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Revised Proposal (February 1981)

AFR/PO/SAP  
(Southern Africa)

OPERATIONAL PROGRAM GRANT PROPOSAL

Country: Swaziland

Project Title: Strengthening the Planning and Management Capabilities of the Ministry of Health

National Executing Agency: Ministry of Health

International Executing Agency: International Human Assistance Programs, Incorporated  
360 Park Avenue South  
New York, New York 10010

Duration of Project: Three Years

Starting Date of Project: April 1981

Date of Submission to USAID:

Total OPG Request: \$1,050,040

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## I. PROJECT SUMMARY

This document presents a proposal by International Human Assistance Programs, Inc. (IHAP), to expand the capability within the Ministry of Health in the areas of planning, management, and policy development related to the provision of health care services in Swaziland. The project will provide long-term technical assistance to improve and institutionalize the functional operation and related organizational structure of the Ministry, and to develop a comprehensive long-range plan incorporating manpower, facilities, services, and financial and other resources. Academic training will be provided for three members of the Headquarters staff so that they will be able to function effectively in their specialized areas of planning and management. Thus by the end of the project in March 1984 the expanded capability will be institutionalized through the provision of established posts, academic training, and on-the-job experience for the three Swazi nationals.

The Ministry of Health is currently at a critical point in its development in view of several key issues and corresponding needs:

- The need to develop a strategy to decentralize many planning and management responsibilities to the district level, in accordance with Ministry policy
- The need to develop a strategy for the integration of curative and preventive health care services, in accordance with Ministry policy
- The need to strengthen the Rural Health Visitor program as a major thrust in expanding and improving rural health services
- The need for increased coordination and cooperation between the Government of Swaziland and the non-Government health care providers

The need for a unification of the fee structure for health services, in order to make the delivery system equitable for all Swazis

The need to strengthen the systems for the provision of drugs and medical supplies, to insure an adequate supply at the time and place of need.

A major problem is the very limited Headquarters staff who have to cope with the operation of the Ministry, and who often don't have sufficient time to deal with the longer-range needs. The Ministry established a Health Planning Unit in 1976, and this first important step has been followed by others to expand the planning capability of the MOH. This project will augment these efforts by providing two long-term technicians to work in the fields of health planning, manpower development, and program development. In turn, the project will insure that Swazi nationals trained in these areas will be able to provide continuity in the future.

In order to provide necessary information with which to prepare the long-range plan, both a manpower assessment and a health facility survey will be completed and incorporated into the plan and other related project activities. The capacity of the health information and statistics unit will be expanded to meet increased planning and evaluation requirements. In anticipation of an increased scope of the national nutrition program, the capability will be provided to coordinate the health-related components of the expanded program. Also, in accordance with GOS requirements, the health sector component of the Fourth 5-Year Development Plan will be prepared.

In order to deal effectively with several major issues and policy decisions, strategies will be developed, and in some cases initiated, in the following areas: To increase co-

ordination and integration of Government and non-Government health service providers; to encourage stronger ties between traditional and Western medicine; and to overcome difficulties in areas of job performance and job satisfaction.

In the area of general manpower development, seminars and workshops concerning MOH policies and programs will be developed and presented at national, district, and local levels during the project. These participatory programs will respond to the needs identified by health workers in the field -- particularly at district and local levels -- to improve their skills, understanding, and involvement within the context of their jobs and the needs of the rural people whom they serve.

In summary, USAID, the Government of Swaziland, and IHAP and other donors will provide the following inputs to achieve the desired project outcomes:

USAID	\$1,050,040
Government of Swaziland	535,730
IHAP and other donors	<u>78,320</u>
TOTAL	\$1,664,090

The project design has conformed to the normal maximum project period of three years for an operational program grant. However, in an institution-building project such as this, a longer time frame is definitely desirable, and may be necessary to insure effective and timely follow-through on the implementation of programs and activities which have only been developed during the initial three-year period. Therefore, at the time this proposal is submitted, IHAP is proposing that a Phase 2 be anticipated, to follow immediately on the completion of this first phase as an extension thereof.

This idea is discussed more fully in Section III, but should be kept in mind as the proposal is reviewed.

## II. PROJECT BACKGROUND AND RATIONALE

### A. Introduction

#### 1. IHAP's role in Swaziland

International Human Assistance Programs, Inc. (IHAP), is submitting this proposal for an operational program grant to carry out a three-year project in the Kingdom of Swaziland aimed at strengthening the planning, management, and policy development capabilities of the Ministry of Health. In April 1980, Dr. J.M. Lopez, MD, MPH, Director of IHAP's Program Department, was requested to visit Swaziland to discuss IHAP's interest and potential involvement in designing and implementing a development project in the health sector. During this initial visit, officials of the Ministry of Health identified a number of priority areas suitable for a potential project. Of these, it was mutually agreed among the MOH, USAID, and IHAP that one of the key areas was to improve the planning and management capabilities of the Ministry, and that IHAP would develop a proposal to carry out such a project.

In August 1980, IHAP brought to Swaziland a three-person design team comprised of Dr. Lopez as Chief of Party, a Nurse Administrator, and a Health Planning and Management Specialist. As the final product of the eight-week design team mission, IHAP is submitting this proposal for the consideration and approval of both the Government of Swaziland and the U.S. Agency for International Development.

In view of the importance of this project to the Ministry of Health and the people of Swaziland in expanding and improving the delivery of health care services, IHAP looks forward to the opportunity to return to Swaziland by April

1981 in order to implement the project with a carefully selected team of qualified long-term technicians.

## 2. IHAP's role in development projects in other countries

IHAP has a long and successful history of carrying out a broad range of development-oriented projects in Asia, the Pacific, and Africa. Projects include such diverse areas as social welfare, community development, women's leadership, integrated rural development, health facilities and services, and primary health care delivery.

IHAP has project in various stages of implementation in the following countries: The Philippines (19), Korea (12), Thailand (4), Nepal (2) and one project each in Sri Lanka, the Maldives, the Solomon Islands, and Djibouti. In addition, potential projects are in various stages of development in several other African countries, concentrating on both health care delivery and integrated rural development.

On the basis of this extensive experience, IHAP has demonstrated its ability to carry out projects effectively in a variety of settings and fields of endeavor. In every case, the project is specifically tailored to suit the social and cultural traditions of the host country, and is implemented by project technicians who are aware of and sensitive to the need to live and work within the context of the local environment. IHAP looks forward to performing this health planning/management project in Swaziland according to the same parameters.

### B. The Health Care Environment

This section provides a profile of the current health situation in Swaziland. Information is presented on population,

several health-related indicators, and on the major aspects of the health care delivery system.

1. Population characteristics

According to the 1976 Census Swaziland's de facto population numbers 494,534, a figure which represents a growth rate over the 1966 Census total population figure of 32 per cent. The population of the four districts is more or less evenly divided, as follows: Hhohho, 133,493; Manzini, 139,538; Shiselweni, 117,172; and Lubombo, 104,331.

While the 1976 Census shows a high growth rate in urban areas, urban population still accounts for only 15.2 per cent of the total population. The remaining nearly 85 per cent live in the rural sector, either on Swazi Nation Land or on individual tenure farm land. A significant characteristic of the rural population is that it is scattered. Rural inhabitants do not live in villages, but rather in more widely scattered homesteads. A widely scattered rural population has important implications for all rural development programs, and particularly those aimed at improving health care delivery systems. The planning of health services must concentrate on providing improved health services to the rural areas where the majority of the population reside.

A second population feature having major implications for planning health care delivery systems in Swaziland's population distribution. The 1976 Census reveals that approximately 19 per cent of the population is under 5 years old, and approximately 48 per cent of the population is under the age of 15. Additionally, although between 1966 and 1976 the infant mortality rate (in the first year of life) dropped from 168 to 156 per thousand live births, there is

still room for improvement. (12)\* Clearly the planning of health care delivery must concentrate in large measure on providing health services for mothers and infants, and the young, and, as the percentage of the young population increases, must take into account the fact that young people require greater amounts of medical attention.

Between the 1966 and 1976 Censuses the crude death rate-- the annual number of deaths per thousand -- declined from 20.5 to 18.9. In addition, the expectancy of life at birth rose from 44 years in 1966 to 46.5 in 1976. These rates are comparable to those of other Southern African countries, but do not compare well with the crude death rates and life expectancy figures of other developing countries with per capita GNP's of about the same level as Swaziland.

As estimated in the 1976 Census the present total fertility rate is approximately 6.87. Although the rate is slightly lower than the 1966 rate of 7.0, it is still a very high one. The crude rate of per annum population increase indicated by the 1976 Census is 3.36 per cent, one of the highest in the world. The UN Demographic Yearbook lists only eight other countries or areas with higher rates, and the rate is considerably higher than those of neighboring countries such as Botswana (2.26%); Lesotho (2.22%) and Malawi (2.40%). Projecting these figures in more graphic terms, a continuing annual growth rate of 3.36 per cent means that Swaziland's population can be expected to double each generation, or every 21 years. This projection has clear implications for Swaziland's economy and for the overall standard of living of most Swazis. If the economy cannot grow at a rate comparable to

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\*Numbers shown in this fashion indicate references to material in the list of references, Annex B.

or slightly higher than the rate of population increase, the standard of living will decline. There will be less food, clothing, and housing for everyone, as well as reduced access to employment, education and, health care. (12)

The planning of health care delivery systems must take into account that the continued high population growth rate will place increasingly heavy demands on health services. Furthermore, health planning must be aimed at improving health services over all population groups so as to create a situation where substantial moderation in the rate of population growth can be achieved. (28; p.218)

## 2. Health-related indicators

Although there are no reliable data on Swaziland's health status, there are a number of major health and health-related problems which can be identified. These include a low resistance to communicable diseases among mothers and children, possibly aggravated by subclinical malnutrition, high fertility rates, and short birth intervals; a high incidence of childhood diseases such as TB, measles, and whooping cough which could be prevented by immunization; and diseases related to water quality and environmental sanitation. (20)

Swaziland's per capita GNP (\$550 in 1977) ranks it as a lower middle income country, but the health status of its population is well below that of countries in the same income category. Considering the Physical Quality of Life Index (PQLI), Swaziland with an index of 36 is well below the average index of 59 for countries in the same income range, and they are primarily health factors which determine its low index. In Swaziland life expectancy is approximately 5 years below the average of other lower middle income countries, and its infant mortality rate is about 50 per cent higher than

the average rate of countries with similar income levels. Nutritionally, Swaziland is approximately 5 per cent below its expected index. However, because there is very little nutritional data on Swaziland available, this figure cannot be considered significant. Clearly, more information on Swaziland's overall nutritional status is required, as it may be related to other health factors. The National Nutrition Council is currently considering implementing programs to obtain more accurate nutritional data, i.e., a national nutrition survey and a nutrition surveillance program.

According to the 1976 Census survey, 33 per cent of Swaziland's population have access to tap water, and 37 per cent have access to toilet facilities. However, these percentages represent an average over all districts with the predominantly rural districts and areas lagging well behind in these facilities. On the other hand, whereas the overall average of homesteads with only temporary housing materials for walls was 40 per cent, the highest figure (51 per cent) was found in Hhohho district, probably reflecting the large squatter population around Mbabane. (23, p. 14) Such factors as safe water supply and adequate sanitation and housing have important implications for health and for health planning.

### 3. The health care delivery system

The Swaziland health care delivery system will be summarized under five headings: (a) Infrastructure and organization, (b) utilization and distribution of health care services, (c) health manpower and training programs, (d) health sector financing, and (e) health sector priorities in the Third National Development Plan.

Infrastructure and organization. Health services in

Swaziland are provided by a variety of organizations and individuals, and can be characterized in five groups:

- Government
- Missions and other non-profit voluntary agencies
- Industry
- Private allopathic practitioners
- Traditional practitioners.

The GOS recognizes, and in varying degrees, supports, all non-Government health services, but with the exception of the mission-sponsored group, there has been little coordination with MOH plans and programs. GOS health services today are based on the old colonial model which emphasizes curative services and tends to be administratively quite centralized. Government health facilities include 4 general hospital, 2 specialty hospitals (TB and mental disorders), 34 rural health facilities (health centers and rural clinics), and 7 urban-based public health units. In addition, the MOH operates a central public health and TB laboratory. (26, 29)

Mission and other non-profit facilities provide the second largest percentage of both curative and preventive services, through two general hospitals and 29 clinics. The major mission groups are partially supported by Government subsidies.

Industries are also significant providers of organized health services. Five major industries provide physician and medical services for approximately 69,000 people, while other companies provide some health services for their employees. Among the industries there is one general hospital and 21 outpatient facilities.

Private allopathic practitioners are comprised of approximately 20 physicians and 18 nurses. Many of these have

located their offices and clinics in the populous Mbabane-Manzini corridor, and therefore have minimal impact on rural health services.

Traditional practitioners are numerous in Swaziland, but little information exists on their numbers and practices. Surveys have shown that the majority of rural Swazis consult traditional practitioners, and they represent a major untapped resource in terms of linkages with the rural people and their health problems.

The mission of the Ministry of Health includes setting Government health policy, coordinating health-related activities within the country, and providing direct health services. On the basis of information provided elsewhere in this document, it is clear that improvements to be made in the first two areas will be a major thrust of this project, including both the infrastructure and organization. In subsection C of this section several examples of issues in these areas requiring considerable effort to resolve are given.

