PN-ABM-602
10727

SWAZILAND HEALTH POPULATION AND NUTRITION SECTOR ASSESSMENT

MARCH 6-25 1989

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This document was underwritten through Contract No. PDC - 1406-00-7144-00 between Medical Service Corporation International, Arlington, Virginia, U.S.A., and the United States Agency for International Development.

Rose Schneider, RN, MPH and Thoko Ginindza PhD served as consultants to Medical Services Corporation International. Kandiah Kanagaratnam MD DPH served as a consultant to the Futures Group.

LIST OF ACRONYMS AND ABBREVIATIONS

CCCD	Control of Childhood Communicable Diseases
FHS	Family Health Survey
FLAS	Family Life Association of Swaziland
EEC	European Economic Community
FRG	Federal Republic of Germany
GOS	Government of Swaziland
HPN	Health Population and Nutrition
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
MCH/FP	Maternal and Child Health/Family Planning
MIS	Management Information System
MOH	Ministry of Health
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PVO/NGO	Private Voluntary Organization/Non-Governmental Organisation
RAPID	Resources for the Awareness of Population Impact on Development
RHM	Rural Health Motivator
RHMT	Rural Health Management Team
SOMARC	Social Marketing Program
UK	United Kingdom
UN	United Nations
UNICEF	United Nations Children Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WS&S	Water Supply and Sanitation

HPN SECTOR ASSESSMENT

EXECUTIVE SUMMARY

I. Introduction

The report is the principal findings, conclusions and recommendations of the Health Population and Nutrition Sector Assessment Team. The team of three consultants worked on the assessment in Swaziland from March 6 - 25, 1989. The team assessed the potential impact of three different options for PHN assistance in the future. The team undertook the assignment based on review of relevant materials, interviews and field visits.

II. Health

The overall health status of Swaziland has improved over the past few years. Much more needs to be done to expand health care to the population. Progress has been made on health indicators in large measure due to several priority interventions. The reported death rate is 17 and the infant mortality is probably lower than the reported rate of 116. There is still a high incidence of infectious diseases. Low levels of chronic malnutrition exist.

The GOS health policy for the past decade has placed an emphasis on preventive and promotive care and expansion of primary health care together with needed manpower development. This policy will continue in the future while at the same time recognizing additional needs in curative care.

The Ministry of Health structure is described. Decentralization to the four regions is a core component. In Swaziland there is a total of 1578 beds. Health centers, public health units and clinics exist and are well distributed around the country. There are some 1000 nurses and 40 physicians and small number of other health professionals. At the grassroots are a large cadre of health motivators and some 10,000 traditional healers. Overall the health manpower situation is stretched.

The GOS provides reasonable support for health care. The MOH budget for 1989/90 is E37.6 million with a satisfactory balance between preventive and curative services. In the area of health assistance USAID has been the major contributor. There are four major projects that total US$20 million besides the centrally funded Project Hope and

Nutrition projects. These projects are briefly reviewed. In overall terms, they

have made significant contributions to the improvement of primary health care, control of childhood communicable diseases and in the water and sanitation situation. There is major support to nurse training. In addition to USAID, several other donors operate in the health area. These include the World Health Organization, United Nations Population Fund, UNICEF, African Development Bank, United Kingdom, Federal Republic of Germany and Italy. Increased assistance from these donors in the health sector is possible.

The socio-cultural context of health care and the role of traditional healers in the provision of basic health care and their influence of health and family planning practices is discussed. Traditional healers have considerable community influence and can play a major role in the further health improvements for Swaziland.

There are a number of strategic issues that affects the future of health care in Swaziland. These include manpower development and retention, increased emphasis on community involvement, the balance within the health system, the role of the traditional sector, the expansion of population programs and other issues.
USAID has played a major role in many of these health sector programs, continued support in a number of these areas will be needed.

The future health sector developments anticipate continued expansion of preventive health services with some increased staff and construction of facilities, expansion and integration of childhood immunization programs, increased MCH ante and post-natal services, continued pre and in-service training of nursing personnel, logistics and materials support to facilities, strengthening of management and support systems at various levels, and continued expansion of water supply and sanitation. To an increasing extent, community leaders and traditional healers will be sought out by the GGS health care system to jointly improve basic health/hygiene services and improve levels of care in rural areas.

III. Population

In this section the severe population situation is reviewed and the impact of the current and future population growth is discussed. Steps are being taken to develop a national population policy. Two workshops were held last year and a Parliamentarians' Committee to develop the policy is being

formed. However, many population-related activities are taking place in the absence of a policy; the environment is positive for these activities.

Among the activities taking place is the range of family planning services provided by the public and private sector. Some modest information, education and communication activities are taking place. The data from the recently concluded Demographic and Health Survey shows a contraceptive prevalence of 16%. A good start has been made in training family planning service providers, both through inservice training and in their basic training.

The paper discusses the dynamics of population change within the context of Swaziland. High literacy rates, urbanization, breakdown of traditional attitudes and impact of modernization are factors that had led to a relatively good contraceptive prevalence rate, even in the absence of an organized program.

It is fortunate that there exists in Swaziland the framework for an organized program. Family Planning Services, IEC programs, Data Collection and Analysis already exist. Other elements like Family Life Education need to be added and current efforts have to be scaled up. The report reviews the socio-cultural context and finds it favourable for expanded population activities.

USAID has a major project of assistance. The Family Health Service project with a total cost of $2.4 million. The United Nations Population Fund has a 3 year program costed at $982,000. At this time USAID, UNFPA and IPPF are the principal donors.

The prospects for a national population policy in the next two to three years are good. Program development can begin through expansion of current services in both the public and private sector with expanded IEC including population education activities.

USAID has a comparative advantage in this sector. It is important to handle its policy and program support with sensitivity so as not to create difficulties but the need for an expanded US role is clearly there.

