !	!
2	!	!Support for Study	!	1,000 !	!	x!xxxxxxx!xxx	!	!	!	!	!	!	!2E !	!
3	!	!Training for vehicle operating licenses	!	5,000 !	!	x!xxxxxxx!xxxxxxx!!	!	!	!	!	!	!	!2E !	!
4	!	!Implementation of interventions and	!	1,000 !	!	!	!!	xxx!xxxxxxx!	!	!	!	!	!2E !	!
5	!	!miscellaneous training if necessary	!	2,000 !	!	!	!!	xxxxxxx!xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!2E !	!
				46,400										

ACT !	NO !	COMMUNICATIONS PROGRAMME	funds !	1989 !	1989 !	1989 !!	1990 !	1990 !	1990 !	1990 !	1991 !	1991 !	USAID !	EXPLANATORY NOTES
NO !	NO !		(E) !	QRT.2 !	QRT.3 !	QRT.4 !!	QRT.1 !	QRT.2 !	QRT.3 !	QRT.4 !	QRT.1 !	QRT.2 !	INDIC !	
!	!	!COMMUNICATIONS	!	!	!	!!	!	!	!	!	!	!	!	!
1	!	!communications study	!	20,999 !	!	xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!2E !	!contract
2	!	!implement recommendations if appropriate	!	99,000 !	!	xxxxxxx!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!2E !	!possible funds for equipment = E99,000
3	!	!training	!	2,280 !	!	xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!2E !	!

DECENTRALIZATION/SYSTEMS DEVELOPMENT AND HEALTH PLANNING

Decentralization provides the framework within which the regional health care delivery system functions. Its purpose is to provide the ways and means for making the health system more responsive to the needs of the people and to bring decision-making closer to the point of delivery. It allows greater input from the local level in the planning and implementation of health services, and is designed to improve staff productivity.

The strategy is to phase in decentralization over time institutional framework for decentralization - the organization structure, roles and responsibilities, communication/team building, and by strengthening the Regional Health Management Teams, Community Health Committees and the Regional Health Advisory Councils; and (2) to regionalize specific administrative functions in the Ministry.

Focus and priorities at this time are:

- (1) Strengthen the institutional framework through:
  - o Improving the functioning of the RHMTs
  - o Strengthening existing Community Health Committees and creating new ones where needed
  - o Facilitating work of the Decentralisation Task Force

HEALTH PLANNING

Planning activities at the regional level are not well developed. Regional planning activities are being addressed by the Project while central level budgeting activities are the focus of the Financial Controller.

Focus and priorities at this time are:

- (1) Funding for the printing of budgeting and planning manuals both centrally and regionally;
- (2) Provision of a consultant for an update of the manpower plan;
- (3) Funds and limited technical assistance for the production and printing of a health planning and statistics guide;

- (2) Strengthen programme management through the development, implementation and monitoring of Regional Annual Plans (including a management component)
- (3) Design, install and strengthen regional management systems:
  - o Decentralized Personnel and Training System
  - o Health Information System
  - o Planning System
  - o Budgeting System
  - o Financial System
  - o Transport System
  - o Supply System
- (4) Evaluation of the impact of decentralization of MOH functions, productivity of MOH employees and effectiveness efficiency in the ultimate delivery of health services to the community.
- (5) Develop and expand the outreach sites programme of the MOH through establishing additional outreach sites in all four regions