The organizational structure of the Ministry of Health is shown in Figure 1, as provided by the MOH. At present the system is highly centralized, which is partly a function of the size of the country. Many of the public health programs remain centrally controlled, but the administration of the district hospitals and their satellite clinics is the direct responsibility of the Senior Medical Officer of the hospital. (26)

#### Utilization and distribution of health care services.

Utilization of health care services is shown generally in Figure 2. The figure indicates that there were 33,088 hospital discharges during 1979; ambulatory services are also

**FIGURE 1: ORGANIZATIONAL STRUCTURE OF THE MINISTRY OF HEALTH  
(AUGUST 1980)**

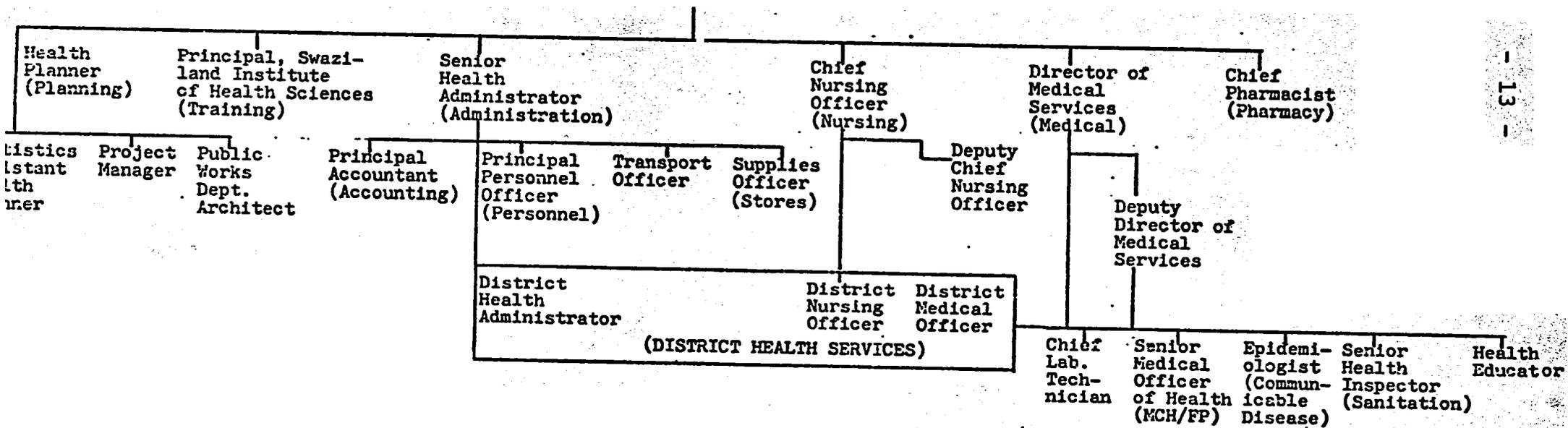


FIGURE 2

SUMMARY OF SELECTED HEALTH SERVICE STATISTICS FOR 1979

(Source: "Swaziland -- Health Situation and Planning",  
Ministry of Health, Government of Swaziland.)

Hospital Discharges: 33,088

<u>Ambulatory Services</u>	<u>First Attendances</u>	<u>Reattendances</u>	<u>Total</u>
General outpatient	173,201	103,531	76,732
Antenatal	20,340	50,401	70,741
Child welfare (pre-school)	28,061	154,236	82,297
Family planning	4,854*	16,034	20,888

\*New acceptors

shown in the categories of general outpatient services, antenatal services, child welfare services, and family planning services.

The present Government and mission health facilities are reasonably well distributed throughout the rural areas, but many lack adequate staffing and are limited in services and equipment. Hospitals are located in each of the four districts, but about 60 per cent of all general hospital beds are located in the Mbabane-Manzini corridor, creating an inequitable distribution in the rural areas. Figure 3 indicates general hospital beds by district and sponsorship.

In addition to inpatient beds available in hospitals, there are approximately 250 additional beds located in non-hospital facilities, as shown in Figure 4. Of these, 91 are maternity beds, and are generally located in health centers, rural clinics, and private clinics.

Outpatient services are provided at a wide range of facilities, ranging from hospitals to rural clinics to private clinics. Figure 5 shows the distribution of outpatient facilities by district and sponsorship. The clinic construction program of the MOH is intended to bring health services closer to the rural people, and has a target of 75 per cent of the population living within 8 kilometers of basic health services by 1983. (At present the figure is 69 per cent.)

Health manpower and training programs. Trained health manpower in Swaziland is at a premium, especially for certain categories, as shown by Figure 6. The figure lists the numbers of health professionals by major category and by sponsorship, as well as indicating posts filled by locals and by expatriates. For the Government posts, where the number of established positions are also shown, it can be

FIGURE 3

GENERAL HOSPITAL INPATIENT BEDS BY DISTRICT AND SPONSORSHIP

(Source: "The Swaziland National Health Inventory: The Design and Implementation of an Inventory System", Wilson, M.C.)

Note: This table does not include the two Government specialty hospitals in Manzini District (200 - bed mental hospital and 100-bed TB hospital).

<u>District</u>	<u>Sponsorship</u>	<u>Number of Hospitals</u>	<u>Number of Beds</u>		<u>Total</u>
			<u>Maternity</u>	<u>Other</u>	
Hhohho	Government	2	35	320	355
	Mission	--	--	--	--
	Industry	1	--	70	70
	Totals	3	35	390	425
Manzini	Government	1	8	31	39
	Mission	1	40	273	313
	Industry	--	--	--	--
	Totals	2	48	304	352
Shiselweni	Government	1	20	180	200
	Mission	--	--	--	--
	Industry	--	--	--	--
	Totals	1	20	180	200
Lubombo	Government	--	--	--	--
	Mission	1	13	87	100
	Industry	--	--	--	--
	Totals	1	13	87	100
<u>All Districts</u>	Government	4	63	531	594
	Mission	2	53	360	413
	Industry	1	--	70	70
	Totals	7	116	961	1,077

FIGURE 4

NON-HOSPITAL INPATIENT BEDS BY DISTRICT AND SPONSORSHIP

(Source: "The Swaziland National Health Inventory: The Design and Implementation of an Inventory System", Wilson, M. C.)

<u>District</u>	<u>Sponsorship</u>	<u>Number of Facilities</u>	<u>Number of Beds</u>		<u>Total</u>
			<u>Maternity</u>	<u>Other</u>	
Hhohho	Government	--	--	--	--
	Mission	8	28	34	62
	Industry	1	--	14	14
	Private	3	4	25	29
	Total	12	32	73	105
Manzini	Government	2	4	16	20
	Mission	6	19	--	19
	Industry	1	--	12	12
	Private	3	6	1	7
	Total	12	29	29	58
Shiselweni	Government	1	--	12	12
	Mission	2	3	5	8
	Industry	--	--	--	--
	Private	1	--	1	1
	Total	4	3	18	21
Lubombo	Government	2	7	--	7
	Mission	5	11	1	12
	Industry	4	2	37	39
	Private	1	7	--	7
	Total	12	27	38	65
<u>All Districts</u>	Government	5	11	28	39
	Mission	21	61	40	101
	Industry	6	2	63	65
	Private	8	17	27	44
	Total	40	91	158	249
		==	==	===	===

FIGURE 5

OUTPATIENT FACILITIES BY DISTRICT AND SPONSORSHIP

(Source: "The Swaziland National Health Inventory: The Design and Implementation of an Inventory System", Wilson, M. C.)

Note: This table includes general hospitals which provide outpatient services.

Number of Static Health Units

<u>District</u>	<u>Government</u>	<u>Mission</u>	<u>Industry</u>	<u>Private</u>	<u>Total</u>
Hhohho	9	9	4	12	34
Manzini	12	10	6	21	49
Shiselweni	15	4	--	2	21
Lubombo	<u>9</u>	<u>8</u>	<u>11</u>	<u>3</u>	<u>31</u>
<u>All Districts</u>	<u>45</u>	<u>31</u>	<u>21</u>	<u>38</u>	<u>135</u>

HEALTH MANPOWER BY CATEGORY AND SPONSORSHIP (JANUARY 1980)

	<u>Government</u>		<u>Mission/ Voluntary</u>		<u>Industry</u>		<u>Private</u>		<u>Total</u>			
	Posts 79/80	Local	Expat	Local	Expat	Local	Expat	Local	Expat	Local	Expat	Total
Doctors	25	8	14	--	8	1	10	5	12	14	44	58
Dentists	1	1	--	--	1	--	--	1	4	2	5	7
Pharmacists	3	2	1	--	1	--	--	--	6	2	8	10
Dispensers	15	15	--	--	1	--	--	--	--	15	1	16
Nurses	348	301	--	57	14	45	22	22	6	425	42	467
Lab. technicians	5	3	1	--	4	3	--	--	--	6	5	11
Lab. assistants	16	26	--	3	2	2	--	--	--	31	2	33
Radiographers	7	4	--	--	2	1	--	--	--	5	2	7
Physiotherapists	1	--	1	--	1	1	--	--	--	1	2	3
Occupational ther.	--	--	--	--	--	--	--	--	--	--	--	--
Health Inspectors	11	2	--	--	--	--	--	--	--	2	--	2
Health assistants	51	42	--	--	--	--	--	--	--	42	--	42
Nutritionist	1	1	--	--	--	--	--	--	--	1	--	1
Nursing Assistants	91	84	--	27	--	9	--	11	--	131	--	131

Note: It is assumed that the non-Government agencies are able to fill posts not taken by locals from expatriate sources.

(Source: "Swaziland -- Health Situation and Planning", Ministry of Health.)

FIGURE 6

seen that there is an overall "vacancy rate" of 11 per cent; that is, 510 of 575 posts were filled in January 1980.

The figure also shows what is already known: That the nurse/midwife is the backbone of the Swaziland health care delivery system. The grand total of the professional categories listed is 788, and nurses represent 467, or 59 per cent of the total. It is instructive to realize that within Government service the "vacancy rate" for nurses is 14 per cent. This means that one out of every seven nursing posts was vacant in January 1980.

A health manpower category not shown in the figure, but nonetheless important, is the Rural Health Visitor (RHV). With UNICEF funding assistance, the MOH is carrying out a program to train these individuals who are selected by their rural communities as health motivators/educators. People with little or no education are given eight weeks' training near their own locale, and then are sent back to cover 40 homesteads each. Currently about 360 have been trained; by 1983 the MOH hopes to have trained 800 RHV's. They are supposed to be supervised by clinic nurses, and receive E20 per month from the GOS as incentive pay for their part-time work. (20).

The MOH has recently produced a ten-year Manpower Development Plan which sets out the requirements of the health services for health care personnel during the decade 1979-1989. At present, shortages of trained personnel exist in a variety of fields within the Government sector, causing major constraints on service expansion. The ten-year manpower plan gives projections for long-term training requirements for the health sector based on estimates of post availability, existing local staff, and attrition.

In-country training of health care personnel is conducted at three centers. The Swaziland Institute of Health Sciences, which opened in January 1980, currently trains registered nurse/midwives, a one-year nursing specialization in diagnostics and public health, health inspectors, and health assistants and technicians, and dental auxiliaries.

The Raleigh Fitkin Hospital, a 300-bed mission hospital in Manzini, has in the past conducted training courses for nurse anaesthetists/dispensers and laboratory assistants, as well as ongoing courses for registered nurse/midwives and nursing assistants. The nurse/midwife course is continuing, but nursing assistant training has been suspended for the time being.

The Good Shepherd Hospital, a 100-bed mission hospital in Siteki (Lubombo District), also conducts nursing assistant training.

All other health professional training is obtained outside of Swaziland, since there is insufficient demand among the various categories to make local training reasonably cost-effective.

In addition to the long-term training courses described, some inservice and continuing education training programs are carried out. Until recently there has been insufficient emphasis on this important aspect of training. The MOH now feels that with its new Institute of Health Sciences, more emphasis can be placed on this aspect of training.

Health sector financing. In fiscal year 1979/80 the total Ministry of Health recurrent budget was E5,670,000, representing 8.3 per cent of GOS total recurrent budget. Al-

though in recent years its percentage share of GOS recurrent budget has fallen, per capita, the MOH recurrent budget has increased 15 per cent. The 1979/80 MOH budget can be broken down into major activity categories as follows:

<u>Activity Category</u>	<u>E000's</u>	<u>Percentage of Total MOH Budget</u>
Minister's Office	39	0.7
Ministry Administration	1,041	18.4
Medical Support Services	341	6.0
Preventive Medicines	941	16.6
Curative Medicines	3,308	58.3
Total	<u>5,670</u> =====	<u>100.0</u> =====

(20; p.52)

It is useful to compare certain 1979, ... expenditures to the same expenditure category in an earlier period. For example, in 1976/77 curative medicine consumed 66.7 per cent of the recurrent budget as compared to 58.3 per cent in 1979/80, and preventive medicine 12.2 as compared to 16.6 per cent in 1979/80. The increase in the percentage of budget devoted to preventive medicine reflects MOH objectives as defined in the Third Five-Year Development Plan to increase the proportion of resources allocated to preventive care. However, the percentage of recurrent budget allocated to preventive care is still low in comparison to the amount spent on curative care.

Unfortunately, the financial information generally available does not provide a clear picture of financing within

the entire health sector. Thus it is difficult to derive the total expenditure for health care services; at best this can only be estimated. However, this has recently been done for the fiscal year 1977/78, with the results shown in Figure 7. According to the estimate, the total health services expenditure of E7,287,000 represents a per capita expenditure of E14.00. Of this amount, an average of E 7.28 (52 per cent) is spent on services provided by Government.

Health sector priorities in the Third Five-Year Development Plan. The Third Five-Year Plan states that the primary objective of the health sector is to improve the quality of life for the Swazi people by raising their standards of health. To achieve this goal the Plan sets forth four priorities:

- "1. To increase the proportion of resources devoted to preventive services to allow special emphasis on the protection of certain vulnerable groups -- mothers and children under five -- and to reduce the incidence of water-borne diseases, especially bilharzia, and diseases of insanitation.
2. To maintain the present ratio of hospital beds to population, to improve the standards and efficiency of curative services, to integrate curative services with preventive services, and to achieve an equitable geographic distribution of services
3. To expand health education programmes with emphasis on nutrition
4. To create a situation in which a substantial moderation in the rate of population growth can be achieved and in which family spacing is practised for the benefit of the family."

(28; p.218)

Inasmuch as the Third Five-Year Plan is now at its midpoint, these objectives are relevant to the planning/management project.

FIGURE 7

ESTIMATED TOTAL HEALTH SERVICES EXPENDITURE, 1977/78

(Source: "Swaziland -- Health Situation and Planning",  
Ministry of Health, Government of Swaziland.)

	<u>Amount</u>	<u>Percent</u>
Ministry of Health recurrent budget	E 3,766,000	
Other Government departments <sup>1</sup>	21,000	
Total Government sector	E 3,787,000	52.0%
Mission sector <sup>2</sup>	800,000	11.0%
Industrial sector	700,000	9.6%
Private sector <sup>3</sup> &	2,000,000	27.4%
Total	<u>E 7,287,000</u> =====	<u>100.0%</u> =====

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<sup>1</sup>Excludes Town Councils sanitary departments, Ministry of Agriculture nutrition program, and Ministry of Works building maintenance.

<sup>2</sup>Excludes Red Cross and Save the Children Fund.

<sup>3</sup>Including private doctors, nurses, and pharmacists.

<sup>4</sup>Excluding traditional sector.

4. Current health issues requiring major planning/management/policy involvement

At the present time, the Ministry of Health in Swaziland is dealing with a number of issues which must be resolved soon in order that the expansion of health care services can be carried out effectively. As with many difficult and complex issues, these are closely interrelated, and almost without exception the resolution of one will have significant effects on the others. The fact that several of these issues were raised by health workers at both district and local levels indicates that their effective and timely resolution is perceived as important throughout the health care system. Each of the issues will be considered briefly in the following paragraphs.

Decentralization strategy. As a consequence of the approved Ministry policy to decentralize many planning and management responsibilities to the district level, a strategy must be developed and implemented to carry out the decentralization effectively. This includes such factors as district-level organization, responsibilities, manpower, and budget; and of course the organizational relationship both with Ministry Headquarters and within the district.

