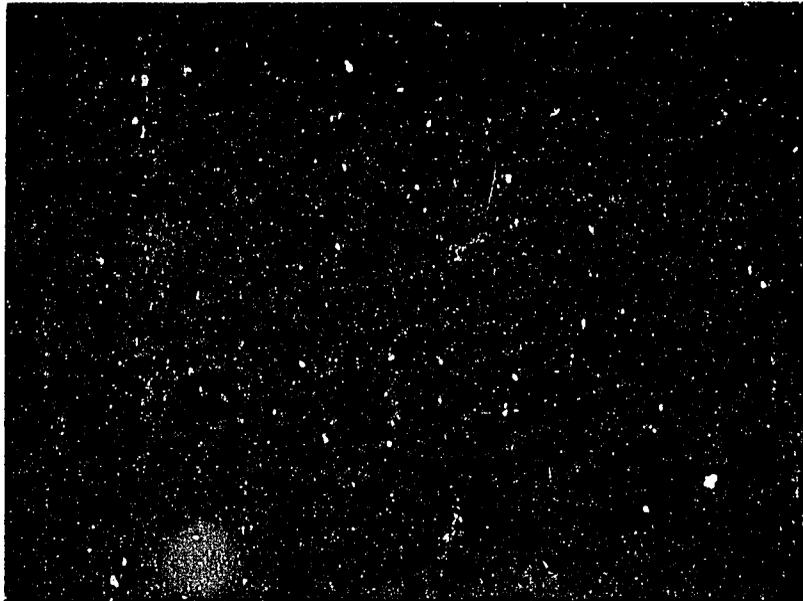


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Medical Service Consultants, Inc.

MEDICAL SERVICE CONSULTANTS, INC.

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FINAL REPORT

SWAZILAND HEALTH MANPOWER TRAINING

Contract AID/afr-C-1236

Catherine E. Demarais
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July 18, 1984

I. OVERVIEW

Medical Service Consultants, Inc. (MSCI) was awarded a contract in 1978 to implement the Swaziland Health Manpower Training Project. The goal of the project was to strengthen the Ministry of Health's manpower resources by:

- training new nurses and other health workers;
- developing continuing education courses;
- developing a regional hospital administrative and logistic support system;
- developing rural health services, administrative and logistic support system.

In 1981 the contract was amended to include the continuing implementation of a new health information system.

MSCI provided six technical advisors to implement this project. They were:

1. Chief of Party/FP Nurse Educator: Claudette C. Baily;
2. Hospital Administrator: Oliver E. Hatfield;
3. Family Nurse Practitioner/Educator: Judith Grybowski (1978-1980), Phyllis Jenkins (1980-1983);
4. Rural Health Services Administrator: Kirk R. Grybowski (1978-1980), K. K. Konturas (1980-1984);

5. Curriculeum Design Consultant: Laura H. Yergan;

6. Health Statistician: Catherine Connolly.

An Advanced Placement Evaluation Specialist was to be provided, but after assessing the projects progress USAID/Swaziland, the MOH, and MSCl felt there was no longer a need for this position. Instead a Writer/Editor was provided to assist the Hospital Administrator and the Rural Health Services Administrator with the development of two policy and procedure manuals.

Participant training, construction, and commodity procurement was handled by USAID/Swaziland through other contractors.

By 1984, MSCl's advisory team had met the goals of the Health Manpower Training Project. The Swaziland Institute of Health Services (SIHS) is a well functioning training institute with a strong faculty. It currently trains:

- Family Nurse Practioners;
- MCH Nurse Practitioners;
- State Registered Nurses;
- Health Inspectors;
- Dental Hygieninst.

In addition, continuing education courses are held regularly for government nurses trained earlier. These courses update their skills, promoted preventive health care, and emphasized the need for community health education.

A decentralized rural administrative system met with some resistance initially. The two MSCI technicians then focussed on developing a functioning support system for the hospital and the rural clinics. Through their efforts, the MOH has accepted the concept of decentralized services and in nondeveloping plans to implement it more fully.

The health information system is in place and provides more data for health planning at the Ministry.

II. ACCOMPLISHMENTS

A. Nurse Training

The MSCI nurse/educators were very successful in implementing their program and accomplishing their objectives. The nurses were responsible for:

- developing the nursing curricula for the SIHS;
- teaching courses while counterparts were in training;
- instituting continuing education courses for nurses already working in the government service; and
- strengthening the faculty at the SIHS.