ACT!	NO.!	DECENTRALIZATION/SYSTEMS PROGRAMME	funds !	1989 !	1989 !	1989 !	1990 !!	1990 !	1990 !	1990 !	1991 !	1991 !	USAID !	EXPLANATORY NOTES
			(£)	QRT.2 !	QRT.3 !	QRT.4 !!	QRT.1 !	QRT.2 !	QRT.3 !	QRT.4 !	QRT.1 !	QRT.2 !	INDIC !	
1 !63	!	!Decentralization Task Force	!	1,000 !	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!	!	!	!3A,3B !
2 !64	!	!eval.decent/personnel system	!	11,000 !	!	!	!!	!	!xxxxxxx!	!	!	!	!	!3A,3B !Consultant (3 weeks)
3 !65	!	!Series of regional manuals for RHMT functions!	!	17,000 !	!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!	!	!	!	!3A,3B !Printing, field testing, etc.
4 !66	!	!Evaluate regional personnel system	!	11,000 !	!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!	!	!	!	!3A,3B !
5 !67	!	!Develop RHMT skills (plng,HIS,budgeting,etc)!	!	7,950 !	!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!	!	!	!	!3A,3B !
6 !68	!	!personnel system training and orientation !	!	43,000 !	!	!	!!	!	!	!	!	!	!	!3A,3B !
!	!	!for RHMT's incl ref. material development	!	!	!	!	!!	!	!	!	!	!	!	!
7 !69	!	!RHMT team building	!	8,000 !	!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!xxxxxxx!	!	!	!	!	!3A,3B !
9 !70	!	!TA for manpower plan update	!	12,780 !	!	!	!!	!xxx !	!	!	!	!	!	!3A,3B !1990 consultant only (2 weeks)
10 !71	!	!expand the number of outreach sites	!	50,000 !	!	!	!!	!xxx !	!	!	!	!	!	!1A !supplies, basic equipment & furnishings

HEALTH INFORMATION SYSTEM

The foundation for a sound Health Information System is operational in the MOH. There is a mechanism for routine data collection and data are, for the most part, routinely collected. There is a growing need for sound information and for a health data base which would allow for greater quantification of existing health and service problems and needs. With the untimely loss of two key staff in the HPSU, the statistics unit is for all intents and purposes non-functional at this time. TA and selected activities could improve operations of the HIS.

Focus and priorities at this time are:

- (1) Work to: (a) establish Regional health information systems for data entry, analysis and supervision; (b) assist CCCD to computerize Central Vaccine Stores; (c) improve family planning planning data collection, analysis and feedback; (d) improve the understanding of and skills of staff in the MOH for data analysis. All 4 regions will be the focus of regional HIS activities (Manzini and Shiselweni initially, in conjunction with decentralization efforts). The Accounting Unit will also be computerized, linking acct. and service statistics for assessments of efficiency and effectiveness, as well as budget monitoring.

- (2) Provide technical assistance to the Statistics Unit to improve the documentation of available data sets, Unit operations, data base management and data storage methods
- (3) Complete Family Health Survey data analysis through national & regional dissemination of findings and working with program managers in use of data for plan & eval
- (4) Collaborate with other donors to assure integrated development of the HIS. Donors include CCCD, WHO, UNFPA, FLAS, the Italian Government.
- (5) Develop the MOH "library" into a central multi-purpose computer room for data processing, data base management, data analysis and financial planning (some equipment may be necessary), and as an archive for past, present and future data sets to be used for planning and evaluation purposes;
- (6) provide training in the use of computers at the headquarters and regional levels to assure proper use of available computers;
- (7) Improve the functioning of the computerized personnel system, accounting department
- (8) Phase out current ongoing data entry assistance in anticipation of permanent MOH positions. Assistance would end mid-1990.
- (9) Assist in computerizing the tracking and monitoring activities of the Training Unit.

ACT!	NO.!	HEALTH INFORMATION SYSTEM PROGRAMME	!funds	! 1989	! 1989	! 1989	!! 1990	! 1990	! 1990	! 1990	! 1991	! 1991	!USAID	!	EXPLANATORY NOTES
		!(E)	!	! QRT.2	! QRT.3	! QRT.4	!! QRT.1	! QRT.2	! QRT.3	! QRT.4	! QRT.1	! QRT.2	!IDIC	!	
1	!72	!Improve Statistics Unit functioning	! 15,000	!	!xxxxxxx!xxxxxxx!	!	!	!	!	!	!	!	!3C	!	!6 week consultant + misc. costs
2	!73	! four (4) region's HIS development. Manzini and Shiselweni initially.	! 47,140	!xxxxxxx!xxxxxxx!xxxxxxx!	!3C	!	!CCCD funds for computer + software - DK's time + misc.								
		! HIS development for Acct's section, Personnel unit, training unit, Admin. unit.	!	!	!	!	!	!	!	!	!	!	!	!	!CCCD funds for computer + software - DK's time + misc.
		! Development of Central Vaccine Stores inventory system	!	!	!	!	!	!	!	!	!	!	!	!	!DK's time and misc. costs
		! set up MOH "library" facility	!	!	!	!	!	!	!	!	!	!	!	!	!CCCD funds for computer + software - DK's time + misc.
3	!74	!data entry assistance - HPSU	!	!	!	!	!	!	!	!	!	!	!	!	!CCCD funds for computer + software - DK's time + misc.
4	!75	!Family Health Survey	! 15,166	!	!	!	!	!	!	!	!	!	!	!	!DK's time and misc. costs
		! . final report printing	!	!	!	!	!	!	!	!	!	!	!	!	!CCCD funds for computer + software - DK's time + misc.
		! . national seminar	!	!	! x !	!	!	!	!	!	!	!	!	!	!Consultant needed for 6 weeks - to include PMU
		! . regional analyses and seminars	!	!	! xxx !	! xxx !	! xxx !	! xxx !	! xxx !	! xxx !	!	!	!	!	!Consultant needed for 6 weeks - to include Central
		! . date set development and archiving	!	!	! xx !	!	!	!	!	!	!	!	!	!	!software, misc. supplies and training materials
		! . misc. Survey-related activities	!	!	! x !	! x !	! x !	! x !	! x !	! x !	!	!	!	!	!
5	!76	!training	! 30,000	!	!	!	!	!	!	!	!	!	!	!	!3A, 3B!