Integration of curative and preventive services. This is another case in which a strategy must be developed to implement a policy. There is a link with the decentralization policy and strategy, and in addition there are implications for the facilities, staffing, and budgetary aspects of the now separate operations.

Strengthening of the Rural Health Visitor (RHV) program. The RHV program is felt by many to be one of the most critical elements of the Ministry's efforts to deliver more and better health care services to the rural people. How-

ever, the program needs strengthening, especially with respect to the need for a strong working relationship between the rural clinic staff and the RHV's, and the need for increased involvement of the communities being served. In addition, the increasing problem (with increasing numbers of RHV's) of financing RHV salaries must be resolved in an equitable way, so that the necessary expansion of the RHV program is not threatened.

Increased coordination between Government and non-Government health services.

This issue is related to all of the others, with varying degrees of importance. In terms of a decentralization strategy, the Ministry must face the fact squarely that in two of the four districts the "district hospitals" will likely be non-Government hospitals. Similarly, there is a need for careful consideration of how the service integration policy will be carried out, and how the RHV program can be expanded to include non-Government health facilities.

Unification of the fee structure for health service regardless of source of care. Both Government and mission officials are seriously concerned about the existing fee differentials between the two groups, for virtually all types of health care services. In the interest both of equity for the patient and of the continued financial viability of the mission institutions, this issue must be resolved as soon as possible.

Strengthening systems for the provision of drugs and medical supplies. In view of the concern over the current status of the central medical stores (as stated in the Hopwood Report (21) and other sources), the situation must be stabilized. In addition, consideration should be given to the implications of decentralization on the drug and medical supply systems from the standpoints of cost, availability, and other relevant factors.

### C. Project Rationale

The discussion thus far has provided a general overview of the health situation in Swaziland, and an indication of the resources currently employed in the health sector. At this point it is useful to summarize the rationale for the project by reviewing the design process and the resulting project focus.

#### 1. The project design process

During the early stages of the design process, the design team studied the health care delivery system, and its strengths and weaknesses, in considerable detail. Through field visits the team obtained a first-hand impression of how the system operates, both by seeing health facilities in operation and by discussing the accomplishments and problems of the health care workers. In addition, a series of meetings with key officials of the Ministry of Health, other ministries and Government departments, and representatives of non-Government agencies and organizations, provided an additional perspective on the strengths and weaknesses of the present health care delivery system.\* By reviewing a large number of reports and other documents, the design team expanded its understanding of the needs which this project could meet.\*\*

In an effort to insure that the project will meet the most urgent needs as perceived by the Government, two important steps were introduced in the design process. First, during the third week of the project design mission, a Project Summary was prepared in working draft form, in order to describe the principal features of the proposed project in the

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\*A list of institutions visited and persons interviewed is presented in Annex A.

\*\*A list of the more important documents reviewed and utilized in the project design is included in Annex B.

early stages, and to encourage feedback from Government and USAID representatives. On the basis of the resulting discussions, agreement in principle was reached concerning the purpose and general scope of the project. Once this was accomplished, the design effort began to deal with this more detailed proposal.

The second important step was to convene a series of group sessions in order to involve key individuals in what might be called a "functional analysis" of the principal activities of the Ministry of Health. The group included representatives from the Department of Economic Planning, the Department of Establishments and Training, the Ministry of Health, and USAID. The outputs of these useful and often lively sessions include the following tabulations and analyses: (1) Scope of health services provided by the Ministry of Health, (2) sources of personal health services, and (3) functions of the Ministry of Health, including an analysis of who does (or should do) each function, whether or not improvement is needed, and if so, what is the level of priority. The results of these group sessions are presented in Annex C, including a list of participants who attended one or both sessions. The group sessions were very helpful in that Ministry of Health and other Government officials helped to identify important gaps and constraints within the present system, and at the same time helped to formulate major project outputs and activities which are necessary to achieve the project objectives.

## 2. Project approach

During the meetings and discussions with Government officials and others concerned with the project development, it was mutually agreed that the project focus should be to expand the planning, management, and policy development capabilities of the Ministry of Health, and to institutionalize these

capabilities so that Swazis will provide leadership and continuity in the future. This project focus was chosen in order to overcome a major limitation within the Ministry. That is, without this project, the ability of the Ministry of Health to plan effectively, to keep pace with the need for expanded health care services, and to support other planned projects and programs, would be restricted to the point of jeopardizing the potential investments in the health care system. Furthermore, it is important to institutionalize the expanded planning/management capability to insure that future efforts to improve the health status of the Swazi people will be adequately supported. Thus, both of the long-term project technicians will have counterparts who will complete long-term training during the project life; and their training will be completed in time to allow at least six months on the job before the project technicians leave.

Therefore, it has been agreed that the most logical approach for this project is to capitalize on the strengths of the ongoing system, and to fill the gaps which currently exist. This type of incremental approach has the advantage of building on the present infrastructure and of not disrupting the system in non-productive ways. Thus, major emphasis will be on institution-building, both in developing the initial strategies and plans to be followed, and in assisting the Swazi nationals to take over the planning/management functions by the end of the project life.

### 3. Interaction with other USAID efforts in the health sector

One USAID project currently being implemented is the Swaziland Health Manpower Development Project, which has been in operation for slightly more than two years of its five-year project period. The project assists the Government of Swaziland to meet its long-term goal of improving the

health of the rural population through expanded and improved health services in rural areas. The project is intended to contribute to this goal through (1) the establishment and institutionalization of training for health personnel to staff rural facilities, and (2) through strengthening of planning and administration for expanded health services. In the latter area the project provides technical assistance in rural health and hospital administration, and participant training for Swazi health administrators. A Health Statistician is also provided through OPEX to assist the MOH to improve data collection for planning purposes.

An interim evaluation of the Health Manpower Development Project (HMDP) was performed in September 1979. The report of this evaluation includes a number of points having direct relevance to the planning/management project being proposed; these points are summarized in the paragraphs which follow. (17)

On the whole, the nursing component of the project was making satisfactory and timely progress. However, the evaluation report states that progress on the administrative component of the project has been much slower. The hospital administrator and the rural health administrator are both located in a rural district. Their work in improving administrative services in their respective areas has been hampered by lack of definition by the MOH on the model or system desired and the strategy to achieve it. Central MOH staff are severely hampered by lack of appropriate senior positions/personnel, poor quality of financial administration, and lack of time and manpower for planning.

One of the conclusions reached by the evaluation report is that the Ministry of Health of the GOS lacks an adequate

central staff to administer and manage a national health program. Therefore, the capacity to effectively plan and manage the project is weak, and the critical components of policy, procedures, staff, positions, leadership, budget, and other resources needed to make meaningful, self-sustaining, long-term improvements in health administration are not in place.

In fairness to both the Health Manpower Development Project and the Ministry of Health, a number of improvements have been made in the administrative component of the project during the last year. On the other hand, many of the underlying problems and weaknesses are precisely those which the proposed planning/management project can resolve. Also, because of the obvious close linkages between the two projects, they will be mutually supportive. Therefore, the successful implementation of the planning/management project will have a major impact in helping to insure a satisfactory outcome of the administrative component of the HMDP.

As a result of the parallel interests of the two projects in planning and administration, opportunities for coordination are plentiful. Many of these opportunities will need to be explored in depth once the IHAP project is underway, and should be developed along mutually agreeable lines. However, one opportunity offering advantages to both projects is the use of Shiselweni District as the pilot district for the development and implementation of many of the IHAP project's plans and strategies. Expansion of services in Shiselweni District is already a Government priority, since among the districts Shiselweni is relatively underserved, and is most in need of improved and expanded services. By linking the two projects in this fashion each will contribute to the other, and the planning/management capabilities in the district will be improved in a major way.

One implication of this approach should be acknowledged and taken into account. There is a great tendency in a "pilot project" situation for an overconcentration of resources in relation to the resources which will be available under normal circumstances. The resulting project development and implementation is therefore easier, and misleading. So long as this is understood, the project development and implementation can be assessed in realistic terms, and allowances made in the normal situation.

Another important relationship with the HMDP project concerns the eventual expanded role of the Institute of Health Sciences (IHS). According to the HMDP Project Paper, the IHS plans to become involved in seminars and inservice training during the life of the project. As already indicated, the IHAP project will also be involved in these training activities. This has already been discussed with the HMDP project technicians and with Ministry officials, and both groups support IHAP's involvement in this area. In fact, due to the heavy workload in building the training capabilities in the nursing, health inspector, and health assistant programs, the HMDP team supports the start of continuing/in-service education by the IHAP project. The two project teams will be able to work out ways in which their efforts can be coordinated, so that both will benefit from their mutual accomplishments.

Another major USAID-funded health project -- the Rural Water Borne Disease Project -- has recently begun in January 1981. This project has three interrelated components: (1) Health education, (2) sanitation and public health engineering, and (3) schistosomiasis and water-related disease survey. Although this project has just started, there are clearly some mutually beneficial areas between the RWBD project and the IHAP project. In general, the IHAP project will provide support in the planning and management areas. Also, because of the RWBD project's involvement in rural health ser-

vices, the two projects will be able to coordinate the development of rural programs and personnel. In addition, the knowledge, attitudes, and practice (KAP) survey to be conducted as the base for development of the national health education plan should provide useful information to the IHAP project on rural practices, attitudes, and communication patterns. Other important linkages between the two projects include the national health education plan and related education program at the rural level, and similarly the reliance of the sanitation component on the rural health service infrastructure. Therefore, there should be a strong synergistic effect between these two projects, and the planning/management project will help to insure the success of the Rural Water Borne Disease Project.

In summary, it is clear that the proposed planning/management project can and should have a major impact on the satisfactory outcomes of two related USAID-funded projects in the health sector. This fact strengthens the case for the planning/management project, and also supports its timely initiation.

#### 4. Summary

From the above discussion, it is clear that the planning/management project will provide critically needed support to the Ministry of Health in expanding and institutionalizing its capacity in the areas of planning, management, and policy development. Efforts to date have not kept pace with the needs, and as indicated, the needs are increasing. Only with an expanded planning and management capability can the Ministry continue to develop its programs realistically in order to achieve its goal of increased services to the rural people.

### III. PROJECT DESCRIPTION

The thrust of this project in institution-building: To assist the Ministry of Health in developing and sustaining a high level of competence in the planning and management of its programs and services. Therefore, the project proposed by IHAP is designed to overcome the present limitation of the Ministry in the areas of planning, management, and policy development; and to develop a long-term capability within the Ministry for carrying out these functions effectively.

This section is a narrative presentation of the logical framework matrix, which is included in this proposal as Annex D.

#### A. Project Goal

The long-term goal of virtually any health care program is to improve the health status of the people being served. However, in this project a more specific goal is appropriate: To improve the delivery of health care services to the people of Swaziland, with special emphasis on increasing the quality, quantity, and distribution of preventive and promotive services.

This project is essentially a "facilitating" project; that is, technical assistance and institution-building is provided at the central level in order to promote changes at the service delivery level. Therefore, the measurement of goal achievement may be objectively determined by measuring an increase in the use of health care services.

As an alternative, goal achievement may be assessed through interviews with key ministry officials during the final evaluation of the project. These individuals will best be able to discriminate among variables which may have been introduced during the project life, and which have (or haven't) influenced the project outcome and the overall utilization of health care services.

This project goal supports the long-range goals and objectives of the USAID Country Development Strategy Statement. (23)

The CDSS long-range goal is: To achieve self-sustaining and equitable growth. In particular, one of the broad objectives underlying that goal is a reduction by one-half of the under-two mortality rate from a level of 192/1000 to 96/1000 within ten years. The intermediate targets to be achieved during the five-year planning horizon are:

- a real reorientation of the health care system from a curative/clinic based to a preventive public health/community based one
- an improvement in the planning and administration of the health care system to take what is now a fairly impressive collection of clinic and manpower infrastructure and transform it from a "collection" into a working system
- a national cadre of 625 community-level rural health visitors, who are actually engaged in delivering appropriate maternal and child health information and are referring clients to clinics as needed
- a potable water and sanitation program which is producing potable water and sanitation facilities at a rate sufficient to achieve virtual nationwide coverage by 1980.

As pointed out in the strategy statement, "in order to achieve these objectives USAID's assistance must be directed to upgrading the planning capacity of the Ministry of Health to design and carry out a well-conceived child health and family planning scheme in particular, and a preventive rural health delivery service in general." Clearly, this project is designed to achieve the targets noted, and is thus in support of the CDSS goal.

#### B. Project Purpose

The purpose of this project is to expand the capability of the Ministry of Health to carry out effective planning, management,

and policy development. Fundamentally, the project is directed at overcoming institutional weaknesses within the Ministry. These weaknesses have impeded the effective development of the infrastructure necessary to improve the health care delivery system, so that the quality, quantity, and distribution of services have been compromised. The project design incorporates specific steps to fill the existing gaps and to build on the positive aspects of the present infrastructure in order to accomplish this purpose.

Purpose to goal assumptions. The following assumptions are considered critical for the achievement of the project purpose, as well as the eventual project impact on goal level objectives:

- Given a conducive health service environment, there are no cultural or related factors beyond the scope of the project which will inhibit the use of expanded health services.
- People will continue to be able to afford health care services.
- The recurrent budget of the Ministry of Health will be sufficient to support planned expansion of services during the project life.
- Coordination and cooperation with non-Government agencies will expand at a rate consistent with project needs.

End-of-project status. At the end of March 1984, when this three-year project terminates, the expanded planning/management capability should be fully developed and operating effectively. More specifically, the following status is anticipated by the end of the project:

- The long-range strategy has been developed and initiated for improving the delivery of health care services throughout Swaziland, including the following major components:
  - .. Comprehensive long-range plan, incorporating manpower, facilities, decentralization, service integration, etc.

- .. Recommendations and strategies in important policy and program areas (increased coordination between Government and non-Government providers, unification of patient fees, stronger ties between traditional and Western medicine, etc.)
- .. Continuing/in-service training programs to meet high priority needs
- .. Seminars/workshops at national, district, and local levels
- The functional operation and related organizational structure of the Ministry of Health has been improved at both central and district levels.
- The planning, management, and policy development functions of the Ministry are being carried out effectively by Swazi nationals.

### C. Major Project Objectives

It was very useful in the project formulation process to develop objectives which the project should be designed to achieve. This was particularly helpful during in-depth discussions with MOH staff members, and also during the group sessions noted earlier. In this case the objectives mutually agreed upon are related to both the goal and purpose of the project. At the same time, the objectives provide an additional level of specificity to the goal and purpose, and help to structure one's thinking about what the project should accomplish. The mutually agreed upon objectives for this project are summarized below:

1. To improve the functional operation and corresponding organizational structure of the Ministry of Health at central and district levels, with special emphasis on the planning, management, and policy development functions; and to institutionalize these changes to help insure the effective operation of the Ministry in the future.
2. To develop and initiate a long-range strategy for improving the delivery of health care services throughout

Swaziland within the accepted framework of decentralization and integration of services, and with special emphasis on increasing the quality, quantity, and distribution of preventive and promotive health services.