By January 1980, the first class of 22 basic nursing students were admitted to the program. They began a three course study of nursing. In the fourth and final year, they were to choose one of two specialty areas: midwifery or psychiatric/mental health. In September of 1983, the first graduation took place. Out of 118 graduates of SIHS, 60 were registered nurses who had completed the Family Nurse

Practitioners or MCH Practitioners course. Thirty-four State Registered Nurses were also graduated.

Seven Swazi nurse educators were sent to the U.S. for training. They all returned to the SIHS as faculty members. Five of them completed a B.A. Nursing degree, one completed an MPH in Maternal/Child Health, and one did an M.A. Nursing/Family Nurse Practitioner degree.

The SIHS is fully operational as planned. The curriculum is in place and the Swazi faculty is well trained. The Institute's Principal and faculty are now examining ways to expand the nursing program such as increasing the kinds of fourth year specialties available to the students. Further expansion of the facility is planned to enable more students to be trained. As the administrative systems were being implemented, clinical practice sites were chosen in rural areas. This improved the practical training availability to the students in both urban and rural areas.

The aspect of the program has done much to turn the Swazi health system from curative care to preventive care.

B. Hospital Administration

The Hospital Administrator began working at the Hlatikulu Hospital in Southern Swaziland. While at this post, he was to begin defining an appropriate management system for the government hospitals. At the same time, he would provide on the job training for counterparts. This

training would be supplemented by a formal training course in Botswana.

However, counterparts were not identified until the final year of the project. They were then placed in U.S. schools for a more comprehensive training program. This change eliminated the opportunity for on the job training in the new system.

The new system did achieve the objective of introducing efficient management procedures into the hospital. Maintenance of the hospital and grounds was improved, a simple budgeting system was introduced, patient records were reorganized to provide more complete data, and the administrative burden was moved from the physicians and nurses to the hospital administrator.

It was then decided to move the Hospital Administrator to Mbabane to upgrade the hospital there. Mbabane Hospital was used as a teaching facility for SIHS and was in great need of better management.

The systems developed in Hlatikulu were then implemented at Mbabane. This provided a more appropriate facility to reinforce the health concepts being taught at the SISH.

When USAID realized that the counterparts would not be returning much before the end of the MSCI contract, they requested that a hospital manual be developed. This document defined the Swazi government policy on hospital

administration and provided a step by step description of the newly developed system. This manual will be used by the new hospital administrators to reinforce their training. It will also serve as a comprehensive guidebook to other hospital personnel. The format is a looseleaf style to allow revisions as the system evolves to meet Swazi health care needs.

C. Rural Health Administration

The Rural Health Administrator was charged with the task of providing logistical support for health services in a decentralized health system. Unfortunately, the MOH had not developed this decentralized policy and were unsure of the need for it.

Throughout this project both rural health administrators worked with the MOH to promote the decentralized concept to illustrate how it could work. Currently the MOH is developing such a policy.

Without guidelines from the MOH, the rural health administrators had to develop several systems to address logistical problems in Shiselweni district. This has resulted in an unofficial decentralized system to support all health activities.

The Rural Health Administrator focussed on the:

- coordination of government, private, and industrial health services, and

- community participation in developing and implementing health services throughout the district.

In addition he:

- developed a medical supply delivery system for Hlatikulu Hospital;
- expanded and improved communications between the hospitals, health centers, clinics and mobile units;
- initiated construction of new health facilities or up-grading of existing ones;
- assisted in implementing the new data collection system;
- developed an administrative manual for rural health services administration.

As in the case of the hospital administrator, no counterpart was identified until the final months of the project. The counterpart was trained in the U.S. and returned to take over the District Health Administrator post. On the job training was minimal due to the time constraints.

The community participation in the Shisilweni District has become a model for the rest of Swaziland. The Rural Health Administrator enlisted local businessmen and community leaders to serve on a hospital board. This group works with health providers to plan the development of

of hospital and community health activities.

To strengthen this committee, he worked with the MOH's Health Education unit to provide continuing guidance to committee members. This provides the board members with information on available resources, how other communities handle similar problems and public health issues effecting their community.

D. Health Statistics

The Health Statistician worked on expanding the pilot system throughout Swaziland and developing the capabilities of the Statistics Unit.

To expand the system, the statistician established procedures to improve the distribution and collection of data forms. This ensured a better response to give the Statistics Unit more complete data. The Unit then published this data quarterly as well as annually. This exchange of vital health data increased the cooperation from all areas in providing this information. The quarterly report also provided the nursing staff with the data they needed in planning health education and other activities.