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FINANCIAL MANAGEMENT/HEALTH FINANCING

Planning for the institutionalization of the PHC Project-supported activities requires good financial planning. In addition, it is fast becoming obvious that the demands on the health care system are outstripping the funds available from the government. Alternative financing methods need to be explored alongside efforts to improve the efficiency of MOH health care operations.

Focus and priorities at this time are:

- (1) Studies should be carried out to improve the financial management procedures of the MOH, recurrent budget planning and the utilization of collected fees;
- (2) If appropriate, alternative financing scheme(s) should be carried out, evaluated and reported in a policy dialogue with MOH officials;
- (3) Institutionalizing improvements in recurrent budget planning, implementation of alternative financing schemes and improvement in the use and collection of user fees
- (4) Collaborate with other agencies in studies or operational activities aimed at understanding the future recurrent budget problem and developing solutions to these problems at a policy and programmatic level;

ACT!	MD!	FINANCIAL MANAGEMENT PROGRAMME	!funds	! 1989	! 1989	! 1989	!! 1990	! 1990	! 1990	! 1990	! 1991	! 1991	!USAID	EXPLANATORY NOTES
			!(E)	! QRT.2	! QRT.3	! QRT.4	!! QRT.1	! QRT.2	! QRT.3	! QRT.4	! QRT.1	! QRT.2	!INDIC	
1	!77	!Carry out three studies: unit cost, !financial management assessment, user !fee study.	! 259,600	!	x!xxxxxx!	xxxxxx!	xxxxxx!	!	!	!	!	!	!4B	!six (6) month contract with CIPFA, Ltd.
2	!78	!EPI/CDD/MALARIA cost study (CCCO collaboratio!	! 500	!xxxxxx!	!!	!	!xxxxxx!	xxxxxx!	!	!	!	!	!4C	!
3	!79	!Investigate and implement if appropriate !alternative financing methods for !generating extra-budgetary income. Implet. !a study, using study findings as appropriate !and ultimately development of a plan for !institutionalizing the alternative strategies!	! 23,500	!	!	!!	!	!xxxxxx!	xxxxxx!	!	!	!	!4C	!three (3) month consultant + DK's time
4	!80	!Financial Mgmt. and budget training	! 23,140	!	!	!!	!	!xxxxxx!	xxxxxx!	!	!	!	!4C	!
5	!81	!DK's participation on plan/budget committee	! 8,000	x	x!	x!	x!	x!	x!	x!	x!	x!	!	!requested by Under Secretary

314,740

END MANAGEMENT ORIENTED PROJECT ACTIVITIES

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OTHER MISCELLANEOUS PROJECT ACTIVITIES

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PUBLIC HEALTH GENERAL

This section deals with miscellaneous areas of needed support within the MOH.