3. To develop a strategy to improve job performance and job satisfaction of MOH personnel at central, district and local levels.
4. To increase MOH staff understanding of Ministry policies and programs, and to increase the involvement of staff at all levels in the planning, development, and implementation of new programs.
5. To provide the capability within the MOH to coordinate the health-related components of the national nutrition program including the establishment of a routine nutrition surveillance system.

The degree of accomplishment of each of these objectives, in turn, may be evaluated in terms of the outputs of the project. These outputs are discussed in the following subsection.

#### D. Project Outputs

Manpower assessment. A comprehensive manpower assessment will be carried out within the MOH during the first project year. This assessment should use a team of key MOH staff members (augmented by consultants), and should include field visits, interviews, etc., according to a well-developed methodology. The study will include at least the following four components: (1) A re-evaluation of the MOH 10-year manpower plan, and an analysis of current staffing, in order to determine the relationship among positions established, positions filled, and critical staffing needs; (2) analysis of manpower utilization, to determine ways in which the utilization of critical skills can be improved; (3) an assessment of personnel policies, regulations, and general working conditions in effect for

important personnel categories;\* and (4) a study of the needs of existing staff (especially clinic staff and others at the local level) for inservice/continuing education and other kinds of formal and informal training which will contribute to improved job performance and job satisfaction.

Health facility survey. A survey of health care facilities will also be carried out during the first year to determine the following: (1) The adequacy of facilities in relation to present workload and staffing; (2) the need for repairs, renovation, and/or expansion (including staff housing), based on future plans and projections; and (3) major equipment needs, including repair, replacement and supply of new items. This survey will use the team approach, and will be coordinated with the manpower assessment to insure the effective utilization of resources. To the extent that programs and projects of other ministries may be related to health care facilities (e.g., the Rural Development Areas of the Ministry of Agriculture; the rural water supplies of the Ministry of Works, Power and Communications), these impacts must be taken into account. To the extent that recent surveys and plans of the MOH can be used (e.g., minimum standards for facilities; an adequate profile against which to decide on needed improvements), then the proposed consolidated survey may not need to include every facility.

Comprehensive long-range plan. A comprehensive long-range plan for the Ministry of Health will be developed during the first 19 months of the project. The individual components of the comprehensive plan will be developed and implemented in accordance with the project implementation schedule. The separate but interrelated components of the plan are listed below:

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\*This assessment should include such areas as: (a) written policies and procedures, (b) professional/technical supervision, (c) promotion, (d) career ladder, (e) hardship posts, and (f) in the nursing service, the interrelationships among nursing education, nursing administration, and nursing practice.

- Decentralization plan. A detailed plan for decentralization of the MOH to district level will be developed during the first project year, in accordance with established MOH policy. In this plan, special attention should be given to strengthening and decentralizing the financial management function so that it is an effective tool in planning and management, and not simply an auditing function to account for expenditures already made. The decentralization aspect of financial management should be flexible in relation to the financial and budgetary responsibilities at the district level. The decentralization plan will be implemented in at least one district by the end of the third project year. As indicated in the discussion of the project rationale, the initial district for implementation will be Shiselweni District. This will support the priority which the GOS has given to expanding services in the district, and it will also provide a strong link with the administrative component of the Health Manpower Development Project. If this implementation goes well, it may be possible to extend the implementation to other districts during the third project year, but for project planning purposes it is assumed that implementation in the remaining three districts will be carried out in Phase 2 of the project. The most important reason for this expectation is that among the component plans and strategies, the development and the implementation must be carefully coordinated to insure a successful outcome.
  
- Service integration plan. During the second year, a detailed plan will be developed for the integration of preventive and curative health services, in accordance with established MOH policy. As with the decentralization plan, the integration plan will be implemented in at least the Shiselweni District during the third project year. Implementation in the other three districts will likely be deferred to Phase 2.

- Logistics and supply systems. During the first project year, recommendations will be developed to strengthen the systems for provision of drugs and medical supplies. It will be important to determine to what extent this function should be decentralized, and to decide on the interventions required to improve the systems. If the resources required can be obtained within the life of this project, implementation should be coordinated with other project activities in order to achieve the most effective outcome.
  
- Manpower plan. As an integral part of the long-range plan, and in light of the manpower assessment, a manpower plan will be developed which prioritizes manpower needs and sets out the related requirements for increased establishment, training, infrastructure, and budget. The initial manpower plan will be completed during the second project year; it should be reviewed annually and amended as required.
  
- Health facilities plan. On the basis of the health facilities survey, and as an integral part of the MOH long-range plan, a consolidated plan for the upgrading of health care facilities will be developed during the second year. This plan must take into account existing plans and projects, including those detailed in the Third Five-Year Plan, but should weigh carefully several interrelated factors: (1) the commitment of the MOH to expand health services to the rural people; (2) the need to upgrade existing facilities in relation to the need for totally new facilities; (3) the need to increase the staffing levels of existing facilities (e.g., rural clinics) in relation to the additional staffing requirement for new facilities; (4) the implications for the health care facilities themselves of the policy to integrate curative and preventive service delivery; (5) the implications of

resettlement programs (such as RDA's) on the need for and location of health care facilities; and (6) the operational difficulties resulting from the control over building construction and maintenance by the Ministry of Works, Power, and Communication.

- Rural Health Visitor program. During the second project year, a detailed plan will be developed to strengthen the Rural Health Visitor program, including increased involvement of the communities being served, and strong linkages between the RHV's and clinic nurses to insure adequate supervision and support.
  
- Strengthening support services. During the first year a plan will be developed in consultation with the Senior Health Administrator, to strengthen the provision of administrative support services (e.g., communication, equipment and supplies, transportation) at all levels, taking into account the impact of decentralization and related elements in the overall long-range plan.
  
- Health education plan. During the life of this project the Health Education Unit of the MOH, which is being expanded under the Rural Water Borne Disease Project, is to develop a national health education strategy and plan. The long-term health education plan should be incorporated into the overall long-range plan for the MOH, to insure compatibility and effective coordination in the use of health education and other MOH resources.

Annual evaluation. An annual evaluation of MOH services and activities will be carried out, including the preparation of annual report(s), during the third project year. This annual evaluation will be established as part of the ongoing planning process.

-- Annual plan. Closely related to the annual evaluation, an annual plan will be prepared during the third project year, in order to update the long-range plan in relation to accomplishments, constraints, etc. As with the annual evaluation, this annual plan will become part of the ongoing planning process after the completion of the project.

Expansion of health information and statistics capabilities.

By the end of the second project year, the health information and statistics capabilities of the MOH will be expanded to meet increased planning needs. The proposed expansion will build on the present capabilities of the unit in two ways: (1) by expanding the kinds of information available within the unit itself (for the most part this information already exists in other units of the MOH), and (2) by expanding the types of analyses of information which will assist in the planning and management of health services. For example, up-to-date information should be available within the unit in the following areas:

- .. Community-based information (geography, demography, agriculture, water resources, social infrastructure)
- .. Facility-based information (non-financial and non-statistical -- such things as sponsorship, services provided, description of facilities, availability of water/sewerage/electricity, accessibility to transport, communication links)
- .. Staffing information (categories and numbers of staff, variations in staffing, staff workload, ongoing training programs)
- .. Financial information (costs, charges, and cost per unit of service; information to determine the effective use of health care resources)
- .. Health statistics -- both health status statistics (morbidity, mortality, etc.) and health service statistics (number of visits by major category of service, drugs

provided, average inpatient stay for major diseases/ conditions, etc.)

The process of expanding the information system will be closely coordinated with the Health Statistician who is provided through the Health Manpower Development Project, in order to insure that the resulting system will meet the long-term needs of the Ministry. The necessary continuity will be maintained in that the Health Manpower Development Project is expected to provide a Health Statistician through at least the first two years of the IHAP project (e.g., approximately June 1983). Once the information system has been expanded, analyses can then be done and the outcomes utilized to assist in the planning and management of health services at national, district, and health care facility levels. Examples include the establishment of disease priorities and service orientation, and the identification of staffing needs.

Increased coordination among health care providers. A policy recommendation will be developed, along with related alternative strategies, for increased coordination and integration of Government and non-Government health service providers, including a uniform fee structure for health services regardless of source of care among public facilities. The policy recommendation will be developed in the second year, and the approved strategy incorporated into the overall long-range plan.

Stronger ties between traditional and Western medicine. Recommendations will be developed to encourage stronger ties and a spirit of cooperation between traditional and Western medicine. These recommendations will be developed by the third project year, with implementation likely deferred to Phase 2.

Continuing and inservice education program design. On the basis

of the education/training component of the manpower assessment, continuing education and other inservice training programs will be designed to meet identified needs. The program design will be completed in the third year, including the establishment of priorities for implementation. However, actual implementation is expected to be carried out in Phase 2.

Strengthening MOH personnel systems. A strategy will be developed by the end of the third year to strengthen MOH personnel systems in such areas as written policies and procedures, professional/technical supervision, promotion, career ladder, and hardship posts. Priorities will be established for implementation, but the implementation itself will likely take place in Phase 2.

Topical seminars and workshops at all levels. Seminars, workshops, and other kinds of participatory meetings will be developed and presented at national, district, and local levels. These sessions will be concerned with MOH policies and programs, and are intended to enhance the health workers' effectiveness in carrying out their work. During the first project year one national-level seminar/workshop will be held, and in the second and third years at least one seminar/workshop will be held at national, district, and local levels.

Nutrition program coordination. During the second project year, the MOH capability will be expanded to coordinate the health-related components of the national nutrition program. Current activities will be expanded to include nutrition surveillance, a liaison function, and the necessary backup for the proposed national nutrition survey, in accordance with GOS decisions.

Trained Swazi counterparts in post. The Swazi counterparts will be trained and in post by June 1983. The Swazi Manpower Develop-

ment Officer will be trained to the Master's level; in addition, the counterpart to the Senior Health Administrator will also receive Master's level training under this project, in order to provide continuity in that position (to be held by an expatriate until approximately February 1983). The Swazi Program Development Officer will be trained to the diploma level by June 1983.

Fourth Five-Year Development Plan. The health sector component of the Fourth Five-Year Development Plan will be prepared in accordance with GOS requirements, during the second project year.

#### E. Project Inputs

The following discussion and tables describe the inputs that will be required to produce the project outputs and to achieve the project purpose. For clarity, the discussion is divided among the three sources of inputs: (1) USAID, (2) Government of Swaziland, and (3) IHAP and Other Donors.

##### 1. USAID

Technical Assistance (\$595,570). The project will provide 6 person years of long-term technical assistance and 1.67 person years of short-term consultancies. The two IHAP long-term technicians who will be assigned for three years are:

(1) Health Planning Officer, and (2) Manpower Development Officer.\* Job descriptions for these technicians are included as Annex E. The two IHAP long-term technicians will have Swazi

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\* Note that the Swazi Program Development Officer will not have an IHAP technician counterpart, but will be a long-term technician in the project funded by the Swaziland Government (see below).

counterparts. Short-term consultants will provide assistance in the following areas: (1) Manpower assessment (including two local consultants), (2) health facility survey and plan, and (3) continuing/in-service education program design.

Training (\$90,500). Five years of academic training are included. Two Swazis will attend Master's level programs at U.S. universities, while a third will attend the East African Management Institute in Arusha, Tanzania. GOS regulations require that all participants receiving long-term, specialized degree or diploma training must either occupy or encumber a post for which that training is applicable. One output of this project will be a long-term training plan which will take into account future training needs to replace personnel lost by attrition, and the need to increase posts generally.

Commodities (\$40,700). Commodities purchased specifically for this project will include two project vehicles to be used by the project staff, a desk-top computer, supplemental furnishings for the technicians' houses, and training materials and supplies.

Monitoring and evaluation (\$38,320). This includes a total of four trips by the IHAP Program Director for project monitoring purposes, as well as the costs of two independent evaluators for the final project evaluation.

IHAP indirect costs (\$155,280). IHAP indirect costs (overhead) are computed at 69.0 per cent of long-term staff salaries and wages as per indirect cost rate agreement with USAID dated March 7, 1979.

Other (\$129,670). This includes \$18,770 for the seminars and workshops; \$15,440 to cover wages for required short-term and/or part-time workers during the project life (survey team assistance, peak-period typing, etc.); and, \$95,460 as a 10 per cent physical contingency.

2. Government of Swaziland\*

Salaries (\$356,970). This includes salaries for the project counterparts and support staff, as well as professional staff time which will be spent directly on project-related work.

Furnishings, equipment, and supplies (\$26,090). Office furnishings, equipment, and supplies; and furnishings for long-term technician houses are included.

Accommodation expenses (\$56,380). Temporary lodging allowance for long-term technicians, plus office accommodation and utilities.

Travel for academic training (\$7,060).

In-country transportation (\$79,240). This includes fuel and maintenance for the two project vehicles, plus additional vehicular support as needed (variable use, but equivalent to less than half-time for one additional vehicle).

In-country per diem allowance (\$9,990). For in-country travel of technicians and counterparts, plus authorized persons in connection with the health facility survey and the manpower assessment.

3. IHAP and other donors

IHAP (\$26,480). Annual cash contribution for general project support.

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\*Of the inputs identified here, the incremental GOS expenditures directly attributable to the project amount to \$224,620 or about 42 per cent of the total GOS inputs. Please see Section V.B. for a more detailed presentation.

World Health Organization (\$24,120). Consultant costs for experts in health statistics and/or nutrition planning and surveillance.

UNICEF (\$27,720). Equipment and supplies for rural clinics.

These inputs have been summarized in tabular form in two different ways. Figure 8 shows the amounts and percentages contributed by USAID, GOS, and IHAP and other donors. The combined percentage of the latter two is 36.9 per cent. Figure 9 indicates total project expenditure by major category, again including both amounts and percentages.

F. Relationship to Other USAID Efforts in the Health Sector

References have been made earlier to two USAID projects in the health sector in Swaziland: The Health Manpower Development Project (HMDP) which has been operating for more than two years; and the Rural Water Borne Disease Project (RWBDP), which began in January 1981. As indicated in the discussion of the rationale for this project, both of these USAID-funded projects have important implications for the IHAP planning/management project, and vice-versa. The projects will reinforce each other in a number of ways, as discussed in Section II.C.