Several personnel were trained to strengthen the manpower in the Statistics Unit. This included a Health Statistician who had one year of on the job training before going to the U.S. for a M.P.H. She will return shortly to continue the work in the Statistic Unit. In addition, training was provided for a Statistical Assistant, a

Medical Coder and six clerks.

In January, 1983, a microcomputer was purchased. This has enabled the Statistics Unit to increase their analytic capabilities as the data is processed more quickly. This has also provided more accurate and timely data encouraging the use of statistics in the MOH's long range planning.

The Statistics Unit worked closely with the Planning Unit to coordinate the types of data collected and how they were used. Special assistance was then provided to other health projects including:

- conducting a national nutrition survey;
- preparing a plan for upgrading nutrition surveillance; and
- developing a system for reporting infectious diseases.

These accomplishments have provided the MOH with the improved statistical capability necessary to meet the growing demands of the health sector.

III. CONCLUSIONS

The Swaziland Health Manpower Training Project has proven to be a successful development project. With strong teamwork among the USAID/Swaziland, the MOH, and the MSCI contract team the objectives were met:

- The SISH is a functioning training institute for nurses and other health personnel which stresses preventive health care services.

- The Shiselweni District has become a model for country-wide decentralization of health services.
- The administrative and logistical support services have been established for both hospitals and rural health services.
- The Statistics Unit is providing more timely and accurate health data to permit long range health planning.

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**SWAZILAND HEALTH MANPOWER
TRAINING PROJECT**

CONTRACT NO. AID/afr-C-1396

**HOSPITAL ADMINISTRATOR
FINAL REPORT**

SUBMITTED BY:

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September 5, 1984

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SWAZI HEALTH MANPOWER TRAINING PROJECT**FINAL REPORT****HOSPITAL ADMINISTRATION SECTION****I. OVERVIEW**

Over all the entire project is considered to be a success. The project goals were either completed or are in the process of completion. Basically the project was to improve three main areas: nurse training at the Institute of Health Sciences, Hospital and Rural Health Administration, and statistical data collection and analysis. The Institute is completed and the nursing education programs have been implemented. Hospital and Rural Health Administration is still not quite complete. Though a decentralized system has been designed, the Ministry of Health is still formulating an overall decentralization policy. In the area of health statistics, new forms were designed, distributed, and are now in use.

II. HOSPITAL ADMINISTRATION

The project goals of the hospital administration portion of the project were three fold. They were:

- institution building;
- implementing various management systems;
- training counterparts.

It was also important to establish the concept of the

hospital administrator, primarily responsible for all non-medical functions of the hospital. These goals were accomplished as far as possible under the constraints of official Swazi government policy. All of the detailed objectives itemized in the December, 1983, work plan have been completed. A brief discussion of the three major goals follows.

A. Institution Building

Institution building was a goal emphasized throughout this USAID project. To achieve this goal the hospital had to become a separate entity, responsible for a specific function, with a separate financial status, managed by a function specific manager. This has been achieved. The hospitals have evolved into institutions in the full sense of the word. The basic goals itemized in the project paper either have been, or are in the process of completion.

One critical part of this first goal was an administrative manual. This manual delineated the philosophy of hospital administration as well as setting down the approved management systems. It will be used as a guideline for the newly trained hospital administrator. In writing this manual, the MOH held several meetings to discuss approved policy decisions.

A second required part was job descriptions. These were

prepared for some 109 hospital jobs.

B. Management Systems

The installation of management systems is critical to the operation of any organization that either consumes or dispenses resources. A brief description of the system installed follows.

Hospital Statistics

A system was installed to collect data, process the data, and present it to health managers in useable form to facilitate decisions. Various formulas were applied to the data to give an indication of hospital performance. Among the indicators provided were:

- average length of stay
- birth rate
- death rate
- Cesarean section rate
- ratios of male/female
- medical/surgical
- adults/children
- patients/lodgers
- general/private outpatients

The dental facility was also included in this analysis.

Hospital personnel were trained to collect, analyze, and present this data on a monthly basis. This was to be

continued on a monthly basis by the new Swazi hospital administrator. Besides local circulation within the hospital the monthly analysis was distributed throughout the MOH, Swaziland University, USAID, and private and missionary hospitals.

Food Control and Preparation

This function was completely reorganized. Classes were held in food preparation, a dietician was assigned, and a master menu was prepared. The staff tea function which has cost the hospital E 30,000 per year was placed on an individual paying basis.