IV. Review of options for future USAID Assistance

Following a review of the health and population sectors and the achievements of past USAID assistance and future prospects the team reviewed the implications of the three options set out in the Scope of Work. In summary, this was

to phase out all health assistance, maintain a modest health portfolio or continue at current levels of assistance to PHC and other priority areas. The assessment was also to evaluate the population situation and evaluate the nature and scope of

USAID assistance in this sector.

The intent of each of the three options are discussed as well as the implications of adopting that option. This is followed by a general discussion of the various considerations that were taken into account in arriving at a final choice of option. The first point was that considerable results have been achieved by past USAID assistance and the Ministry of Health is a much stronger institution and its PHC and other basic services considerably strengthened. The next point was to consider the balance between the present large scale support and the possible shift to undertake selected strategic inputs and development and the Ministry of Health to take on more project implementation responsibilities. The third point is that there is a need to address areas that make programs sustainable such as adequate physical facilities, equipment and commodities combined with selected technical assistance. The fourth point was that in structuring future assistance the PVO mechanism has a limited role as international PVOs with in-depth capability are limited in number. The potential for growth of local PVO/NGOs is a complementary role to the public sector, not one that can take on a major role of health or population support. The fifth point is the need for real dialogue between the USAID and the GOS (and other donors) on priorities and medium and long term HPN directions and the assistance which should be in conformity with that dialogue. The sixth point is that more attention needs to be given to the strengthening of management inputs at all levels of the system to enable institutional development to be sustained. The seventh point addresses health and population linkages and states that selected health programs reinforce family planning in as much as the latter improves maternal and child health; however not all health programs reinforce family planning and health programs may at the same time increase the birth rate if done in isolation.

On the basis of the above points and the consideration that

(1) Swazis can take on more program implementation responsibilities
(2) Ministry officials desire selected strategic inputs consistent with their health strategies
(3) PVO and other mechanisms can be used

(4) other donors who are currently less active may be willing to do more
(5) linkages between USAID and GOS will continue in the health areas,

the team has selected Option II as the one which they recommend for Mission consideration.

The paper recommends an expansion of US population assistance and identifies certain areas for the short term.

I. INTRODUCTION

This report provides the principal findings, conclusions and recommendations of the Health Population and Nutrition Sector Assessment Team. The team of 3 consultants worked in Swaziland from March 6 - 25 1989. The assessment was to consider in the context of the HPN situation and USAID assistance the directions and balance of future USAID in this sector.

The team was provided with relevant back-ground material, project reports, evaluation reports and other related documentation. This documentation included evaluation reports on major programs of current assistance in the HPN Sector. The team worked with the HPN office which provided logistic and other support. The team met with USAID Mission Staff, Ministry of Health, Department of Economic Planning Officials and from UN Agencies and other donors, and persons from Non-Government organizations and technical assistance teams. The team undertook field visits to Government and private health and family planning service facilities and to two hospitals. The team had open discussions with a range of persons knowledgeable about Swaziland's health and general development environment. This report is written within the constraints of time and is focussed on the key issues covered by the scope of work. Detailed information collection has not been possible.

The task of the team covered the following areas:

(1) Overview of the Health and Population sector situation.

(2) Progress made to date on these sectors and the implications of this progress for future aid.

(3) Assessment of the Ministry of Health's future role for the sustainability and management of ongoing programs and their priorities in the next phase.

(4) Assessment of past USAID assistance and its contribution to the development of the sectors and the future role of USAID assistance.

In carrying out its task, this team was impressed with the significant contribution made to Swaziland by USAID health assistance and the achievement of a significant level of local institutional capability as well as improvements in the performance of a number of targetted programs.

USAID Health Sector assistance has been focussed primarily on the public sector with strong programs in the areas of manpower development (short and long term training) institution building in primary health care and disease prevention (immunizable diseases) diarrheal disease control water supply and sanitation, nutrition surveillance and promotion and family planning support.

On the basis of the assessment, the team carefully reviewed the issue of the relative thrust and focus in the future of USAID assistance in the HPN Sectors. This issue is discussed in the final chapter of this Report.

This assessment was carried out by a team of Consultants. The members of team were: Rose Schneider, RN, MPH (Team Leader, Health Care Management/Policy Specialist, Kandiah Kanagaratnam MD, DPH (Population/Family Planning Specialist) and Thoko Ginindza, PhD, (Anthropoligist/Sociologist).

II. THE HEALTH SUB SECTOR

A. Health Status/Profile

The overall health status of Swaziland has improved over the past decade with increase in resources and activities, especially in the past five years. However, much remains to be done to expand preventive and curative care to meet the needs of the disperse rural population.

Although 1976 census data continues to be quoted for some indicators, there are some questions as the accuracy of the data given the current current conditions, the lapse of time since collection, and the number of specific health interventions which have taken place in the interim. It is reasonable to assume that progress has been made on certain health indicators, especially infant and child morbidity and mortality due to the MOH's programs (with generous donor assistance) in Primary Health Care(PHC), Combatting Communicable Childhood Diseases(CCCD), Maternal and Child Health/Family Planning(MCH/FP, Water Supply and Sanitation (WS&S) and nutrition. In addition, the general improvement in the economic situation, educational levels and other health related factors have caused the reported level of infant mortality to dropped from approximately 150 in 1983 to 116 in 1987 per thousand live births. The success of the aggressive intervention programs and other mentioned factors suggest that current infant mortality rates are probably lower than 116 and could even be in the range of 80 - 90 per thousand. The death rate has been reported as around 17 per thousand population.