G. Proposed Phase 2 of the Project

In the earlier discussions, primarily on project outputs, a number of references were made to a possible Phase 2 for this project. This is a useful concept, since it would extend the continuity of the initial three-year project to accomplish several related outcomes. In an institution-building project such as this, a second phase could make the difference between a mediocre project outcome and a very good one. While it is too premature to propose the second phase in detail, it seems important for IHAP to make known its intentions now. Based

FIGURE 8

SUMMARY OF SOURCES OF PROJECT FUNDS

<u>SOURCE</u>	<u>AMOUNT</u>	<u>PER CENT</u>
USAID (OPERATIONAL PROGRAM GRANT)	\$1,050,040	63.1%
GOVERNMENT OF SWAZILAND	535,730	32.2%)
IHAP AND OTHER DONORS	78,320	4.7%) 36.9%
	<hr/>	<hr/>
TOTAL PROJECT FUNDS	\$1,664,090	100.0%
	=====	=====

FIGURE 9

TOTAL PROJECT EXPENDITURE BY MAJOR CATEGORY

<u>CATEGORY</u>	<u>AMOUNT</u>	<u>PER CEN</u>
Technical Assistance	\$ 619,690	37.0%
Local Salaries	356,970	21.3%
Academic Training	90,500	5.4%
Vehicles	19,080	1.1%
Equipment and Supplies	75,430	4.5%
Transportation, Accommodation, and Other Local Costs	186,880	11.7%
Monitoring and Evaluation	38,320	2.3%
IHAP Indirect Costs	155,280	9.3%
Contingency	95,460	5.8%
IHAP Cash Contribution	26,480	1.6%
	<hr/>	<hr/>
Total	\$1,664,090	100.0%

on the project description for the initial three years, a number of possible extensions have been suggested, as indicated below:

- Additional Swazis should be sent for relevant training in planning and management, to provide backup in the planning/management functions which were developed and strengthened during the first three project years. While these people might not go immediately into one of the counterpart jobs, their training would be of value in many posts within the Ministry -- and they would be trained and experienced sufficiently to take almost any one of the original project posts should it become vacant.
- The implementation of the decentralization plan could be extended to the other three districts
- The implementation of the service integration plan could be extended to the remaining three districts.
- The plan for upgrading health facilities could be implemented.
- The plan for strengthening the Rural Health Visitor program could be implemented.
- The recommendations to encourage stronger ties and a spirit of cooperation between traditional and Western medicine could be implemented.
- The strategy to strengthen MOH personnel systems could be implemented.
- The continuing/in-service training programs which have been developed could be implemented.

The concept of a Phase 2 will be pursued realistically during the initial three-year project. A draft proposal for a second phase will be prepared jointly by the MOH and IHAP during the second project year, and this draft will be considered during the intermediate evaluation. Depending on the outcome, further steps will be taken as necessary.

#### IV. PROJECT ANALYSES

##### A. Economic Effects

The goals of this project -- to improve the delivery of health care services to the people of Swaziland, and eventually to improve their health status -- lead to benefits that cannot be measured in monetary units. Thus economic "analysis" is not very well suited for projects of this nature. However, this section will summarize the types of benefits to be expected, as well as the cost-effectiveness of the project.

Many aspects of the project will contribute to the increased efficiency and effectiveness of the health care delivery system. One principal mechanism to expand low-cost health services to the rural poor is to increase the effectiveness of the Rural Health Visitor program. The remuneration of Rural Health Visitors is low, but their skills match the primary needs of the communities they serve; this results in a cost-effective expansion of services at the community level.

The integration of curative and promotive/preventive services will result in several related improvements. On the one hand, it will mean better use of scarce human resources, and better utilization of critical skills. By expanding the range of services available at all static health units, the facilities will be more efficiently utilized. Furthermore, by having expanded preventive and curative services available at one location, there are potential benefits to patients both in reduced charges per visit, and in reduced transportation costs by having access to multiple services at the same time and place.

Also, the project will result in a better utilization of

services provided at the static health units. The rationale for this is that in the typical case, Rural Health Visitors will motivate community members to seek needed care at the rural clinics, and will refer certain patients to these clinics for professional services. This means that in general the utilization of the rural clinics will increase. Based on the manpower and health service statistics provided in Section II. B., the average outpatient facility is under-utilized in relation to its staffing. Thus if typically the staffing stays the same, productivity will increase and the unit cost of providing services will decrease. While this reduction in unit cost is not reflected in the charge for services, it does mean that the costs of providing the health facilities and staffing will increase at a slower rate than the increase in services provided. Eventually this effect will level off, but it should be significant during the project life due to the present general under-utilization of facilities and staff. The increased productivity will continue to be a long-term benefit accruing from the project.

The project is designed to improve the management of the health care system and to streamline its operation at all levels. In the process of accomplishing this the project will eliminate wasteful practices and make the system generally more efficient. For example, by making better use of vehicles in the transportation system many unnecessary or inefficient trips can be eliminated, e.g., multi-purpose trips carrying people and/or materials in both directions will be planned. There are many other examples of this type in which actual reductions in expenditure can result from better management systems and practices.

On a different level, one can expect that an eventual outcome of the project will be a reduction in curative services in general and hospitalization in particular through successful disease prevention programs. Since much morbidity and mor-

tality result from preventable diseases, then successful preventive health service programs -- especially in the rural areas -- will result in less demand for expensive curative services. While it is not possible to quantify this benefit, it is reasonable to expect a significant impact over time.

Similarly, by expanding family planning services as part of the overall expansion of services at the rural level, the project should have an impact on the current high fertility in Swaziland. To the extent that it does so, there will be a reduction in the incidence of communicable diseases and health problems associated with high fertility, and a consequent reduction in the demand for health services.

In addition, the project will increase coordination and integration of Government and non-Government health service providers, including the development of a uniform fee structure for health services regardless of source of care among public facilities. At present there are nominal, uniform charges made at all Government (MOH) health units; charges at mission and other non-profit health units are non-uniform, and typically are much higher. Given the geographic distribution of health care facilities in Swaziland, these differences in fees create a major inequity in the system. For many people, especially in the rural areas, the cost of their health care is much higher simply by virtue of the fact that the closest facilities are sponsored by non-Government agencies which must charge higher fees in order to keep the facilities operating. The situation is even worse for hospital care, especially in the Manzini district. Therefore, if the project is successful in assisting to develop and implement a uniform fee structure, the result will be

a much more equitable system for the Swazi people.

Finally, the project will develop systems and mechanisms so that future planning will be based on expanded and improved information and statistics. As a result, the plans and programs which are implemented will be much more appropriate to meet the needs of the delivery system -- and their impact will be greater in improving the health status of the people. For example, by having the necessary information and analyzing it carefully, it will be possible to establish disease priorities; and based on these priorities, services can be specifically targeted to reduce high morbidity and/or mortality from certain diseases.

In summary, this analysis has shown that the health benefits of the project should be significant, although no estimate of the magnitude of the benefits has been attempted. The project as designed is a cost-effective approach to improving the delivery of health care services to the people of Swaziland. In addition, the project should result in a more equitable delivery system by standardizing the charges made for health care services at public facilities.

#### B. Appropriateness of Technology

The technologies used in this project fall into two main categories: (1) Development of planning and management systems, and (2) human resource development. As can be expected, the two are interrelated, and it will be important to capitalize on the synergistic effect of each on the other.

The concepts underlying the planning and management systems are simple. These concepts will be developed into

workable systems by integrating them into the present infrastructure as much as possible, and by insuring that the resulting systems and mechanisms can be handled by the Swazi counterparts and others who will carry on the planning/management functions. As has been pointed out, the project will train three Swazis in health planning and management, and this long-term training will help them to function effectively in their specialized areas of responsibility.

The planning capacity of the Ministry will be expanded to encompass manpower, facilities, services, training, and resource development. By incorporating mechanisms such as annual evaluations, reports, and updating of plans based on progress made and constraints encountered, the Swazi personnel will be able to maintain the continuity of the planning and management functions, as well as to modify the systems as needed to meet future requirements and conditions. By having an approximately nine-month overlap with the project technicians after the counterparts have returned from training, there should be sufficient time for the Swazis to become fully familiar with the systems and assume full responsibility by the end of the project.

Human resource development will take place in several forms. It is clear that health care services can improve and expand at the local level only if there are sufficiently qualified and trained health workers available. One thrust of the project is to develop programs to meet high-priority needs in the areas of inservice training and continuing education for district and local level staff. By designing the technologies used to meet the needs within the framework of the ongoing delivery system, the quality of health services should increase.

The project will also strengthen the Rural Health Visitor program by increasing community involvement in the program and by strengthening the linkages between RHV's and clinic nurses. The RHV's are local people chosen by and from their own communities, and are trained to provide primary health care services within their own local areas. This local-level technology is a key element in the improvement and expansion of health care services to the rural people. The concept of RHV's is already accepted in Swaziland, and the project will focus on improving the effectiveness of its implementation.

Finally, in order to further develop health manpower at the service delivery level, the project will carry out a number of seminars and workshops for health workers at central, district, and local levels. It is expected that these participatory sessions will be a channel of communication whereby front-line workers can convey their perceptions of the health care needs of the people they serve; and whereby they can gain a better understanding of the operations of the health care delivery system and the policies and programs of the MOH. With such two-way communication, there should be continued improvement in the appropriateness of services provided.

## C. Sociocultural Analysis

### 1. Background

Most Swazis incorporate both traditional and modern concepts into their view of the causes of illness, and they use both components of the health care system. Traditional beliefs instilled during their process of socialization are not easily dismissed, even though people recognize the value of modern health care. Modern health care services are readily used by rural Swazis, although shortages of facilities and staff, as well as limited services available, often mean that the full potential of the health care system is underutilized.

### 2. Social consequences of the project

Many social implications of the project are evident from the expected project outcomes. These include the following:

- Place the responsibility for the planning and management within the health sector in the hands of trained and capable Swazi nationals
- Help reduce the dependence on expatriate personnel in planning and management functions at all levels of the health care delivery system
- Integrate the delivery of curative and preventive health services, and give priority to the expansion of preventive/promotive services which will be much more widely available among the rural population
- Encourage stronger ties and a spirit of cooperation between traditional and Western medicine
- Strengthen the Rural Health Visitor program in

order to provide better coverage of basic health services for rural Swazis

- Develop a decentralized service delivery system which should be more responsive to local needs
- Strengthen the overall planning and management of the health sector, so that scarce resources will be better utilized
- Improve coordination among the major health care providers, including the unification of fee structures among public providers regardless of source of care.

The project will result in an improved state of health, especially among the rural population, through expansion of health care services. The expansion of preventive and promotive services will reduce the incidence of preventable diseases and the morbidity and mortality which otherwise would result.

By lessening the incidence of preventable diseases, there will be an increase in the potential productive capacity of the beneficiaries. School attenders will miss fewer days at school and will have greater ability to concentrate on learning. Other members of the population will be better able to undertake their day-to-day responsibilities, in wage employment and in the homesteads. It should also lessen the loss of potential attributable to chronic incapacity, semi-invalidism, and death. Furthermore, it will liberate time spent by women caring for sick family members and taking them for treatment.

There will also be cash savings by reducing the amount of money households spend on transport, medical consultations, and medicines. Currently, fees paid to public/nonprofit

health care providers are modest, but much larger sums are paid to private practitioners. The overall effect of increasing preventive services and decreasing curative services should tend to balance out, so that existing health care personnel should be able to cope with the shift without major personnel increases.

The project will assist the Government in its aim to correct the current imbalance in the delivery of health services between urban and peri-urban areas and the rural regions. Also, by focusing on preventive and promotive services, the project will insure that a broader-based group is reached through simple, low-cost techniques applied at the local level.

The project will include techniques for consideration of existing cultural beliefs and norms. Through the use of seminars, workshops, and other participatory forms of discussion, cultural factors will be taken into account by the participants. This is especially true at the local level, where extension agents, local officers, and community leaders will be involved.

The delivery of health care services cannot take place in a vacuum, but must be supported at all levels by a delivery system which is rationally planned and managed. This is especially critical in the rural areas to insure adequate logistical support and access to sources of referral. This project is designed to expand and support the delivery system in these ways. Therefore, the beneficiaries will be the Swazi population, and especially the 85 per cent who are rural dwellers.

The strengthened delivery system will not only make an

expanded range of basic services available now, but will also allow for future service expansion at the local level. This will be important as new priorities are formulated, such as in moderating the rate of population growth through family spacing.

### 3. The role of women

As a result of industrialization and modernization in Swaziland, women have entered every sector of public life, and have made themselves indispensable to the general development of the country. They constitute the predominant work force in health, especially among the front-line care providers.

Education and Christianity have also contributed considerably in changing attitudes among and toward women. There is a greater expression of freedom by women than ever before, as exemplified by their growing demand for higher education and opportunities to enter the professions. There is also a new defiance of traditional social forms and taboos. Their attitudes toward birth control and family planning indicate a greater progressive attitude and sense of responsibility which is a departure from tradition. Furthermore, women are becoming the best agents for social change due to their receptivity to new ideas and the realization that development will add to the total sum of their freedoms.

The project will contribute in a major way to the expanding role of women in the development of Swazi society. Women are the front-line health care providers, and the project will expand this role. It has been noted that nurses alone comprise 59 per cent of the health care professionals. In addition, most rural health visitors are women, and they have the opportunity to contribute to the

health and general well-being of their own communities. The number and distribution of rural health visitors will be expanded during the project life, and the linkages with rural clinics strengthened. As a result, their impact on overall community development will become even greater.

D. Relationship to PVO Guidelines

Although the team of technicians will be based at the Ministry of Health headquarters in Mbabane, the ultimate impact of the project will be on the health status of the whole population, and particularly on those living in rural areas.

This project is closely linked to two other USAID-funded projects in the health sector -- the Health Manpower Development Project and the Rural Water Borne Disease Project. (See Section II.C.3, pages 29-31, for a discussion of these relationships.)

The project is a national-level one, and will have an impact on the health care delivery system over the whole country.

E. Potential for Institutionalization

The concept of institutionalization is integral in the design of this project. The project will insure that there are trained counterparts for the long-term technicians and a trained Swazi Project Development Officer by the end of the project; and that all will have assumed full responsibility in their planning/management roles by that time. Based on the commitment being made by the GOS in relation to this project, it is clear that by the end of the project life, funding for the project's continuation as an integral part of Ministry operations will come from within the GOS budget.

F. Environmental Considerations

The project focus is on institutional development within the Ministry of Health. No construction or other environmental interventions will be undertaken. In view of this, a project checklist has not been prepared. However, the Initial Environmental Examination (Annex G) concludes that no significant impacts on the natural or physical environment will result as a consequence of this project, and recommends that a negative determination be made.

## V. FINANCIAL PLAN

### A. Funding Summary

As proposed, the total project cost is \$1,664,090. Of this amount, USAID will finance \$1,050,040 (63.1%), the Government of Swaziland will provide \$535,730 (32.2%), and IHAP and other donors will contribute \$78,320 (4.7%). These contributions have already been summarized in Section III.E., Project Inputs, including two summary tables showing different breakdowns of the component costs (see Figures 8 and 9, pages 50 and 51). More detailed cost estimates for each project component can be found in Annex F.