Swaziland College of Technology (SCOT), which ran a food catering course; conducted a course at the hospital. Food preparation, as well as food management, was presented. This was very important as the hospital had no trained cooks. A dietician was added to the staff and given responsibility for the kitchen; analysis of patients needs, and preparation of special diets. A master menu was prepared and the staff trained in its proper use. This menu, supplemented by a portion size chart, enabled the staff to order the precise quantity of food required. It also served as a check on food usage and theft. In addition it made daily food preparation easier and provided a medically approved diet.

Equipment Procurement

A plan was formulated to govern the procurement of equipment. This was essentially a checklist which covered the following areas:

- Is the item now obsolete?
- Is it standard?
- Future repairs?
- Parts?

Once all the questions were answered the decision to purchase or not to purchase was clear. The plan also covered equipment purchased in the context of an overall master plan of future hospital utilization.

Basic Budgeting Procedures

It was determined that the Swazi hospitals would use a very basic budgeting system more effectively than more sophisticated techniques. The system covered such questions as:

- What is the cost of a patient per day?
- What is the cost of cleaning the hospital per day?
- How does a department (e.g. lab, x-ray, pharmacy) calculate its yearly costs?

This provided the MOH with information to determine how much it costs to run the hospital for a year.

A budget sequence was also provided. It covered such

areas as how to collect information to justify a request to the MOH for a certain amount of money. The approved master menu illustrated this concept as it served to justify money for food. All hospital areas for a simple, basic system were covered.

Master Maintenance Plan

Maintenance was always a major problem in Swaziland as it was handled as a crisis, emergency type operation. To help change this condition a master maintenance plan for the hospital was prepared. Meetings were held with PWD officials to discuss the plan. The plan gave a listing of maintenance according to priority and a suggested time schedule. This did not solve but greatly improved the problem. PWD was happy that they could schedule known maintenance requirements and the MOH used the schedule for their budgeting.

Transport

This area also proved to be a continuing hospital problem--especially routine servicing and repair. To help solve the problem, scheduling charts were designed and transport personnel instructed in their use. Certain trips were scheduled each week at the same time and all hospital personnel were given the schedule. This had the effect of reducing the number of required trips by 25-30%. This in turn helped improve maintenance. A system to analyze usage

on a monthly basis was installed. This system provided information on vehicle utilization, driver utilization, petrol used, and kilometers traveled by vehicle. This was very useful as it revealed several glaring discrepancies that were resolved.

Area Maintenance Plan

The area surrounding the hospital was divided and personnel assigned to each area. In this way responsibility for maintenance tasks could be determined. This greatly improved the appearance of the hospital. Special attention was given to improving security and appearance by repaving the entrance and installing fences where needed.

Inventory Control

A system of inventory control covering both consumable and non-consumable supplies was instituted. This included ordering, receiving, storage, and issuing. A training outline was drawn up and lectures given to all supply personnel. This training covered economical quantities to order, when to order, cost of supply storage, and various issue strategies. This resulted in a substantial reduction in the cost of supplies.

Waste Management

This system involved the calculation of waste generated by department and the separation of hazardous from routine waste. As a result of this analysis it was known how many

containers were needed so that the Town Council pick-up could be rescheduled, and hazardous waste properly disposed.

Emergency Services

Emergency supplies were identified and stocked, ambulance drivers given a first aid course, and a triage system installed for outpatients. Doctors were placed on 24 hour call in the hospital. Radio contact was established between driver and hospital.

Counterpart Training

Prior to the counterparts coming to the U.S. for formal training they spent a number of months in training at the hospital. A training outline was formulated, approved by the MOH, and lectures given to students. All aspects of the hospital were covered from basic organization to computers.

Hospital Administrator

Perhaps the most valuable accomplishment was the implementation of the concept of the hospital administrator. Prior to this time, hospitals were run by the physician in charge. By placing an administrator in the system, a more efficient and effective use of hospital resources was implemented. The MOH is now committed to this concept of hospital management. A U.S. trained hospital administrator is in place in Mbabane and it is planned that more will be trained.

III. PROBLEM AREAS.

The project was not without its problems. Discussions were held among the MOH, USAID, and MSCI to address these issues. In many cases no clear cut solutions were effected as the MOH had to make decisions on a new or revised policy. The major problems are discussed below.

Lack of a Hospital Organizational Chart

An organizational chart for the hospital was never approved. One was submitted to the MOH by the administrator, however it was never approved or distributed. This resulted in no definite chain of command and responsibilities. Decisions were often made without consultation among top managers. Many of the decisions would later have to be retracted causing confusion among the staff and workers. The need for an approved hospital organization chart is still an issue.