Focus and priorities at this time are:

(3) Provide financial support to the 1989 AGM

- (1) Provide limited financial support for the PHC Review sponsored by the WHO. Little staff time is envisioned.
- (2) Financially support the MOH's 1989 annual report;

ACT! NO.!	!	PUBLIC HEALTH GENERAL	!funds !(E)	! 1989 ! QRT.2	! 1989 ! QRT.3	! 1989 ! QRT.4	!! 1990 !! QRT.1	! 1990 ! QRT.2	! 1990 ! QRT.3	! 1990 ! QRT.4	! 1991 ! QRT.1	! 1991 ! QRT.2	!USAID !INDIC	EXPLANATORY NOTES
!	!	PUBLIC HEALTH GENERAL	!	!	!	!!	!	!	!	!	!	!	!	
1	!82	!PHC Review	!	2,000	!	!	!!	!	x x x	!	!	!	!	
2	!83	!print Pub.Wlth.annual rpt	!	4,380	!	!	!!	!	x x x	!	!	!	!	!money only
3	!84	!AGM meeting - 1989 only	!	3,000	!	x x x	!!	!	!	!	!	!	!	!clinic nurses
				9,380										

78 GENERAL PROJECT ADMINISTRATION

General project administration includes all financial management, representation, administrative support and other support activities necessary to keep the Project functioning and following necessary USAID regulations, MSH Boston accounting requirements. Funds allocated to this area include monies for salaries and wages, Project expenses which are not easily allocated to individual Project

activities such as photocopying. In addition, this area includes funds for Project transportation either for support staff or for direct Project activities which are difficult to allocate directly to an individual Project activity identified above.

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END OTHER MISCELLANEOUS PROJECT ACTIVITIES

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FUNDS AVAILABLE UNDER DREW UNIVERSITY SUBCONTRACT

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ACT NO.:	DREW UNIVERSITY-SUPPORTED ACTIVITIES	1989 QRT.2	1989 QRT.3	1989 QRT.4	1990 QRT.1	1990 QRT.2	1990 QRT.3	1990 QRT.4	1991 QRT.1	1991 QRT.2	EXPLANATORY NOTES
1	Nigeria health education training	XX									!2 people-1989, 2 people-1990
2	U.S. training (statistics, hlth education)	XX									!2 people to extent until June, 1991
3	consultant-lab quality control			XXXXXX!							!four (4) weeks
4	consultant-lab mgmt information system			XXXXXX!							!two (2) weeks
5	consultant-lab inventory system			XXXXXX!							!one (1) week
6	consultant-lab standards and protocols			XXXXXX!							!two (2) weeks
7	consultant-health education (TB,hypertension)			XXXXXX!XXXXXX!							!four (4) months
8	consultant-training needs assessment					XXXXXX!					!one (1) month
9	lab trainees - Lesotho	XXXXXXXXXXXXXXXXXXXX!									!returning for one yr intership end 1989
10	4 months short term 3rd country training										!timing of the training to be determined during the course of 1989-90

Funds under the DREW subcontract include miscellaneous consultants as identifies above as well as support to the Clinic Management Associate. The consultant activities above are individually identified under the appropriate work plan programme area but listed here separately for the purpose of clarity. Each activity will cost a given amount of Project funds depending on the nature and duration of the activity. The activities listed here are, of course, open for review and comment and can be changed if necessary.