The recent Family Health Survey (FHS) data currently being analyzed should assist to clarify the current situation. Although it is assumed that indicators have improved, it is recognized that the change has been the results of hard-won gains and these can back-slide in the face of deteriorating health services, economic conditions and other related factors. The FHS survey data currently being analyzed should also shed light on the issue of perinatal mortality. It has been quoted that 70% of the mortality of infants occurs before six months of age. Again, CCCD intervention programs, increased antenatal care, increased in hospital deliveries to almost 50%, improved nutritional status and other related factors have given credence to the probability that perinatal mortality has also declined. It is judged that, however, it still remains a significant cause of mortality in the 0 - 1 year age group.

The statistics from the MOH indicate there are still high levels of preventable tetanus, whooping cough and measles. There is a high incidence of turberculosis and malaria cases. The prevalence of sexually transmitted diseases is also high, and has been estimated to be around 25%. Bilharzia is also an important public health problem. Morbidity data, received from only same outpatient and hospital records are inadequate and reflect under-reporting.

The top ten diseases reported in 1986 among outpatients at the MOH and Mission clinics were:

1.	Upper Respiratory Infections	175,605
2.	Diarrheal Disease (under 5 years)	160,918
3.	Diseases of skin and subcutaneous	69,472
4.	Diseases of the Digestion System	55,893
5.	Diseases of the Genito-Urinary	52,178
6.	Sexually transmitted disease	41,911
7.	Liver Respiratory Infection	41,778
8.	Accidents and trauma	38,860
9.	Musculo-skeletal disease	28,448
10.	Diarrheal Disease (5 yrs and over)	26,151

The nutritional status of children shows levels of chronic malnutrition at 30.3% in the rural areas and 23% in the peri-urban areas. This is evidenced in stunting or chronic childhood malnutrition. Rates of acute malnutrition, seen more commonly elsewhere in Africa, is rare in Swaziland.

Although, there are questions as to the accuracy of the data, in the absence of a sound health information system, the overall health situation must be assessed by a range of imperfect indicators. It is however reasonable to assume that progress has been made in recent years through several preventive health programs.

B. Health Policy

The Fourth National Development Plan (1983/84 - 1987/88) referred to the high infant mortality and high incidence of communicable and infectious diseases. The 1983 GOS/MOH policy defined the shift in the emphasis from curative care to preventive and promotive services. Since 1983 Primary Health Care programs have been initiated and PHC has been the major focus of GOS and international assistance. The new initiatives include several strategies to strengthen key elements of primary health care and control of communicable diseases. The strategies included:

(i) expansion of primary health care
(ii) childhood immunization program
(iii) increased grass roots and community health services (Rural Health Centres, static and outreach clinics)
(iv) expansion of nurse midwife and sanitarian training.

The principles in the GOS Health Policy issued in 1983 continue to be currently valid. It's goals are to improve the health status of the Swazi people by providing preventive, promotive, rehabilitative and curative health services which are relevant and accessible to all. As in the National Development Plan the health policy has placed a major focus on primary health care, on prevention and health promotion and on health manpower development. Hospitals services will develop to serve as points for patients referred from health centres and the rural clinics. The Policy also states the right of each Swazi to equal and equitable access to health services; this covers not only geographic access but also stresses the need for financial access and cultural access and improved co-ordination between public and private sectors. In discussion with policy makers they reiterated their commitment to primary health care while recognizing their responsibility in curative care.

C. Organizational Structure and Functions

The Ministry of Health is responsible for preventive, promotive and curative care under the direction of the Minister of Health and the Principal Secretary and the organizational structure is presently under review. Annex 3 presents the current structure of the MOH central headquarters, and the organizational relationships between the MOH headquarters, the regions their clinics and the community. The Regional Health Management Teams (RHMTs) have been established in each region as the organizational body to coordinate the development and implementation of preventive and curative care within the regions. The RHMTs consists of the regional administrator and heads of hospital and health center divisions and other program heads.

It should be noted that a National Health Advisory Committee advises the Minister of Health Regional Advisory Committee and provides advice and guidance to the health structure at the regional level. Local communities have Community Health Advisory Committees recognized officially by the MOH who play an active role in decision making. Local leadership and traditional healers have an important part of the community level of care and is described in more detail in the section on Socio Cultural Considerations.

Curative health facilities are provided by the MOH, Missions and the private sector. The MOH provides the majority of beds space in 7 hospitals and 2 rural health centers covering approximately 420 beds. The bed capacity in hospitals and health centers for curative services in the private sector while not negligible, accounts for only approximately 10% of in-patient bed capacity. The following table shows the distribution of static health facilities:

DISTRIBUTION OF STATIC FACILITIES

Region	General Hospitals	Rural Health Centers	Public Health Units	Clinics	Outreach Sites
Manzini	2	0	2	53	50
Hhohho	3	1	2	30	27
Shiselweni	1	0	1	19	12
Lubombo	1	1	1	30	24
Total	7	2	6	132	112

The total number of beds available are in 5 Government Hospitals, 2 Health Centers and at the Mental Hospital and Tuberculosis Hospital as well as through the 2 Mission Hospitals and 1 private hospital is 1578 giving a bed/population ratio of 2.1. per 1000 of population. Most of the hospitals are essentially at the level of basic care District Hospitals are overcrowded and inadequately equipped and with inadequate staff.

Health centers and clinics are generally small, with limited space for patient examination, storage of medicines and for staff housing. Some clinics, have little basic equipment to provide antenatal care, simple curative care and laboratory tests or other basic preventive services. More recently work loads have increased and the size and patient flow does not allow privacy for examinations, especially for pre and post natal visits.

D. Health Manpower

Within the public and private health care system, nurses are the largest category of health personnel and they number an estimated 1000. There are some 40 physicians most of whom are generalists. The number of technical personnel, laboratory technicians X-ray workers, sanitary inspectors etc is low. There are, to date, relatively few personnel trained in health administration, finance and personal management. The Ministry of Health is experiencing a decline in most categories manpower, especially physicians from the stated 1983 level of 104. For nursing personnel, despite the continued production in Ministry of Health schools the attrition rate is considered serious. The MOH has lost nurses to the private sector, to other countries and through normal attrition such as retirement. Almost all the scarce physician manpower and a large majority of professional nurses are found in hospitals and clinics. The Chief Nursing Officer acknowledged an overall shortage but stated that the staffing in hospitals was particularly thin. Nursing assistants are being trained to fill the gap and often provide services in the absence of professional nurses.