Hospital Policy

A hospital policy was outlined in the manual described above. However, there is still some uncertainty in several areas. Revisions will be needed to define the hospital role within the system and to clarify intra hospital relationships. This will be critical to the institutionalization of the project goals.

Counterparts

For the first three years no counterparts were provided. When they were finally identified, sufficient time was not left in the project for proper training. Though they received the planned U.S. training, a year of on the job training was to follow. This was not implemented.

In addition the counterparts were selected by Establishments and Training. Random selection was used rather than determining who was interested in hospital work resulting in some inappropriate candidates for hospital administrator.

Budget Problems

Government financial laws precluded the installation of proper, efficient, budget procedures. In fact, within the MOH itself no budget procedures were in existence. An effort was made to install budget procedures in the hospitals as discussed above. However the almost total lack of money (e.g. no drugs, gasses, or supplies) hindered the implementation of the budget process. This is a continuing problem.

Personnel

There are two major problems concerning the personnel. One, personnel at the Ministry level are not familiar with

hospital operations and administrative procedures. Often a major problem could not be understood by those who must make the policy or decision. Secondly, far too many people at the hospital were totally unproductive. However, due to Swazi government regulations it was often impossible to institute changes. This will most probably continue to present problems as no workable solution can be implemented.

IV. FUTURE RECOMMENDATIONS

1. Insure that what has been agreed to does not run counter to the host countries existing laws.
2. Insist on the host country fulfilling its agreement within a reasonable time frame.
3. Extend the project until the goals in the project paper are completed. In this case the project ended approximately one year short of project paper completion of goals.

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**SWAZILAND HEALTH MANPOWER
TRAINING PROJECT**

CONTRACT NO. AID/afr-C-1396

**RURAL SERVICES ADMINISTRATOR
FINAL REPORT**

SUBMITTED BY:

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September 5, 1984

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IV. RECOMMENDATIONS

PART I. ACCOMPLISHMENTS

The Rural Health Services Administrator Advisor concentrated on the development of infrastructures and procedures that have improved the organization and operation of health services in southern Swaziland.

At present a logistical support system exists within the Shiselweni District to facilitate the delivery of health care services within the district hospital catchment area. Administration for the district has unofficially been decentralized and has become the pilot and showcase for the remainder of the country. The coordination of curative and preventative health care delivery is being handled through the newly created District Health Team, made up of both curative and preventative health workers. The creation of the Rural Health Services Administrator (now known as the District Health Administrator/DHA) post, establishes the nerve center for coordination and the provision of management assistance to an interlocking complex of health care units.

A counterpart is trained and presently operational. This counterpart will be responsible for the institutionalization of developed procedures and organization. The District Health Operations Manual was written to assist with this process.

PART II. INITIAL OVERVIEW

The first task undertaken by the DHA was to make an administrative assessment of the Hlatikulu Hospital catchment area. It was noted that the district hospital was the administrative center for the Shiselweni and half of the Lubombo districts.

With the transfer of the Hospital Administrator to Mbabane Hospital and the premature removal of the hospital secretary position, unresolved personnel, transport and physical problems relating to the building, renovation, upgrading and expansion of all health facilities throughout the southern part of the country came to a standstill.

The Senior Medical Officer of the hospital, traditionally in charge, soon found it impossible to cope on the many problems needing attention. It was at this point that the DHA assumed a portion of the responsibilities dealing with hospital administration and development.

During the assessment period it came to light that rural clinics and health centers were in a state of low morale and structurally in need of major and minor repairs. Many had no access to basic items such as potable water, electricity, sanitation and a means of communication. All suffered from a lack of medical

supplies, equipment and basic needs, i.e., firewood, coal, kerosene. All of these shortcomings were due to a total lack of administrative control, direction, coordination and personal follow-up. Efficient transport use and logistical support systems were non-existent. Further health care services development was impossible and health care services in the rural areas were in a state of regression with little community involvement. At this stage of the project counterparts were being recruited and assigned to Mbabane Hospital for the initial stages of training.

PART III. PROJECT GOALS

A. Develop working relationships with District Health Sectors

Early in the project contact was made with the Mission, Private, and Industrial Sector. The purpose was to develop rapport and a working relationship in order to address district health needs in a cooperative manner. Through formal and informal meetings at the district level, issues were discussed which focused upon:

- (1) Cooperative planning in the delivery of health care;
- (2) Assessment of cold chain for immunization storage;
- (3) Development of schedules for physician visitation;
- (4) Assessment of medication requirements;
- (5) Standardization of health record keeping system;
- (6) Development of strategies for increasing community involvement; and
- (7) Water and sanitation issues.