### B. Project Impact on the MOH Budget

As with any project, there are certain GOS expenditures which are directly attributable to this project, and which must become part of the MOH recurrent budget for the corresponding project years (either by addition or by substitution). On the other hand, other GOS expenditures are focused on the project, but would normally be spent on other activities if the project didn't exist.

In order to estimate the impact of the project on the MOH current budget, the GOS expenditures shown in the project budget (Annex F) have been divided into these two categories. Figure 10 shows that the incremental GOS expenditures directly attributable to the project amount to E168,890 (\$224,620) over the three-year project life. This is 42 per cent of the total GOS contribution. The highest annual amount (E69,620) falls in the first project year, but even this amount is only slightly more than one per cent of the projected MOH budget for the 1981/82 fiscal year;

FIGURE 10

SUMMARY OF INCREMENTAL GOS EXPENDITURES DIRECTLY ATTRIBUTABLE TO THE PROJECT (E1.00 = \$1.33)

ITEM	<u>YEAR 1</u>	<u>YEAR 2</u>	<u>YEAR 3</u>	<u>TOTAL</u>
Salaries -- Project counterparts	E 7,760	E 1,410	E 16,070	E 25,240 (\$33,570)
-- Support staff	5,580	6,520	6,980	19,080 (\$25,380)
Temporary lodging allowance for long-term technicians	12,600	--	--	12,600 (\$16,760)
Office accommodation and utilities	9,000	9,900	10,980	29,880 (\$39,740)
Travel for academic training	1,880	550	2,880	5,310 (\$ 7,060)
Project vehicle fuel and maintenance	15,000	16,500	18,150	49,650 (\$66,030)
Office furnishings, equipment, and supplies	5,000	2,200	2,420	9,620 (\$12,790)
Furnishings for long-term technician houses	10,000	--	--	10,000 (\$13,300)
In-country per diem allowance	2,800	1,500	3,210	7,510 (\$ 9,990)
	<u>E 69,620</u>	<u>E 38,580</u>	<u>E 60,690</u>	<u>E 168,890</u>
	(\$92,590)	(\$51,310)	(\$80,720)	(\$224,620)

the proportion is even less in the other two project years.

On the basis of the figures shown, and the fact that the project is considered high priority by the MOH, it is felt that adequate recurrent budget funding will be available.

## VI. IMPLEMENTATION PLAN

### A. Implementation Schedule

The schedule on the following pages presents the major actions to be taken during the course of the project. For convenience, the chronology is shown in two ways -- calendar month and year, and sequential project month beginning with the arrival of the team of long-term technicians. The agency(ies) responsible for taking the action are also indicated.

In order that the implementation schedule may be viewed in relation to the key project-related staffing, Figure 11 graphically shows the status of these staff members over the three-year project period. In particular, the figure shows the impact of out-of-country training for the four Swazi officers involved.

### B. Implementation Responsibilities

#### 1. Government of Swaziland

The GOS is required to establish official Government posts for the following three positions by April 1981: Manpower Development Officer, Principal Health Administrator, and Program Development Officer. The first two posts must be established, or the positions otherwise committed (e.g., by selecting the incumbent of an already established position), so that these two staff members can be sent for U.S. training in September 1981. In any event, the posts must be formally established by April 1983, so that these two staff members returning from training in June 1983 can assume these positions. In the case of the Program Development Officer, he or she will assume the position during the 1981/82 fiscal year (see below). With all

**FIGURE 11: STATUS OF PROJECT-RELATED STAFF OVER 3-YEAR PROJECT PERIOD**

Calendar Year	1981												1982												1983												1984																							
Project Year	1st YEAR												2nd YEAR												3rd YEAR																																			
Project Month	2	4	6	8	10	12	14	16	18	20	22	24	26	28	30	32	34	36	26	28	30	32	34	36	26	28	30	32	34	36	26	28	30	32	34	36																								
Calendar Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M												
IHAP HEALTH PLANNING OFFICER																																																												
IHAP MANPOWER DEVELOPMENT OFFICER																																																												
SWAZI HEALTH PLANNING OFFICER	(Training)																																																											
SWAZI MANPOWER DEVELOPMENT OFFICER													(Training)																																															
SWAZI PROGRAM DEVELOPMENT OFFICER													(Training)																																															
SWAZI PRINCIPAL HEALTH ADMINISTRATOR													(Training)																																															
SWAZI STATISTICAL ASSISTANT																																																												
SWAZI SHORTHAND TYPIST																																																												

PROJECT IMPLEMENTATION SCHEDULE

<u>Date</u>	<u>Project Month</u>	<u>Action</u>	<u>Responsibility</u>
Mar 81	-1	OPG Agreement signed	USAID/IHAP
Mar 81	-1	Memorandum of Understanding signed	GOS/IHAP
Apr 81	1	IHAP long-term technicians arrive	IHAP
Apr 81	1	Posts established for Manpower Development Officer, Program Development Officer, and Principal Health Administrator; candidates selected; applications submitted for training programs (MDO and PHA to U.S. in 1981; PDO to Tanzania in 1982)	GOS/USAID
May 81	2	MOH support staff assigned to project (Statistical Assistant and Shorthand Typist)	GOS
Jun 81	3	National workshop on decentralization/ integration	IHAP/GOS
Jun 81	3	Swazi staff members in newly established posts	GOS
Jul 81	4	Design of manpower assessment methodology begins	IHAP/GOS
Jul 81	4	Design of health facilities survey methodology begins	IHAP/GOS
Aug 81	5	Manpower assessment team trained	IHAP/GOS
Aug 81	5	Manpower assessment begins	IHAP/GOS
Aug 81	5	Health facilities survey team trained	IHAP/GOS
Sep 81	6	Health facilities survey begins	IHAP/GOS
Sep 81	6	Manpower Development Officer and Principal Health Administrator leave for training in U.S	USAID/GOS

Date	Project Month	Action	Responsibility
Oct 81	7	Recommendations to strengthen systems for drugs and medical supplies completed	IHAP/GOS
Nov 81	8	Manpower assessment field work completed; analysis of data begins	IHAP/GOS
Dec 81	9	Swazi Health Planner returns from training	GOS
Dec 81	9	Health facilities survey field work completed; analysis of data begins	IHAP/GOS
Jan 82	10	Decentralization plan completed	IHAP/GOS
Jan 82	10	Seminars/workshops for health workers	IHAP/GOS
Feb 82	11	Manpower assessment analysis concluded and findings available	IHAP/GOS
Mar 82	12	Health facility survey analysis concluded and findings available	IAP/GOS
Mar 82	12	Plan to strengthen administrative support services completed	IAP/GOS
Apr 82	13	Service integration plan completed	IAP/GOS
Apr 82	13	Capabilities expanded to coordinate health-related components of national nutrition program	IHAP/GOS
May 82	14	Policy recommendation on coordination with non-Government providers completed and submitted to MOH for approval	IHAP/GOS
May 82	14	Manpower plan completed	IHAP/GOS
Jun 82	15	Health facility plan completed	IHAP/GOS
Jul 82	16	Program Development Officer leaves for training in Tanzania	USAID/GOS
Jul 82	16	Order placed to UNICEF for equipment and supplies for rural clinics	GOS/IHAP

Date	Project Month	Action	Responsibility
Jul 82	16	Seminars/workshops for health workers	IHAP/GOS
Aug 82	17	Plan to strengthen Rural Health Visitor program completed	IHAP/GOS
Sep 82	18	Health sector component of Fourth Five-Year Plan completed	IHAP/GOS
Oct 82	19	Comprehensive long-range plan for MOH completed, incorporating component plans	IHAP/GOS
Nov 82	20	Proposal for Phase 2 of project prepared	IHAP/GOS
Dec 82	21	Expansion of health information and statistics capability completed	IHAP/GOS
Jan 83	22	UNICEF equipment and supplies for rural clinics received	GOS
Jan 83	22	Intermediate project evaluation	USAID/IHAP/GOS
Feb 83	23	Seminars/workshops for health workers	HAP/GOS
Apr 83	25	Policy recommendation on cooperation with traditional practitioners completed and submitted to MOH for approval	HAP/GOS
May 83	26	Health education plan incorporated in MOH long-range plan	IHAP/GOS
May 83	26	First annual evaluation of MOH services and activities completed	IHAP/GOS
Jun 83	27	Manpower Development Officer, Principal Health Administrator, and Program Development Officer return from training to assume their respective posts	GOS
Jul 83	28	First annual MOH plan completed	IHAP/GOS
Jul 83	28	Order placed to UNICEF for equipment and supplies for rural clinics	GOS/IHAP
Aug 83	29	Seminars/workshops for health workers	IHAP/GOS

Date	Project Month	Action	Responsibilities
Sep 83	30	Strategy to strengthen MOH personnel systems completed	IHAP/GOS
Oct 83	31	Continuing and inservice education program design completed	IHAP/GOS
Jan 84	34	UNICEF equipment and supplies for rural clinics received	GOS
Feb 84	35	Final evaluation	USAID/IHAP/GOS
Mar 84	36	IHAP long-term technicians leave, and Swazi counterparts assume full responsibilities	IHAP/GOS

three positions established/committed in April 1981, the candidates will be selected and in post by June 1981, which for the two leaving for training in September provides three months on the job prior to leaving. By starting in June, the Swazi Program Development Officer will be able to participate in the health facilities survey as his/her first job activity.

The GOS will be responsible for the cost of travel to and from academic training for the three Swazi staff members, in accordance with the established training schedule.

The GOS will also provide two support staff for the project: a Statistics Assistant and a Shorthand Typist. These two posts must be established, or the positions otherwise committed (e.g., by secondment), by April 1981. The rationale for these posts is to insure adequate manpower to meet the increased information-handling workload of the project. Without this additional support staff, project activities and documentation will not be able to keep pace with the implementation schedule.

The GOS will provide suitable office accommodation for the IHAP long-term technicians (and their counterparts during the overlap period), either within the MOH headquarters building or in other proximal quarters. The GOS will also provide the necessary office furnishings, equipment, and supplies to support the project.

The GOS will be responsible for the cost of temporary lodging for the IHAP long-term technicians, within the limitation indicated in the project budget, until the technicians are established in their respective long-term accommodation. In addition, the GOS will provide the usual project team support including furnishings for the technicians' accommodation.

The GOS will provide in-country transportation support, and in-country per diem allowance, in accordance with the project budget.

The GOS will insure duty- and tax-free importation (and as necessary, re-exportation) of equipment, supplies, and other materials which are required by the IHAP long-term technicians in the performance of their official duties; and of the personal effects of the IHAP long-term technicians. The GOS will also insure that the IHAP long-term technicians and other project-related staff may enter or leave the country freely, and will grant them residence permits and/or work permits as required. The GOS will also exempt the IHAP long-term technicians from Swaziland taxes on their respective incomes.

The Government of Swaziland and IHAP will negotiate and sign a Memorandum of Understanding concerning the project, which memorandum will include the key provisions indicated above. The purpose of this Memorandum of Understanding is to make clear the responsibilities of each party to the other, in order to help insure a successful outcome in the project.

## 2. USAID

USAID/Swaziland will be responsible for project monitoring. The USAID/S project manager will serve as the primary contact point for IHAP's Chief Project Advisor, and will be responsible for obtaining decisions on grant and project matters. USAID/S will also provide guidance and direction for the two project evaluations, as well as participation in both.

USAID will disburse funds for local costs on a reimbursible basis following procedures to be defined in the Grant Agreement. A waiver will be requested for the project vehicles and other commodities to allow for Code 935 procurement.

3. IHAP

IHAP will provide the technical assistance proposed for the project, and will be responsible for the timely provision of the required technical assistance personnel as well as all administrative arrangements related to recruitment, transportation, shipment of household effects, etc.

The technical assistance team, under the leadership of the IHAP Chief Project Advisor, will be responsible for implementing project activities as described in this project proposal (detailed job descriptions are included as Annex E). In addition to in-country and on-the-job training responsibilities, the technical assistance team will advise the GOS in the selection of the project counterparts for long-term training.

The IHAP technical assistance team will be required to submit annual work plans to be approved by the MOH and USAID. In addition to fulfilling the reporting procedures of the MOH, required reports will consist of quarterly status reports during the first six months of the project, followed by semi-annual reports for the remaining project life, and a final, end-of-project report.

## VII. EVALUATION PLAN

In addition to the routine monitoring functions based on reports and other project documentation, the Director of IHAP's Program Department, or his designee, will make an in-country visit annually to monitor project progress and to provide a direct liaison between IHAP and the project team.

There will be two formal evaluations during the life of the project. These are summarized in the following subsections.

### A. Intermediate Evaluation

The intermediate evaluation is scheduled for the 22nd month (January 1983). It will be conducted during an approximate three-week period. The external evaluator will be an evaluation officer from REDSO/EA along with the USAID/S Project Manager. In addition, the evaluation will involve both an appropriate representative of the Ministry of Health, and the Director of IHAP's Program Department. The main part of the evaluation will consider the timeliness with which inputs have been provided, as well as an assessment of output achievement. The evaluation team will compare targets actually achieved to those in the project proposal, and will evaluate the consequent achievement rate. If necessary, the evaluation team will recommend modifications regarding project inputs in order that the project goal and purpose can be achieved by the conclusion of the project.

In addition to the normal intermediate evaluation scope, the evaluation team will recommend on the extension of the project. As indicated in Section III and in the project implementation schedule, the IHAP team and the MOH will jointly prepare a proposal for Phase 2 of the project, to be considered by the evaluation team during the mid-pro-

ject evaluation. On the basis of the proposal itself, as well as the general outcome of the intermediate evaluation, the evaluation team will make a recommendation to the Government of Swaziland whether or not Phase 2 should be pursued through the formal application processes; and if so, for what period of time.

B. End-of-Project Evaluation

The end-of-project evaluation team will be comprised of an evaluation officer from REDSO/EA and two independent consultants. The evaluation is scheduled for the month of February 1984 -- the month before the termination of the three-year project.

The end-of-project evaluation will determine the effectiveness of the total project, with major emphasis on the impact of project outputs on the indicators of end-of-project status. The evaluation will determine the degree to which MOH capacity has been developed in health care system planning, management and policy development. In view of the limitations of the three-year project format, goal level achievement should probably be confined to the Shiselweni District -- the only district in which all of the scheduled project outputs will have been completed by the end of three years.