Several thousand rural health motivators have been trained to function at the community level to promote health and serve as a link with the rural clinics. As a result of alteration, the number providing services is lower.

There are some ten thousand traditional healers who provide care and guidance to their commnunities.

E. Health Financing

The Recurrent budget of the Ministry of Health for 1989/90 is E37.6 million. It represents an increase from E26.7 million over the previous year. The distribution of these between different health activities is as follows:

	Amount
Minister	0.5 %
Ministry Administration	10.6 %
Medical Support Services	2.0 %
Preventive Medicine	14.0 %
Curative Medicine	73.0
Total	100.00

The Ministry of Health expenditure has ranged around 8% of the National budget in the past several years. The Government has provided reasonable support for the health services. It has shifted an additional 1% annually of resources from curative to preventive services. It should also be noted that curative medicine category in the budget includes all the clinics which also provide preventive, MCH and school health services.

An analysis of total health expenditures showed that public sector expenditure on health is around 30% of the total, private expenditures were 47.5% and foreign assistance around 8.3%. Swazimed administers a private contributory health financing scheme on the conventional insurance model; its costs have in recent years considerably increased as cost containment has been difficult. It covers a number of persons in the employed sector. A Health Maintenance Organisation (HMO) also provides health care services.

F. Health Assistance

(a) USAID Assistance

The current USAID/Swaziland Health Population Nutrition Sector portfolio includes several major AID projects and several smaller, health related projects. Current projects include the following:

Primary Health Care (PHC)	$5.7 million
Rural Water Borne Disease Control (RWBDC)	$5.3 million
Combatting Childhood Communicable Disease (CCCD)	$.7 million
Family Health Services (FHS)	$2.4 million
Nutrition/Weaning	$140.00
Innovative Research	$32,000

The following is a brief description of each project before an assessment of progress in the Sector and as a basis for analysis of the options.

Primary Health Care Project (PHC)

The PHC Project was funded at $5.7 million with the overall goal to improve the health status of Swazi children under five years and women of child bearing age. The impact was to be reached by the identification and technical inputs to eight targeted service delivery priorities to improve direct service delivery and the related systems which supported these identified services.

The project provided major inputs for long term technical assistance from a 5 person contractor team in the areas of MCH/FP, clinic management, health administration and planning. Short-term technical assistance was included for the areas of health education and laboratory services.

The project inputs were designed to include out-of-country long and short-term training. Health education and information system training was included for long-term training in the U.S.. Short courses for health administration, health education and other specialized areas were also funded as part of the projects.

Management/institutional strengthening component was a key input. A modest component was defined to supply commodities to supporting service delivery, staff training and health education. In addition, a component was allocated for research, monitoring and evaluation.

The Rural Water Borne Disease Control Project (RWBDC)

The RWBDC Project funded at $5.3 million has the goal to increase the capacity of the Government of Swaziland to deliver effective preventive services to combat disease related to poor quality water and sanitation and to assist the GOS to provide piped water to 33% of the rural population. The project focuses on construction of new and rehabilitation of existing water systems, pit latrine construction, health education and community participation and support to national planning for the water and sanitation sector.

Project inputs provided one long term advisor, the major input: construction was the second largest input with almost one quarter of the budget. Commodities, participant training, research and other activities were also supplied to support project activities in construction, maintenance, training and institution building.

Combatting Childhood Communicable Diseases (CCCD)

The CCCD Project was funded at $.7 million with the goal of reducing mortality and morbidity among children due to diarrheal diseases, vaccine preventable diseases, malaria and acute respiratory infections. The project inputs include commodities as a major component, (more than 30 percent) in-country training, health education, operations research, and a national program meeting. The project will therefore strengthen the health information system for CCCD service delivery, increase access and coverage of selected priority services, EPI, CDD, and malaria for children under five and women 15 - 49 years of age. CCCD activities also were planned to include in-service clinic staff training on these selected interventions, and support and strengthening of the MOH Health Education Unit in the development, design and testing of health education messages.

The project extension has broadened the scope of the project to incorporate several planned activities: broader training in management and service delivery for all levels of personnel; epidemiology and MIS training for staff; sentinel surveillance system development and establishment of a national central and regional ORT centres.

Family Health Services (FHS)

The FHS Project at $2.4 million has a goal to increase the use of modern contraceptives and practice the of child spacing with the expansion of family planning services, upgrading education and information and improving clinical services provided by FLAS and the for profit sector.

The project's input provide one long-term advisor, short-term technical assistance and in-service training to FLAS during the first phase to assist in the strengthening of the FLAS research and evaluation, IE and C and other general management system capabilities and, indirectly, family planning services. The second phase will focus on s rengthening the system with family planning services in industrial clinics for the expansion of private sector services.

Project Hope

The Project Hope Nurse Training and Drug Supply System Project's in its current second phase is funded at $1.3 million (plus HOPE matching funds). Its goals are to improve quality of nurse, nurse tutor and nurse assistant education/training curricula in the areas of community health, maternal child health, PHC and midwifery. A second stated goal was to develop and implement a drug and medical supply system. Major project inputs include a five person team providing T.A. for the following: direct pre-service nurse training, training in post basic community nursing, curricula development, strengthened nurse tutor capability, and some in service training of nursing personnel. Some T.A. has been included for the development of the drug supply.