Due to the rapport that has been developed at the district level, the Mission, Private and Industrial sectors have taken on some of the responsibilities within their spheres of influence in order to help health care reach more of the rural population.

Some Examples of this are:

- (1) Health Record Keeping System has been standardized to incorporate Mission and Industry facilities.
- (2) Private physicians are beginning to cooperate with the PHU by supplying statistics on family planning progress. They in turn, receiving contraceptives from government stores.
- (3) Mission clinics are presently receiving government physician visits on a scheduled basis and are now taking on a more active role in assisting in district development

At present a feeling of interdependence exists among the various sectors. Given the opportunity it can be broadened and strengthened.

B. Counterpart Training

Upon assuming the role of DHA a counterpart training program was developed and submitted to the MOH for approval. The program called for a rotation of counterparts between the Mbabane Hospital Administrator and the DHA Shiselweni. Each counterpart would spend three months in each area understudying their respective Advisors in a semi-operational capacity.

Problems arose when one counterpart died in a tragic accident and another was found to be unsuited due to a lack of responsibility and motivation.

The remaining counterpart candidates left for training in the U.S. only to return at the end of project. This late return necessitated an extension of three months in order to provide an overlap period with the advisors.

Presently, in the Shiselweni District, the DHA post has been officially filled and is an operational position.

C. Development and Strengthening of Community Health Committees

The need for community organization, interest and participation became a major part of rural health development. Earlier attempts at the organization health committees encountered problems mainly due to:

- (1) A lack of an administrative structure at district level that could assume responsibility and provide management assistance for development.
- (2) A lack of an organized capability to provide direct support and technical assistance for community education to facilitate participation.

This resulted in a plan where by the DHA would have overall responsibility for health committee development throughout the district hospital catchment area including the creation of a District Hospital Board. It called for a strong working relationship between health facility staff, community leaders, chosen health committee members, and the DHA who would represent the interests of the District Health Team as well as the MOH.

The methods used to reach communities was through the "General Meeting". The general meetings focused on major community issues and it was here that the traditional system could be utilized to:

- (1) Structure community thinking towards understanding the need for Health Committee development and community cooperation.

- (2) elect members and officers to the local health committees.
- (3) introduce the need and mechanics of community money collection together with the establishment of a properly banked Health Fund under committee control.
- (4) identify local health needs, priorities, and to stimulate community initiatives for construction or renovation of health facilities.

To counter the lack of district support and technical assistance for community education, the Health Education Unit was called upon to assist in the planning and implementation of a strategy that would strengthen community committee participation.

This led to organized seminars where groups of Health Committees, together with their respective health facility staff and local traditional healers, were introduced to:

- (1) Problem solving techniques relating to community participation or the lack of.
- (2) Resources available for community development (agriculture, FWD, MOH, other doners, etc.).

- (3) Group discussions on how different communities handle similar problems.
- (4) Demonstrations on pit latrine construction, spring protection, etc.
- (5) Lectures and demonstrations on Public Health issues and all health services available to rural communities.

The seminars are proof of the serious intentions of the district health administration to work closely with local grassroots health committees. They have acted as a catalyst in encouraging community participation.

At present Hlatikulu District Hospital boasts of a dedicated functioning hospital board. The members consist of local concerned businessmen and community leaders who volunteer their time and take an active part in directing hospital and community development.

The district hospital catchment area boasts of the most developed grassroots community administrative infrastructure within Swaziland.

D. Establishment of District Health Offices

Office space for three offices were negotiated by the DHA and Postmaster of the Nhlanguano Post Office.

Office furniture, equipment and telephones were purchased out of the Hospital Clinics budget. A post was created to employ a secretary that will be shared by both the District Health Administrator and District Health Inspector.

At present, these offices are in use and an additional office has been created for the DHA of Hlatikulu Public Health Unit. The reason for this is to have the DHA near the District Hospital until such time as a hospital administrator takes over hospital responsibilities.

E. Development of District Health Team

To better coordinate district administration and health issues, a need developed to establish a District Health Team.

Members include:

- a) District Health Administrator;
- b) SMO/Hlatikulu Hospital;
- c) MO/Sitobela Health Center;
- d) District Health Inspector;

- e) District Pharmacist;
- f) Senior Matron (District);
- g) Sister-in-charge Nhlango;.
- h) Sister-in-charge PHU.

At present, team members meet on a monthly basis where priorities for district development are made. It acts as a coordinating body between the MOH, other ministries and local community leaders. It is attempting to create a sense of cooperation and teamwork with all available resources (community, private sector, mission and government) for the improvement and development of health care delivery at the district level.