LIST OF PERSONS INTERVIEWED

Ministry of Health

Dr. Samuel Hynd - Minister of Health  
Mr. M.N. Dlamini - Permanent Secretary  
Dr. Z.M. Dlamini - Director of Medical Services  
Matron A.C.T. Mabuza - Chief Nursing Officer  
Matron A.M. Dlamini - Matron Public Health  
Mr. Andrew Green - Economist (Health Planner)  
Mr. John Wilson - Health Statistician  
Dr. Ruth Shabalala - Director of MCH Services  
Mr. L. Menuta - Health Educator, Health Education Unit  
Dr. Nimrod Mandara - MCH Medical Officer  
Ms. R.K. Habedi - Chief Pharmacist, Central Medical Store  
Mr. Michael Cooke - Senior Health Administrator

Department of Establishments and Training

Mr. Geoffrey Wood - Director, Management Services Division  
Mr. John Hamilton - Management Services Officer  
Mr. K. Kumalo - Senior Management Services Officer  
Ms. N. Nxumalo - Assistant Management Services Officer

Department of Economic Planning

Mr. Neal Campbell - Chief Economic Planning Advisor  
Mr. T.M. Nkonyane - Manpower Planner  
Ms. Veronica Walford - Planning Officer

Institute of Health Sciences

Ms. M. Makhubu - Principal  
Dr. Prabin Henningson - Physician Trainer  
Ms. C. Bailey - Nurse Practitioner/Trainer  
Ms. P. Jenkins - Nurse Practitioner/Trainer

Ministry of Agriculture

Ms. Cristabel Motsa - Senior Home Economics Officer

USAID/Swaziland

Mr. Julius Coles - Director  
Mr. Jimmy O. Philpott - Assistant Director  
Ms. Constance Collins - Regional Health Development Officer  
Ms. Joy Riggs-Perla - Assistant Regional Health Development  
Officer  
Mr. L. Sainers - Program Officer

Embassy of the United States of America

Hon. Richard Matheron - Ambassador to the Kingdom of  
Swaziland

British High Commission

Mr. David Macleod - Second Secretary

Swaziland Red Cross

Ms. T. Dlamini - Director  
Ms. E. Maseko - Program Officer

Family Life Association of Swaziland

Ms. Fiona Duby - Project Administrator  
Ms. Agnes Mabuza - Nurse/Midwife

UNFPA

Mr. Saad Raheen Sheikh - Regional Coordinator

UNICEF

Mr. Ted Murphy - Project Coordinator

Raleigh Fitkin Memorial Hospital

Mr. Elisha Mdluli - Administrator  
Dr. Howard Miller - Administration Advisor

Raleigh Fitkin Nursing School

Sr. Sharon Jones - Director  
Sr. Ellen Dlamini - Assistant Director  
Mrs. Dorothy Davis Cook - Retired Former Director

Good Shepherd Hospital

Sr. Cecile Appleman - Hospital Superintendent  
Sr. Anna Zwane - Matron  
Dr. Mia Poot - Medical Officer  
Sr. Mirjam T. Koeroets - Tutor Nurse Assistant Training  
School

Siphofaneni Clini

Ms. B. Masondo - Staff Nurse  
Ms. B. Mhlungu - Staff Nurse  
Ms. Irene Mamta - Nurse Assistant  
Ms. D. Zwane - Orderly

Singceni Clinic

Ms. Elda Natsenjuna - Staff Nurse  
Ms. Innocent Masuku - Nurse Assistant

Sitobela Health Centre

Sr. Doreen S. Dlamini - Staff Nurse

Hlatikulu Hospital

Dr. Gama - Medical Officer  
Dr. Abdul Mabin - Medical Officer  
Ms. L. Abrahams - Matron

Mankayane Hospital

Dr. Henri van Asten - Medical Officer

Cana Clinic

Ms. C.P. Mziyako - Staff Nurse

Others

Dr. Joseph Kreysler - WHO Nutrition Consultant

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SUMMARY OF GROUP DESIGN SESSIONS

As indicated in the proposal narrative, a series of three group sessions was planned during the project design phase, in order to obtain ideas and information from staff members within the Ministry of Health and other relevant Government departments - the people who know the problems and opportunities best. Based on the steps outlined below, the group reached consensus in several important areas, as shown on the following pages. The outcome of the two sessions actually held was extremely useful to the project design team.

The steps in the group process

1. Tabulation of the major functions of the Ministry of Health
2. Tabulation of related parameters:  
Scope of health services provided by the MOH  
Sources of personal health services  
Health care system problems and constraints
3. Analysis of major MOH functions:  
Who does it (or should do it)?  
Improvement or strengthening required, if any, and  
priority of need
4. Allocation of major functions by organizational level(s):  
headquarters, central, district, health facility, and  
community
5. Functional organization of the Ministry of Health

MAJOR FUNCTIONS OF THE MINISTRY OF HEALTH (9/9/80 session)

Policy: development  
recommendation  
approval  
interpretation  
execution

Program: planning  
implementation  
evaluation

Regulations: formulation  
interpretation  
enforcement

Coordination and consultation

Health service delivery: promotive  
preventive  
curative  
rehabilitative

Manpower: planning (including career structure)  
development (training, continuing education, etc.)  
staffing/utilization  
supervision -- technical  
administrative/supportive  
personnel management

Financial management

Support services: diagnostic services (lab, x-ray)  
information and statistics  
communication systems  
equipment and supplies  
transport  
construction  
maintenance

SCOPE OF HEALTH SERVICES PROVIDED BY THE MOH (9/9/80 session)

Personal health services

Examination (including history-taking)  
Investigation (including tests)  
Diagnosis  
Treatment  
Prescription  
Education  
Referral  
Record-keeping

Environmental health services

Safe water (protected springs, water testing)  
Human waste disposal (latrine construction)  
Disease control (malaria, bilharzia, etc.)  
Education (groups, mass media)  
School health  
Regulatory promotion and enforcement:  
    Food safety  
    Occupational health  
    Construction standards

SOURCES OF PERSONAL HEALTH SERVICES (11/9/80 session)

Traditional practitioners

Faith healers

Traditional midwives

Rural health visitors

Government health facilities

    Rural clinics

    Rural health centers

    Public health centers

    Hospitals -- inpatient  
                    outpatient

Mission health facilities

    Rural clinics

    Rural health centers

    Hospitals -- inpatient  
                    outpatient

Industrial health facilities

Private doctors

Private clinics (nurses)

Mobile clinics (sponsorship varies)

Pharmacies

Commercial sources of patent medicines

Referral facilities outside Swaziland

PROJECT DESIGN SUMMARY  
LOGICAL FRAMEWORK

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

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

NARRATIVE SUMMARY	OBJECTIVELY VERIFIABLE INDICATORS		MEANS OF VERIFICATION	IMPORTANT ASSUMPTIONS
<u>Outputs (Cont'd):</u>				
Seminars/workshops developed and presented at national, district, and local levels.	Seminars and workshops concerning MOH policies and programs developed and presented during each project year (national-level only during first year).			
Capability provided to coordinate health-related components of the national nutrition program.	Activities expanded to include nutrition surveillance, liaison function, and backup for proposed national nutritional survey, in accordance with GOS decisions.			
<u>Inputs:</u>	<u>USAID</u>	<u>GOS</u>	<u>IHAP/OTHER</u>	<u>TOTAL</u>
Technical Assistance				
Long-term: 6 person-years	\$ 470,410	--	--	\$ 470,410
Short-term: 1.67 person-years	125,160	--	24,120	149,280
Local Salaries	--	356,970	--	356,970
Academic Training: 5 person-years	90,500	--	--	90,500
Vehicles	19,080	--	--	19,080
Equipment and Supplies	21,620	26,090	27,720	75,430
Transportation, Accommodation, and Other Local Costs	34,210	152,670	--	186,880
Monitoring and Evaluation	38,320	--	--	38,320
IHAP Indirect Costs	155,280	--	--	155,280
Contingency	95,460	--	--	95,460
IHAP Cash Contribution	--	--	26,480	26,480
<u>Total Inputs</u>	<u>\$1,050,040</u>	<u>\$535,730</u>	<u>\$78,320</u>	<u>\$1,664,090</u>

ANNEX E: JOB DESCRIPTIONS FOR LONG-TERM PROJECT TECHNICIANS

JOB DESCRIPTION: HEALTH PLANNING OFFICER  
(IHAP Long-term technician)

PERIOD OF ASSIGNMENT: Three years.

QUALIFICATIONS:

Master's degree in health services planning and/or administration.

At least two years' experience in health services planning at the national level in a developing country, preferably in sub-Saharan Africa.

At least four additional years' experience in health services planning, administration, and/or policy development.

DUTY STATION:

This technician will be stationed at the Ministry of Health Headquarters in Mbabane, but will be required to travel throughout Swaziland in the performance of the job.

REPORTING RELATIONSHIP:

The Health Planning Officer will initially serve as Director of the Health Planning Unit, and as such, will report to the Under Secretary. Once the Swazi Health Planner has taken over as Director of the Unit,\* the IHAP Health Planning Officer will officially assume an advisory role, but the reporting relationship will remain the same.

RESPONSIBILITIES:

Serve as Chief Project Officer for IHAP and the chief liaison officer between IHAP and the Government of Swaziland.

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\*During the mid-project evaluation it will be mutually agreed among the MOH, USAID, and IHAP at what point in time the Swazi Health Planner will take over as Director of the Unit.

Direct and supervise the staff of the Health Planning Unit in the absence of the Swazi Director.

Act as the "responsible officer"\* for the following major tasks, in accordance with the Project Description:

- Development and initiation of a comprehensive long-range plan for the MOH
- Preparation of an annual review/plan to update the long-range plan
- Preparation of the health sector component of the Fourth Five-Year Development Plan
- Performance and reporting of an annual evaluation of MOH services and activities
- Development of a detailed plan for decentralization to district level; and implementation in at least one district
- Development of a detailed plan for the integration of preventive and curative health services in accordance with established MOH policies; and implementation of the plan in at least one district
- Expansion of the health information and statistics capabilities of the MOH to meet increased planning and evaluation needs (information on health facilities, staffing, finances, health service statistics, etc.)
- Development of proposed organizational changes necessary to strengthen the functional operation of the MOH
- Analysis and utilization of health information and statistics to assist in the planning and management of health services (to establish disease priorities and service orientation, staffing needs, etc.)
- Development and follow-up of a policy recommendation for increased coordination and integration of Government and non-Government health service providers, including a uniform fee structure for health services regardless of source of care among public facilities

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\*The term "responsible officer" is used to designate the individual who is ultimately responsible for carrying out the task; however, in each case the task requires the involvement of other key officers (for example, budget preparation).

- Development of recommendations to strengthen the systems for provision of drugs and medical supplies
- Building on the present capability of the health information and statistics unit of the MOH to establish a routine nutrition surveillance system
- Establishment of mechanisms to coordinate the health-related components of the national nutrition program, including liaison with the National Nutrition Council, the Ministry of Agriculture, and other appropriate bodies, in accordance with GOS decisions
- Development of a detailed plan, in consultation with the Senior Health Administrator, to strengthen the provision of administrative support services (e.g., communication, equipment and supplies, transportation) at all levels, taking into account the impact of decentralization and related elements of the overall long-range plan
- Development of recommendations to encourage stronger ties and a spirit of cooperation between traditional and Western medicine

JOB DESCRIPTION: MANPOWER DEVELOPMENT OFFICER  
(IHAP Long-term technician)

PERIOD OF ASSIGNMENT: Three year

QUALIFICATIONS:

Master's degree in administration or management preferably in the health care field.

At least two years' experience in health manpower development at the operating level in a developing country, preferably in sub-Saharan Africa; plus two additional years in manpower planning, preferably with mid-level health workers.

Experience in project or program development, implementation, and evaluation is also required.

DUTY STATION:

This technician will be stationed at the Ministry of Health Headquarters in Mbabane, but will be required to travel throughout Swaziland in the performance of the job.

REPORTING RELATIONSHIP:

The Manpower Development Officer will report to the Director of the Health Planning Unit. Once the Swazi Manpower Development Officer has taken over the established position, the IHAP Manpower Development Officer will officially assume an advisory role, but the reporting relationship will remain the same.

RESPONSIBILITIES:

Coordinate overall manpower development efforts within the MOH, in accordance with established policies.

Act as the "responsible officer"\* for the following major tasks, in accordance with the Project Description:

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\*The term "responsible officer" is used to designate the individual who is ultimately responsible for carrying out the task; however, in each case the task requires the involvement of other key officers (for example, budget preparation).

- Carry out a comprehensive manpower assessment by major responsibility center, including analyses of staffing, utilization, personnel policies and general working conditions, and needs in the area of in-service and continuing education
- Develop a manpower plan which prioritizes manpower needs and sets out the related requirements for increased establishment, training, infrastructure, and budget
- Strengthen the working relationships among relevant Government units to insure that at least the highest-priority MOH training is carried out on schedule
- Design continuing education and other inservice training programs to meet identified needs; and establish priorities for implementation
- Develop a strategy to strengthen MOH personnel systems in critical areas; and establish priorities for implementation
- Develop and organize a series of seminars, workshops, and other kinds of participatory meetings at national and district levels in order to enhance the health workers' effectiveness in carrying out their work; and encourage and support local-level efforts to present similar meetings for front-line workers and community members.
- Develop a detailed plan to strengthen the Rural Health Visitor program, including increased involvement of the communities being served, and strong linkages between the RHV's and clinic nurses to insure adequate supervision and support

JOB DESCRIPTION: PROGRAM DEVELOPMENT OFFICER  
(Swazi Long-term technician)

PERIOD OF ASSIGNMENT: Indefinite

QUALIFICATIONS:

In accordance with GOS requirements.

DUTY STATION:

This technician will be stationed at the Ministry of Health Headquarters in Mbabane, but will be required to travel throughout Swaziland in the performance of the job.

REPORTING RELATIONSHIP:

The Program Development Officer will report to the Director of the Health Planning Unit.

RESPONSIBILITIES:

Coordinates and participates with other members of the project team and MOH staff preparing planning documents outlined in the Project Description.

Specific inputs include:

- (a) A survey of health care facilities to determine the adequacy of the existing delivery system and priorities for improvement and expansion.
- (b) A long-range plan for upgrading health facilities.
- (c) Recommendations on the need for external assistance in meeting high priority areas of need.
- (d) Establishment of MOH support system for national nutrition program.

Acts as liaison with relevant Government units (Establishments and Training, Economic Planning, Finance, etc.) concerning administrative, managerial, and operational procedures involved in the development and implementation of approved donor projects.

Monitors, supervises, and evaluates donor projects and programs.