Nutrition Project

A jointly supported (UNICEF and USAID Weaning Project funded at $140,000 has as its goal to improve breast feeding and weaning practices assistance to the Swaziland National Nutrition Council's Weaning Project. Recent short-term technical assistance has been provided to the project to finalize nutrition research studies and to develop a communications approach for materials production, radio messages and drama.

Innovative Research Project

Another HPN project the molluscicide Project is a relatively small $32,000, innovative research project funded at the University of Swaziland. The project has as its goal to test an effective plant cultivation of ENDOD as a molluscicide. The project provides for local researchers, technical assistance and some small amount for construction and commodities.

(b) Role of Other Donors

There are United Nations bodies, the African Development Bank and bilateral donors who provide support to the Government of Swaziland; donors who are active in the health field are, however, limited.

United Nations Development Programs and UN Agencies

The World Health Organization has a broad-based program covering several health areas. Most of this is technical assistance and short-term training and studies as well as the provision of experts. WHO has an annual budget for Swaziland of $838,000 in the 1989 - 90 period. No significant increases are expected in the future.

UNICEF is a major donor in the health field and provides assistance in childhood communicable diseases, in expanded immunization project, child survival program and women in development activities. UNICEF supported the Bamako initiative for essential drugs and is investigating the possibility of such assistance. UNICEF assistance is approximately around U.S. $1 million annually and could be expanded if needed with UNICEF or bilateral funds being channelled through UNICEF.

The United Nations Population Fund supports health related programs that are linked and related to their population mandate. Support for MCH Services and Health/MCH Data collection is covered in a recently concluded 3 year agreement for $980,000. It also supplied funds for work on the analysis of the 1986 Census. No other assistance is envisaged in the short-term.

African Development Bank

The Bank operates in the health field and currently is supporting the rehabilitation and extension to Mbabane Government Hospital. They are a potential source for expanded assistance.

United Kingdom

As has been traditional in former British territories the United Kingdom is a major aid donor. Considerable emphasis has been given to manpower development in all fields including health. An average of 60 persons per year are trained by U.K. assistance and some 5 - 6 are in health. Most of this assistance is for long term training. In addition U.K offers seminars and short-term training. U.K does not have a fixed manpower assistance plan and are responsive to GOS requests and needs. They are prepared to adjust their assistance on the basis of local needs and other donor priorities.

Federal Republic of Germany

The Federal Republic of Germany (FRG) has a major project of hospital rehabilitation and would support other selected health infrastructure support.

European Economic Community

The European Economic Community and other European donors (except U.K. and FRG) are not in the health field in Swaziland in any significant way. However EEC provides health assistance in other countries and may support health infrastructure development.

G. Socio-Cultural Considerations

Traditional healers - structure

A major socio cultural factor that influences Swazi health needs and approaches is the traditional healer. They are an essential part of the community and exercise considerable influence. Swazi traditional healing is part of the religious system and is associated with ancestral spirits. Illness of whatever kind falls within the category of misfortune and major illness cannot be cured without identifying its secondary and final causalities. Traditional healers function at the level of the individual and play a role in national events and rituals.

Acceptance by Swazi Society

While traditional healing is inseparable from ancestral religion, Swazis accept and distinguish normal kinds of illnesses such as ordinary headaches, stomach aches, common colds, etc. But even these, if they occur frequently or develop complications, the ancestral spirits are given as the final cause and have to be appeased. Swazi traditional healing is surrounded by religious ritual which also satisfies certain psychological needs of patients and the healers treat mental illness. The treatment of mental problems, often linked to tradition and cultural circumstances is often lacking in modern health services. It is probably primarily for this reason that all strata of Swazi society relate to and have confidence in traditional healers.

In hospitals, relatives of patients bring in medication from traditional healers and thus a number of patients are often treated simultaneously by both health systems. This double treatment may cause problems and side effects for patients. However, in the communities the traditional healers and rural health motivators are working side by side.

Healers and health practices

Traditional healers will be around for a long time, are in important part of Swazi life and have to be reckoned with. They intervene at all levels of the health cycle, pregnant mothers, infant/childhood and adult levels. The main problem with their healing process is the fact that their treatment is highly empirical and involves mainly strong purgatives, enemas and vomiting. Other treatments include incisions on the skin to let out blood and powders that are rubbed in. Most of their drugs are taken as fluids. All this is for curative purposes. However, their dosages have no standardized measure and the concoctions differ for each healer. There is also the fact that different plants are used in different regions for any one illness. This depends on locally available flora.

Traditional healers play an important role in protecting pregnant mothers from the forces of jealous neighbours and other evil forces. They also make prescriptions for the healthy development of the foetus and throughout pregnancy treat the woman for an easy healthy delivery. After the birth, the infant is treated for protection against evil forces of nature and witchcraft and also ritual incorporation into its father's lineage.

Changing roles of healers

Historically, the function of traditional healers was separated. Diviners would divine the illness, its physical and other social and religious causes and then refer the patient to an expert herbalist for treatment. In all this he was guided by the ancestral spirits of the patient and of the healer. Presently many traditional healers have combined the functions causing a measure of confusion among the public. The current president of the traditional healers association argues for a return to specialization.

Healers as a political and community influence

Traditional healers are also a major 'political' force in the country and chiefs fear their power and often avoid conflicts with them. The power base of traditional healers lies in their being a medium between the living and the world of ancestral spirits. In Swazi cosmology, supernatural forces are all pervasive and there is the ordinary and the potentially extra ordinary which overlap and interact. It is the potentially extraodinary which traditional healers control.

Relationship of healers and the Ministry of Health

The relationship between traditional healers and the Ministry of Health is at present not very clear. There are mixed feelings about the role which they should play in the modern health sector. Their role will be largely influenced by the attitude of top officials in MOH.

Some people are sympathetic and tolerant but others mistrust and spurn them. There has been some communication between the association of traditional healers and MOH in the form of a seminars with the aim of establishing good working relationships.