F. Development of Medical Supply Delivery System to Hlatikulu Hospital

Prior to the arrival of the DHA medication and medical supplies necessary for running a District Hospital were delivered in a haphazard and incomplete fashion.

The problem focused upon driver and transport availability at Central Stores level. Orders were often filled by individuals unfamiliar with the proper handling and descriptions of the various medications and supplies.

The solution to this problem was to choose a dispenser at Hlatikulu Hospital Pharmacy who would obtain a government license, at the same time negotiating with the MOH for a truck used solely for the collection of medical supplies at Central Medical Stores (CMS).

At present the Hlatikulu Hospital Pharmacy has a dispenser/driver and truck.

Scheduled runs to CMS are made on a weekly basis. This has not only improved the morale in the hospital and pharmacy, but has made it possible to maintain a reserve of medical supplies and medication for district use and distribution.

G. Development and Coordination of Medical Outreach Program

To serve the population beyond the clinic catchment areas, a pilot outreach program was started for 8 areas, chosen by their population density and need.

Schools were used to disseminate information to homesteads being served. Headmasters and teachers were anxious to cooperate in this endeavor providing classrooms and personal assistance in organizing indoor facilities.

Temporary transport was organized for carrying immunization supplies, medication, soy powder and dry milk as well as two public health nurses, one assistant and a driver. Upon arrival at an Outreach site, the nurse in charge would give health talks on the need for immunization, good nutrition, availability of family planning information and community responsibilities. Often, a health assistant participated in discussing sanitation and water protection.

At present, the Hlatikulu Public Health Unit Outreach Program has become an established service. Permanent transport has been assigned specifically for outreach and further development of the kinds of services that can be rendered to remote areas are under consideration. It has become a vital link to isolated areas.

H. Development and Distribution of District Health Operations Manual

The manual was developed:

- (1) To consolidate existing administrative responsibilities.
- (2) To act as a comprehensive reference.
- (3) To reinforce the role of the Health Administrator.

- (4) To be utilized as a format and basis for future development and change during the next administrative phase of decentralization.

To assess the manual's potential as an administrative tool, copies were issued to mission, private and government health sectors. All sectors praised the clarity and comprehensiveness of the document.

A meeting was then arranged with the MOH Planning and Development committee. At the meeting the manual was reviewed and accepted with minimal changes.

At present, 30 copies have been distributed and are being utilized as originally envisioned.

I. Communication Systems Development

Early in the project, a need was assessed to expand and improve communications among the hospital, health centers, clinics and mobile units. Expansion and improvement would mean 24 hour coverage within the hospital and that health centers and clinics would have access to the district hospital and mobile units.

Acting as liaison between STBC and communication technical personnel, the DHA arranged for the placement of the district antenna at Hlatikulu.

A radio communication base station was established at the district hospital, including a staff paging system. Radio's were installed in designated health centers and clinics, as well as public health mobile units involved with outreach work and ambulances on call. To further improve communication, applications were made to Post and Telecommunications to install telephones in health facilities where ever possible.

At present, the Hlatikulu Hospital catchment area has a fully functioning communication system which has, as a result, greatly improved morale of rural staff by minimizing the feeling of isolation.

J. Initiate District Health Facility Construction and Upgrading Utilizing Community and Government Resources

Upon completion of the district health facility assessment by the DHA, areas were chosen where new health facility construction would take place and older facilities would be upgraded to improve their access to water, electricity, sanitation and an ongoing maintenance scheme. Major factors in considering an area were community interest, motivation, and participation.

The period 1982-83 witnessed the formation of the "Rural Clinic Building and Renovation Project". It was responsible to the MOH but had offices in the Ministry of Power Works and Communication (PWD). During this period, the project manager and counterpart worked closely with the DHA to develop a format and strategy for involving local communities. (The prerequisites are noted in Section J of the District Health Operations Manual.)

The DHA would play a major coordinating role within the district to:

- (1) Assist in the development of a community infrastructure - Health Committee and Fund.
- (2) Introduce and explain the role and responsibility of the community in assisting in their own development.
- (3) Introduce the Rural Clinic Building and Renovation Project to the community as well as other technical advisors, i.e., water, sanitation.
- (4) Follow-up on progress of project and liaise between community and government when specific needs arise.

- (5) Be administratively responsible through the District Health Team for all health facility development.