Provides routine field supervision for donor projects and programs including monitoring of health facility construction and upgradir~

SWAZILAND OPERATIONAL PROGRAM GRANT BUDGET

	<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
<b>A. <u>IHAP DIRECT OPERATING COSTS (US \$)</u></b>					
<b>1. <u>LONG-TERM TECHNICIANS</u></b>					
<b>a. <u>HEALTH PLANNING OFFICER/ CHIEF PROJECT ADVISOR</u></b>					
(1) Basic salary	7%	38,000	40,660	43,510	122,170
(2) Housing allowance (\$800/month (1981))	10%	9,600	10,560	11,620	31,780
(3) Shipping allowance	10%	16,500	--	19,970	36,470
(4) Education allowance	10%	4,800	5,280	5,810	15,890
(5) Medical Insurance	7%	1,500	1,610	1,720	4,830
(6) International travel	10%	5,630	--	6,810	12,440
(7) Rest and recuperatio	10%	10,130	11,140	--	21,270
<b>b. <u>MANPOWER DEVELOPMENT OFFICER</u></b>					
(1) Basic salary	7%				
(2) - (7) (Same as :					
<b>SUBTOTAL LONG-TERM TECHNICIANS</b>					
<b>SALARIES</b>		<u>70,000</u>	<u>74,900</u>	<u>80,150</u>	<u>225,050</u>
<b>ALLOWANCES</b>		<u>96,320</u>	<u>57,180</u>	<u>91,860</u>	<u>245,360</u>
		<u><u>166,320</u></u>	<u><u>132,080</u></u>	<u><u>172,010</u></u>	<u><u>470,410</u></u>

A. IHAP DIRECT OPERATING COSTS (CONT'D) (US \$)		<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
2. <u>SHORT-TERM CONSULTANTS</u>						
a.	<u>SALARIES</u>	7%				
(1)	Manpower Assessment					
(a)	Overseas Consultant (150/day for 4 months)		18,000			18,000
(b)	Local Consultants (2) (Each 80/day for 3 months)		14,400			14,400
(2)	Health Facility Survey and Plan					
(a)	Overseas Consultant (150/day for 4 months)		18,000			18,000
(3)	Continuing/Inservice Education					
(a)	Overseas Consultant (Year 2: 150/day for 3 months) (Year 3: 150/day for 3 months)			14,450	15,460	29,910
SUBTOTAL CONSULTANT SALARIES			<u>50,400</u>	<u>14,450</u>	<u>15,460</u>	<u>80,310</u>
b.	<u>PER DIEM EXPENSE</u> (55/day USAID rate)	7%				
(1)	Manpower Assessment (Total 10 months)		16,500			16,500
(2)	Health Facility Survey and Plan (Total 4 months)		6,600			6,600
(3)	Continuing/Inservice Education (Total 6 months)		--	5,300	5,670	10,970
SUBTOTAL CONSULTANT PER DIEM			<u>23,100</u>	<u>5,300</u>	<u>5,670</u>	<u>34,070</u>
c.	<u>TRAVEL EXPENSE</u>	10%				
(1)	Manpower Assessment (1 trip USA/Swaziland)		2,500			2,500
(2)	Health Facility Survey and Plan (1 trip USA/Swaziland)		2,500			2,500

A. IHAP DIRECT OPERATING COSTS (CONT'D) (US \$)	<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
2. <u>SHORT-TERM CONSULTANTS (CONT'D)</u>	10%				
c. <u>TRAVEL EXPENSE (CONT'D)</u>					
(3) Continuing/Inservice Education (2 trips USA/Swaziland)			2,750	3,030	5,780
SUBTOTAL CONSULTANT TRAVEL		<u>5,000</u>	<u>2,750</u>	<u>3,030</u>	10,780
3. <u>ACADEMIC TRAINING</u>	7%				
a. <u>MASTER'S DEGREE - USA (2 YEARS)</u>		20,000	21,400		41,400
b. <u>MASTER'S DEGREE - USA (2 YEARS)</u>		20,000	21,400		41,400
c. <u>DIPLOMA - AFRICA (1 YEAR)</u>		--	7,700		7,700
SUBTOTAL ACADEMIC TRAINING		<u>40,000</u>	<u>50,500</u>		<u>90,500</u>
4. <u>VEHICLES</u>					
a. <u>SEDAN (4-DOOR)</u>		9,100			9,100
b. <u>STATION WAGON</u>		9,980			9,980
SUBTOTAL VEHICLES		<u>19,080</u>			<u>19,080</u>
5. <u>EQUIPMENT AND SUPPLIES</u>					
a. <u>DESK-TOP COMPUTERS</u>		10,000			10,000
b. <u>SUPPLEMENTAL FURNISHINGS FOR TECHNICIAN HOUSES</u>		5,000			5,000
c. <u>EQUIPMENT, MATERIALS, AND SUPPLIES</u>	10%	2,000	2,200	2,420	6,620
SUBTOTAL EQUIPMENT AND SUPPLIES		<u>17,000</u>	<u>2,200</u>	<u>2,420</u>	<u>21,620</u>

A. <u>IHAP DIRECT OPERATING COSTS (CONT'D) (US</u>	<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
<b>6. <u>OTHER LOCAL COSTS</u></b>					
a. <u>SEMINARS AND WORKSHOPS</u>	10%				
(1) Participant Per Diem (4.70/day x 450 days (year 1)) (4.70/day x 600 days (years 2 & 3))		1,880	3,100	3,410	8,390
(2) Travel (10/participant x 80 (year 1)) (10/participant x 190 (years 2 & 3))		800	2,090	2,300	5,190
(3) Meeting Materials (10/participant x 80 (year 1)) (10/participant x 190 (years 2 & 3))		800	2,090	2,300	5,190
b. <u>SHORT-TERM/PART-TIME WORKERS</u>	7%				
Average 4 person-months p (5/hour average rate)		4,800	5,140	5,500	15,440
SUBTOTAL OTHER LOCAL COST		<u>8,280</u>	<u>12,420</u>	<u>13,510</u>	<u>34,210</u>
<b>7. <u>MONITORING AND EVALUATION</u></b>					
a. <u>MONITORING BY IHAP TECHNICAL STAFF</u>					
(1) Travel (1 trip/year, years 1 & 2 2 trips year 3)	10%	2,500	2,750	6,060	11,310
(2) Per Diem (20 days per trip @ 55)	7%	1,100	1,180	2,520	4,800
b. <u>INDEPENDENT EVALUATORS (2)</u>					
(1) Salary (180/day x 30 days)	7%	--	--	12,370	12,370
(2) Per Diem (55/day x 30 days)	7%	--	--	3,780	3,780
(3) Travel	10%	--	--	6,060	6,060
SUBTOTAL MONITORING AND EVALUATION		<u>3,600</u>	<u>3,930</u>	<u>30,790</u>	<u>38,320</u>

	<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
A. <u>IHAP DIRECT OPERATING COSTS (CONT'D) (US \$)</u>					
<u>TOTAL IHAP DIRECT OPERATING COSTS</u>		<u>332,780</u>	<u>223,630</u>	<u>242,890</u>	<u>799,300</u>
B. <u>IHAP INDIRECT COSTS (69.0% of LONG-TERM SALARIES*)</u>		<u>48,300</u>	<u>51,680</u>	<u>55,300</u>	<u>155,280</u>
<u>TOTAL IHAP DIRECT AND INDIRECT COSTS</u>		<u>381,080</u>	<u>275,310</u>	<u>298,190</u>	<u>954,580</u>
C. <u>CONTINGENCY (10%)</u>		<u>38,110</u>	<u>27,530</u>	<u>29,820</u>	<u>95,460</u>
		<u>419,190</u>	<u>302,840</u>	<u>328,010</u>	<u>1,050,040</u>

D. GOVERNMENT OF SWAZILAND EXPENDITURES  
(Emalengeni; E1.00 = \$1.33)

1. SALARIES

7%

a. PROJECT COUNTERPARTS

(Note: No salaries are paid during long-term training)

(1) Health Planning Officer (Grade 20)	1,680	7,190	7,690	16,560
(2) Manpower Development Officer (Grade 20)	1,680	--	5,770	7,450
(3) Program Development Officer (Grade 18)	4,400	1,410	4,530	10,340
(4) Senior Health Administrator (Grade 20)	1,680	--	5,770	7,450

b. SUPPORT STAFF

(1) Shorthand Typist (Grade 10 (12))	2,790	3,260	3,490	9,540
(2) Statistical Assistant (Grade 12)	2,790	3,260	3,490	9,540

\* Computed at 69.0% of long-term technician salaries and wages per indirect cost rate agreement with USAID dated March 7, 1979

	<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
<b>D. GOVERNMENT OF SWAZILAND EXPENDITURES (CONT'D)</b>					
<b>(Emalengeni: E1.00 = \$1.33)</b>					
<b>1. SALARIES (CONT'D)</b>	<b>7%</b>				
<b>c. PROFESSIONAL STAFF</b>					
<b>(1) Headquarters Staff</b>					
(a) 6 Staff Members (25% FTE) Average Grade 22		13,770	14,730	15,770	44,270
(b) 2 Staff Members (10% FTE) Average Grade 22		1,840	1,960	2,100	5,900
(c) 3 Staff Members (25% FTE) Expatriate Contracts Average Salary E25,000		18,750	20,060	21,470	60,280
<b>(2) District Staff</b>					
(a) 20 Staff Members (15% FTE) Average Grade 18		18,000	19,260	20,610	57,870
(b) 40 Staff Members (10% FTE) Average Grade 12		12,190	13,050	13,960	39,200
<b>SUBTOTAL SALARIES</b>		<u>E79,570</u>	<u>E84,180</u>	<u>E104,650</u>	<u>E268,400</u>
		(\$105,830)	(\$111,960)	(\$139,180)	\$356,970)
<b>2. TEMPORARY LODGING ALLOWANCE FOR LONG-TERM TECHNICIANS</b>		12,600	--	--	12,600
<b>3. OFFICE ACCOMMODATION AND UTILITIES (E750/month (1981))</b>	<b>10%</b>	9,000	9,900	10,890	29,790
<b>4. TRAVEL FOR ACADEMIC TRAINING</b>	<b>10%</b>				
a. <u>AIR FARE TO TANZANIA</u> (one way = E500)			550	610	1,160
b. <u>AIR FARE TO USA (2)</u> (one way = E940)		1,880		2,270	4,150
<b>5. IN-COUNTRY TRANSPORTATION</b>	<b>10%</b>				
a. <u>PROJECT VEHICLE FUEL AND MAINTENANCE</u> (2 vehicles x 25,000 km/year x 0.30/km)		15,000	16,500	18,150	49,650

	<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
<b>D. <u>GOVERNMENT OF SWAZILAND EXPENDITURES (CONT'D)</u></b> (Emalengeni; E1.00 = \$1.33)					
5. <u>IN-COUNTRY TRANSPORTATION (CONT'D)</u>	10%				
b. <u>TRANSPORT IN EXCESS OF PROJECT VEHICLES</u> (10,000 km/year x 0.30/km)		3,000	3,300	3,630	9,930
6. <u>OFFICE FURNISHINGS, EQUIPMENT AND SUPPLIES</u> (Year 1 = E5,000; years 2 & 3 = E2,000/year)	10%	5,000	2,200	2,420	9,620
7. <u>FURNISHINGS FOR LONG-TERM TECHNICIAN HOUSES</u> (E5,000 per house x 2 houses)		10,000			10,000
8. <u>IN-COUNTRY PER DIEM ALLOWANCE</u> (Health Facility Survey, Manpower Assessment, Technician and Counterpart Travel @ E3.50/day) (By year: 1 (800), 2 (400), 3 (800))	7%	<u>2,800</u>	<u>1,500</u>	<u>3,210</u>	<u>7,510</u>
<b>TOTAL GOVERNMENT OF SWAZILAND EXPENDITURES</b>		<u><u>E138,850</u></u> (\$184,670)	<u><u>E118,130</u></u> (\$157,110)	<u><u>E145,830</u></u> (\$193,950)	<u><u>E402,810</u></u> (\$535,730)
<b>E. <u>IHAP AND OTHER DONOR CONTRIBUTIONS (US \$)</u></b>					
1. <u>IHAP</u>					
<u>ANNUAL CASH CONTRIBUTION (\$8,000/YEAR)</u>	10%	8,000	8,800	9,680	26,480
2. <u>WORLD HEALTH ORGANIZATION</u>					
<u>CONSULTANT COSTS (SALARY, PER DIEM, AND TRAVEL)</u> <u>FOR EXPERTS IN HEALTH STATISTICS AND/OR</u> <u>NUTRITION PLANNING AND SURVEILLANCE</u> (\$250/day x 30 days/year)	7%	7,500	8,030	8,590	24,120

<u>E. IHAP AND OTHER DONOR CONTRIBUTIONS (CONT'D) (US \$)</u>	<u>Annual Increment</u>	<u>Year 1</u>	<u>Year 2</u>	<u>Year 3</u>	<u>Total</u>
<u>3. UNICEF</u>					
<u>EQUIPMENT AND SUPPLIES FOR RURAL CLINICS</u> (Based on outcome of Health Facilities Survey; Estimated \$12,000/year in years 2 & 3)	10%	--	<u>13,200</u>	<u>14,520</u>	<u>27,720</u>
<u>TOTAL IHAP AND OTHER DONOR CONTRIBUTIONS</u>		<u>\$15,500</u>	<u>\$30,030</u>	<u>\$32,790</u>	<u>\$78,320</u>

INITIAL ENVIRONMENTAL EXAMINATION

Project Country: Swaziland

Project Title: Strengthening the Planning and Management Capabilities of the Ministry of Health

Life of Project: Three years

Funding: (Operational Program Grant)

Implementing Agency: International Human Assistance Programs, Inc.  
360 Park Avenue South  
New York, New York 10010

IEE Prepared By: Environmental Officer  
USAID/Swaziland

Threshold Decision Recommended: Negative Determination  
Julius Coles, Director  
USAID/Swaziland

Date:

Assistant Administrator's Decision:

Approved: \_\_\_\_\_

Disapproved: \_\_\_\_\_

Date: \_\_\_\_\_

## I. Description of the Project

The project will expand the capability within the Ministry of Health in the areas of planning, management, and policy development related to the provision of health care services in Swaziland. The project will provide long-term technical support to improve and institutionalize the functional operation and related organizational structure of the Ministry, and to develop a comprehensive long-range plan incorporating manpower, facilities, services, and financial and other resources. Academic training will be provided for three members of the Headquarters staff so that they will be able to function effectively in their specialized areas of planning and management. Thus by the end of the project, the expanded capability will be institutionalized through the provision of established posts, academic training, and on-the-job experience for Swazi counterparts to the long-term project technicians and for the Swazi Program Development Officer.

## II. Discussion of Impact

Due to the nature of this project and the activities which will take place with funds provided by USAID, a project checklist has not been prepared. It has been determined that no significant impacts on the natural or physical environment will result as a consequence of this project.

## III. Recommendation

On the basis of an Initial Environmental Examination, it is clear that this project can be justifiably designated as environmentally benign. Therefore, it is recommended that a Negative Determination be made on this project.