For their part the traditional healers have accepted basic hygiene and are aware of other dangerous practices on their part including dehydration for instance. They do admit that there are cases of illness beyond their capabilities and do refer patients to clinics medical doctors and hospitals. But traditional healers strongly claim that there are illnesses which can only be cured by them. And this will keep them in their profession.

Dealing with traditional healers is also a very sensitive area for, they operate at individual and national level and not only serve the physical well being but also the religious and psychological needs of the people. Western forms of religion do not appear to have adequately fulfilled this function. As traditional healers fulfill community needs they should be accepted as a reality of Swazi life and be made allies in the health and community effort. They could also help in expanded utilization of primary care facilities.

Summary of health sector assessment

Infant mortality and overall health status in Swaziland has improved although formal data is not yet available to document the progress. Much remains to be done especially to expand services to the rural population. Progress has been made by the recent expansion of priority programs and their support systems at the central and regional levels of the MOH. Mission health services and the private sector also contribute to expand this coverage. Continuing effort is needed to address childhood immunizable diseases, diarrheal diseases, upper respiratory infections and other priority health problems. The high rates of sexually transmitted diseases, tuberculosis and bilharzia indicate the need to strengthen these existing programs. The Health Policy document of the GOS/MOH states a commitment to the expansion of Primary Health Care through the provision of preventive, promotive rehabilitative and curative health services. The MOH structure operates at the headquarters, regional, and local levels with increasing responsibility being decentralized to the Regional Health Management Teams. At all three levels, Health Advisory Committees provide community input into decision making.

Hospitals, public health units, health centres, and clinics are well distributed throughout Swaziland. Infrastructure is in need of repair and expansion to meet the growing needs. Manpower, predominantly nursing personnel, staff facilities and provide some outreach services. Despite considerable effort in manpower development, the overall levels of different categories are low; these include physician, nurses, laboratory, X-ray and other technicians and health inspectors. Manpower shortages exist in both preventive and curative facilities. More than a thousand rural health motivators are community based and provide preventive health services and health education.

Some 10,000 traditional healers provide services and support to communities. Traditional healers and their practices are widespread and their influence within their communities is considerable. Their acceptance within all levels of Swazi society makes it important that dialogue continues between the MOH and traditional healer leadership. The benefit of cooperation between the MOH and traditional healers is increasingly being recognised.

The GOS budgetary support to the health sector is reasonable at E37.6 in 1989/90 with satisfaction balance between preventive and curative services. USAID the major international donor, has current project totalling approximately $15 million. These projects have contributed to the improvement in immunization coverage, primary health care services and support system, extension of water supply and sanitation, the training of nurses and other priority areas. A number of other donors support health programs; this includes World Health Organization, United Nation's Population Fund, UNICEF, African Development Bank and some bilateral donors. An increase of other donor support is possible.

H. Strategies, Issues and Implications for Future Programs

From the above analysis it is clear that the overall health situation and its trends are complex and not easy to discern. Significant progress has been made. There is little nation-wide data as hard evidence and the judgements are based on the observation of officials, field personnel and others in the health sector as well as the team's own experiences.

(a) Utilization of Health Services

Although an in depth examination of the issue was not possible given time limitation, it is most likely that the attendance in health clinics and health centres has increased. Several factors are operating:

(i) the training, motivation, increased supplies and equipment and support to nurses in at least some regions

(ii) increased referrals to services by rural health motivators

(iii) increase availability of vaccines and medications for well-child services

The Report on the Annual General Meeting of PHC, May 1988 however, discusses the contraints which still exist in providing care at clinics and outreach services. The availability of medicines, basic equipment and supplier is irregular, supervision is infrequent. The transport, accommodation and communication difficulties were cited as limiting factors to full utilization.

Hospital in-patient and out-patient facilities are severely strained. Occupancy rates hover at 100%; out patient clinics experience high attendance rates. Many of the patients may bypass clinics to seek care associated with hospital service.

Given the need to continue to improve referral service at clinics and hospitals, the need to equip and staff current facilities and perhaps construct new ones, with staff housing, will need study.

(b) Community Based Services:

Some thousands of RHM's have been trained in basic promotion and health education skills. Based in the community, they have varying degrees of interaction with the health clinic personnel. Some serve as assistants to nurses during clinic call. Any efforts to expand health services to the community will involve RHM's, to promoting vaccination days, hygiene and child care, family planning services, etc. Since direct supervision of RHM's in difficult, innovative communication, mass media support, simple reporting/in-service education methods can be considered.

Expectations for broad expansion of community services will need to take into account the logistics, transport, supply, supervision and other support systems which will be needed to sustain the effort.

(c) Balanced Development of the Health Care System:

The success of the expansion of support to the periphery of the health care system appears to have been at some cost to curative care. The GOS health policy envisaged the primary care system need for back-up referral and institutional care services. It does not appear that the hospital system can adequately carry out this role with the high occupancy and attendance rates and with inadequate staff and equipment. This imbalance in the system has to be addressed in the planning for future programs.

(d) Other Health Program Development:

While support by USAID to the PHC areas is valid, there is a need to balance other important public health needs. There is a need for a broader program for the management of the high incidence of sexually transmitted diseases, some of which masks the incidence of HIV infections. Similarly, the high incidence of tuberculosis, bilharzia and malaria probably requires more attention to the prevention and management of these diseases.

(e) Manpower Issues:

Manpower issues were discussed earlier in the light of shortages in essentially all technical and clinical areas in both preventive and curative care. Previous USAID and other donors have provided funding for training and several schools produce professional nurses, and nurse assistants, health inspectors and other technical personnel. Attrition however, has affected manpower levels. Future directions in health would need a policy dialogue with GOS to address long range manpower development needs.