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PROGRAMMATIC AREA	***** CLINIC BASED ACTIVITIES *****						***** MANAGEMENT ACTIVITIES *****					***** OTHER *****		***** SUMMARY *****			
	RHM	NAT. MLTH. FAM. PLNG.	HEALTH EDUCATION	GROWTH MONITORING	CLINIC MANAGEMENT	CLINIC LAB	CLINIC TRAINING	TRANSPORT	DECENT & PLNG/BUGG	COMMUNIC	MIS	FIN MGMT. HC FIN	PUB MLTH. GENERAL	PHCP OFFICE	EMALANGENI TOTAL	U.S. \$ TOTAL	CONTRACT BUDGET (E)
FIELD STAFF PROF. SHORT TERM																	
THIRD COUNTRY NATIONALS																	
CONSULTANTS																	
LOCAL		4,000	1,000	2,000	6,272	14,000	4,000	7,000	28,000	8,000				74,272	33,760	74,272	
INTERNATIONAL		8,099						25,000	7,000	13,000				53,099	24,136	53,099	
TRAVEL AND TRANSPORTATION PER DIEM																	
local consultants		2,500			1,000	1,155		1,170	3,010					8,835	4,016	8,835	
L.T. staff outside M													70,017	70,017	31,876	70,017	
research staff outsi		2,000			1,050			780						3,830	1,741	3,830	
OTHER DIRECT COSTS																	
TEL/TELEX														36,582	16,628	36,582	
REPRODUCTION/PRINTING		8,000	2,000	5,620	5,000	6,500		20,000	14,000	8,000		3,380	20,120	92,620	42,100	92,620	
POSTAGE														17,184	7,811	17,184	
OFFICE SUPPLIES														34,368	15,622	34,368	
VEHICLE MAINTENANCE														35,004	15,911	35,004	
COMPUTER SUPPLIES									4,396					10,540	4,789	14,936	
OUTSIDE SERVICES		8,000	1,000	6,000	6,000	6,000	2,000	11,500			2,000	3,000	23,580	69,080	31,400	69,080	
MISC. EXPENSES														29,460	13,391	29,460	
EQUIPMENT/COMMODITIES																	
OFFICE EQUIPMENT								4,280						65,000	71,280	32,400	71,280
LAB EQUIPMENT						232,826								232,826	105,830	232,826	
MEDICAL SUPPLIES		37,400												37,400	17,000	37,400	
COMPUTER/MIS									20,900					20,900	9,500	20,900	
OUTREACH SITES				5,000				50,000						55,000	25,000	55,000	
COMMUNICATIONS EQUIPMENT									99,000					99,000	45,000	99,000	
NURSES HOUSING					44,000									44,000	20,000	44,000	
EDUCATIONAL MATERIALS		7,000	2,400			6,000								15,400	7,000	15,400	
PARTICIPANT TRAINING																	
IN-COUNTRY	15,000	14,200	3,680	2,080	17,960	136,800	3,000	40,000	2,280	30,000	26,140	3,000		294,140	133,700	294,140	
3-RD COUNTRY																	
CONTRACTS																	
FINANCE											259,600			259,600	118,000	259,600	
HEALTH EDUCATION			3,300											3,300	1,500	3,300	
TRANSPORT								37,400						37,400	17,000	37,400	
COMMUNICATIONS									20,999					20,999	9,545	20,999	
TOTAL	15,000	91,199	13,380	20,700	81,282	232,826	170,455	46,400	161,730	122,279	107,306	57,140	9,380	341,855	1,730,532	786,606	1,730,532

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PHC PROJECT CONTRACT BUDGET: MAY 26, 1989  
 exchange rate used: 2.20 /

1.00 USD

PROGRAMMATIC AREA	TOTAL USD	TOTAL EMALENGANI
FIELD STAFF SHORT TERM FROM BOS:		
THIRD COUNTRY NATIONALS	75,093	165,205
CONSULTANTS		
LOCAL	33,760	74,272
U.S. SHORT TERM	24,136	53,099
TRAVEL AND TRANSPORTATION		
PER DIEM		
LOCAL CONSULTANTS	4,016	8,835
L.T. STAFF OUTSIDE MB	31,826	70,017
RESEARCH STAFF OUTSID	1,741	3,830
OTHER DIRECT COSTS		
TEL/TELEX	16,628	36,582
REPRODUCTION	42,100	92,620
POSTAGE	7,811	17,184
OFFICE SUPPLIES	15,622	34,368
VEHICLE MAINTENANCE	15,911	35,004
COMPUTER SUPPLIES	6,789	14,936
OUTSIDE SERVICES	31,400	69,080
MISCELLANEOUS EXPENSES	13,391	29,460
EQUIPMENT/COMMODITIES		
OFFICE EQUIPMENT	32,400	71,280
LAB EQUIPMENT	105,830	232,826
MEDICAL SUPPLIES	17,000	37,400
COMPUTER/HIS	9,500	20,900
OUTREACH SITES	25,000	55,000
COMMUNICATIONS EQUIPMENT	45,000	99,000
NURSE HOME FURNISHINGS	20,000	44,000
EDUCATIONAL MATERIALS	7,000	15,400
PARTICIPANT TRAINING		
IN-COUNTRY	133,700	294,140
3-RD COUNTRY		
CONTRACTS		
FINANCE	118,000	259,600
HEALTH EDUCATION	1,500	3,300
TRANSPORT	17,000	37,400
COMMUNICATIONS	9,545	20,999
<b>TOTAL</b>	<b>861,699</b>	<b>1,895,737</b>

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