K. Present Status of Health Facility Building and Renovation

There are four brand new clinics under construction:

1. Jericho;
2. Enthlejeni;
3. Mashobeni;
4. Kazenzile.

Four clinics have been renovated and upgraded:

1. Hluti;
2. Mahlandle;
3. Mhlosheni;
4. Zombodze.

Two clinics were replaced with ones having an improved design:

1. Dwaleni;
2. Ntshanini.

Two clinics are in the process of being replaced with an improved design:

1. Sinceni;
2. Lubuli.

Two new Health Centers are under construction:

1. Matsonjeni;
2. Nhlangano.

Three clinics are in the process of organizing replacement structures (improved design):

1. Lavumisa;
2. J.C.I.;
3. Gege.

Hlatikulu Hospital is undergoing renovation.

Community participation and the local collection of funds by the various health committees have advanced the Hlatikulu Hospital catchment area to the forefront of health and community development.

L. Upgrading District Health Record Keeping and Data Collection

The changeover from the old health data collection system to the patient retained model was accomplished in the Hlatikulu Hospital catchment area in collaboration with the MOH Statistician. This system is presently operational and has improved data collection as well as drastically cutting down on administrative work for health staff.

M. Upgrading of Hlatikulu Hospital through Community and Government Cooperation

With the emergence of a hospital board made up of local businessmen and government officers, meetings were arranged to discuss strategies on how to address the rapid structural deterioration of Hlatikulu Hospital. The local community together with board members, government officers and hospital staff organized and staged various fund raising projects, the proceeds of which went for hospital repair and expansion projects.

Some Examples are:

- 1) Repair and replacement of roofs.
- 2) Replacement of broken windows and doors.
- 3) Construction of workshops, TB examination and treatment

annex, duty stations for nurses and storage space for pharmaceuticals and medical equipment.

- 4) Purchase of medical instruments and equipment.
- 5) Purchase and installation of hot water geysers.
- 6) Work begun on the expansion of the maternity ward and the building of a new outpatient unit.

The cooperation between the community, donor agencies, local and central government, proves that, if organized properly and administratively directed and supported, communities are an invaluable and willing resource.

N. Financial Management of District Health Warrants

Financial management was shared between the Senior Medical Officer and DHA. Responsibilities focused on the:

- 1) Collection of financial data for the coming fiscal year.
- 2) Submission of budget together with justification for MOH approval.

- 3) Monitoring of budget activities and accounts officers to ensure that proper accountability procedures are followed.

Presently, the newly installed DHA is a full warrant holder, which is essential in order to neutralize the traditional overshadowing effect of the Senior Medical Officer.

O. District Transport and Fuel Accountability Systems

The duties of the District Transport Officer are presently a function of the DHA. This includes both the procurement and effective use of transport at district level.

Decisions on use and type of transport needed for the various health sectors are made in coordination with the District Health Team. The DHA, when a team decision has been reached, makes a formal request with justification to the MOH, with follow-up.

P. Fuel Accountability

With the withdrawal of the Fuel Coupon System by the Ministry of Transport, it was decided that the accounts section would monitor fuel consumption and costs. Presently the DHA has the added responsibility to make spot checks to insure that proper accounting procedures are maintained.

PART IV. RECOMMENDATIONS

With the development of community infrastructures and continued motivation, the coordination and provision of management assistance to an interlocking complex of health care facilities has been accomplished. A few recommendations are noted here to further reinforce, and expand the role of the District Health Administrator.

- (1) The Hlatikulu Hospital catchment area should be utilized as a model for the decentralization of health administration at the district level.
- (2) New and relevant health projects should be instituted in the Hlatikulu Hospital catchment area because of the districts' unique administrative capability. Coordination, monitoring and evaluation of health projects are possible at a local level.
- (3) Implement a functioning, reliable Health Education Unit at district level. (This cannot be overemphasized.) Without this very necessary resource, much which has been gained, can quickly be lost. Without educational follow-up

infrastructures and systems weaken and eventually disappear.

Possible future projects in health and social development areas:

- (1) Health care for the aged
- (2) Health care for the disabled
- (3) Occupational health dangers and issues
- (4) Strategies for dealing with the deaf, blind and retarded
- (5) Strategies for youth education, i.e., drug abuse, venereal diseases, development of local youth centers.

One last comment has to do with follow-up on the Health Administrator position itself. Follow-up can take the form of periodic discussions with those administrators already in an operational role and those who are newly trained or about to be trained.

The newness of the Health Administrator concept necessitates keeping updated and in touch in order to maintain a running account on new developments and problem areas. Follow-up must be continued until the Health Administrator role and position is securely entrenched.