(f) Traditional Healers

The practices and profession of traditional healers is described at some length in the socio-cultural section. The interaction between western and traditional systems is a sensitive matter. However, the frequent use of healers by the vast majority of the population appear to indicate the need for increased dialogue between traditional practitioners and the Ministry. This will be particularly beneficial in the expansion of community based services.

(g) Private and public sector roles in health care

Based on observation and discussions, there is already a significant private sector role in health care. These services are the services of missionary institutions (who receive substantial Government subventions), private physicians, private nurses, and the industrial sector who run clinics in their establishments.

There are different estimates of the extent to which the private sector provides health care. But there is a significant amount of outpatient/ambulatory care. Only a small proportion of inpatient hospital care is covered by the private sector. At this stage of health evolution the issue is how much more the private sector can absorb in health care provision. A further modest expansion in this would be possible and employers may persuaded to provide somewhat broader health benefits but industry as a whole would be cautious of increased costs that are not obligatory. The private health insurance scheme and HMO system in existence could absorb an additional number of people who are in the formal sector. However, a significant shift in the private sector/public sector balance is probably not feasible in the forseeable future.

(h) Commercial Sector Expansion

The development of commercial sector activities often has an indirect and negative effect on health. For that reason USAID support to commercial sector expansion programs should be examined for their impacts on health, especially on women and children. Expansion of commercial employment may provide some immediate can be gains but with wages and benefits so that their health is compromised. The GOS may need assistance to study the implications and benefits to further commercial expansion.

III. THE POPULATION SUB SECTOR

A. Demographic Profile

The population of Swaziland was estimated to be 728,800 in 1988 compared to 681,059 in 1976 (Census) and 712 131 in 1986 (Census). Some 77% live in the rural areas. The population based on current (trends) is expected to increase to 1.0 million in 2000 and 1.9 million by 2020. The birth rate at 50.8 per 1000 of population is one of the highest rates in the world and the death rate at 17 per 1000 of population is also high. The average number of children per woman is 6.5 compared to a level of around 2.1 to stabilize population growth. As mentioned earlier in (this Report) on health status, this infant mortality rate of 119 per thousand live births and under 5 mortality rate of 177 per thousand at risk (0-4 yrs) are high. The population of Swaziland is extremely young; 46% of the population is under 15 years and only 4% are over 65 years of age. The literacy rate is high compared to most African nations; the overall rate is 64%, a rate that has risen from 50% in 1976. The disparity in the literacy rates for males and females is small, being only 2% higher for males. The skilled manpower talent is limited as those who have completed university/vocational education is only 1%. It is estimated that there are 75,000 persons in this organised formal sector, some 25,000 in the public sector and about 240,00 in the informal sector. The growth rate in the economy (GDP) has been uneven over the past two decades but generally the overall growth rate has been below the rate of population growth. Very recent performance has been better but the long term outlook remains uncertain.

The significance of the above demographic profile is best summed up as presenting a serious threat to economic development and improvement in the overall quality of life. Population growth will cause considerable pressure on all services and especially on health, education social and community services and housing. The capacity to generate new employment for entrants to the labour force is already difficult and will become worse. The rapid pace of urbanisation in the past decade has led to poor peri-urban conditions that could become worse with these high rates of growth. The danger of a serious stagnation and decline in the GNP and in the health and educational levels is real.

B. Population policy

The Government of Swaziland does not have an explicit and broad-based population policy. In the past few years, several African countries with a somewhat comparable socio-cultural and political environment have formulated or are in the process of formulating national population policies. These policies have been modelled on the Kilimanjaro Declaration on Population and Development (Arusha, 1983) and the

recommendations of the International Population Conference (Mexico City, 1984). GOS participated and subscribed to both these instruments.

Significant GOS development in this policy area are the recommendations of the two workshops on "Population and Development" (organised by) the Family Life Association of Swaziland for Parliamentarians in June 1988 and for Principal Secretaries and Senior Government Officials in November 1988. A key recommendation at these workshops that was (adopted unanimously) was for the GOS to formulate a population policy and take steps to develop strategies with a view to implementing them. It is understood that a Parliamentarians Committee to develop such a policy is in the process of being formed. The recently concluded Fourth National Development Plan (1983/4 - 1987/8) states in its chapter on "Health" that this Plan, inter alia, "aims to provide services that contribute towards an increase in child spacing and a moderation of this rate of population growth".

Despite the absence of a formal GOS population policy, several activities currently being undertaken by the GOS reflect positive support for population and family planning. An open environment appears to exist where family planning services are provided in public and private sector institutions; contraceptives are made available to all providers from the Government's Public Health Unit free of charge. There is ample evidence, discussed in this section on "Socio-Cultural Considerations" that attitudes to population and family planning are changing. The attitudes of individuals and their behavior in these population and family planning matters is moving faster than more formal or official positions expressed - as happened in Brazil and Thailand.

It is reasonable to expect the transition from an implicit policy to an explicit national population policy can be achieved in the short-term. As has occurred in several African nations, policy change will be accelerated as the economic and social costs become more apparent and widely recognised and when the need for sustainable development becomes urgent. In this regard the Minister for Health has indicated to the Team that GOS might need technical assistance in policy formulation and in program planning for the policy.

C. Family Planning Services, IEC and Training

There are a number of ongoing family planning activities that reflect this positive environment for child spacing and the moderation of population growth. The following is a list of family planning services available:

(a) Services provided by some 90 Ministry of Health Institutions (public health units, hospitals and clinics).

(b) Services provided by the Family Life Association of Swaziland, including the Community based distribution of non-prescription contraceptives.

(c) Services provided by private medical practitioners (21 doctors at 7 practices).

(d) Services provided by the industrial sector for workers through factory based health clinics (some 60 service points).

(e) Services provided by pharmacies.

(f) Services provided by "Man-Talk", a condom marketing program..

A large number of short-term training courses for existing MOH staff has been conducted over the past several years. A small number of staff have attended training course outside the Country, some in the U.S. and others in the Region. The overall level of the training is basic and the needs to be re-inforced through refresher courses in clinical services and client skills and on the job practice.

Information, Education and Communication (IEC)

The Ministry of Health Education Unit and the Family Life Association of Swaziland have undertaken some communication effort through the production of materials and through publicity activities. The efforts are small but there are plans to expand the scale of the efforts.

Training

A good start has been made towards the creation of an adequate pool of trained family planning service providers. All nurses and Nursing Assistants have in their training curriculum a module on family planning; this includes practice at family planning clinics. A number of nurses have been trained in IUD insertion. Health inspectors are also trained in population and family planning motivation. Public sector institutions are responsible for nearly 60% of acceptors; this shows the important role they will have in any future program effort.

Service Indicators

The following preliminary data from the recently concluded Family Health Survey reflect the most recent information available on the status of family planning.

1. Current contraceptive use 16%.
2. Distribution of contraceptive methods:

Oral Contraceptive Pill	28.7%
IUD	8.6%
Injectable	26.7%
Condom	3.9%
Barrier/Foam	1.0%
Female sterilization	14.9%
Male sterilization	7%
Natural Family Planning	6.3%
Other	9.3%

3. Distribution of providers:

Public clinics	54.5%
Hospitals	14.3%
Private clinics	7.6%
FLAS clinics	16.8%
Pharmacy	1.3%
Other	6%

The above service data highlight the high level of contraceptive prevalence (16%) even in the absence of an organised program. The popularity of the injectable (26.7%) and the large proportion of women have sterilisation for convenience and privacy is a level of sophistication in a new effort. The fertility impact of sterilization and injectables is high but the data and evidence suggest low continuation rates for other methods.

According to available service data, these efforts are relatively modest. The number of new acceptors has been at the level of 8-9000 per year and the number of continuing acceptors has been around 22 - 24,000. The Government provided the following amounts of Contraceptives to all service points in 1988:

Type	Quantity
Oral Contraceptive Pill	67,710 cycles
Injectables	20,000 ampoules
Intra-Uterine Device	150 units
Condoms	463,000 pieces
Barrier Methods	140 units

D. Dynamics of population change

This section of the report will review the dynamics of population change and then attempt to place it in the context of Swaziland. The earlier experience in developed countries and the more recent Asian experience has shown that to achieve meaningful demographic change there will be a number of factors operating in the society that will determine such change.

The direct determinant of fertility change is the practice of family planning. The number of women practicing contraception directly influences births and well-run family planning services providing access through a variety of service delivery channels are essential.

However, several other factors influence attitudes and behavior to create the motivation to achieve fertility decline. In the literature, linkage has been made to several indirect determinants of fertility. These are:

(a) reduced levels of mortality and in particular infant, child and maternal mortality.
(b) improvements in literacy levels, especially of women through expansion of girls' enrollment and retention in schools.
(c) improved opportunities for women's employment in the formal sector and for income generation.
(d) improvement of the social and legal status of women in marriage, inheritance etc.
(e) overall improvement is socio-economic conditions and the process of "modernisation".
(f) male attitudes towards family planning
(g) better income distribution and social equity.

The experience in the past two decades in Asian and other countries has demonstrated that population change can occur at lower levels of development and in the absence of some of the more favourable determinants referred to above, provided organised and systematic program efforts are undertaken.

The progressive increase in contraceptive use in Swaziland in the absence of organised program efforts is not fully understood. It is however clear that some of these indirect fertility determinants are in operation. This includes the high literacy rate and the entry of women into the formal employment sector. However, this increase in contraceptive use is not likely to be sustained at a significant level without organised program action.

E. Programme framework

It is recognised that population and family planning have been sensitive subjects. The framework on which a national population program can be established now exists, but only as a range of activities that are relatively weak and modest in performance. The following are the program elements:

(a) Family Planning: 150 service points in public and private sector.
(b) Information, Education and Communication: Done through the Health Education Unit and FLAS and includes training programs.
(c) Data Collection and Analysis: Census, special surveys, Service.data collection.
(d) Population and Development and Women in Development programs.

The following expanded program elements need to be established to ensure program results:

(a) Family Life Education, Population Education.
(b) Leadership and Community Awareness programs.
(c) Research and Evaluation.
(d) Population and Development Planning.

These program elements need to be introduced and existing activities need to be considerably be strengthened. In addition, because of their considerable impact programs that will influence infant child and maternal mortality and morbidity must le sustained as an important component of family planning services. The survival of children improves the motivation to moderate family size.

F. Socio-Cultural Considerations

The socio-cultural element discusses Swazi traditional values to fertility and sexuality, the importance of children and(especially male children) and sex behavior patterns. It also discusses the current environment as changes take place and newer attitudes to marriage are adopted. All this add to a rapidly changing environment, and its implications for population and family planning are discussed.

Fertility and Sexuality

The attitudes and practices in Swazi tradition considers every woman as a potential bearer of children. Cases of barrenness were structurally adjusted through the seed-bearer (for men) and the sister co-wife (for females).

Importance of Children

Children are important for the continuity of the lineage though this is itself fast disintergrating. Children are also seen as an extension of their parents who after death become the fulfillment of marital status and the achievement of adulthood (manhood/womanhood). Children were also regarded as "social security" for old age. Boys were preferred since lineage continuity depends on the male line. Although at this present time girls have been proven to be more responsible. Children also provide help in domestic and farm tasks. It was a stigma not to have children - something is physically wrong.

Fertility and Sex Behavior

Premarital sex was permissible between men and women, but not child-bearing. Certain conventions were established to avoid pregnancy. This consists sex education, counselling and guidance promoted by peer group leaders who had been trained by chosen

adults. Sex education was taught separately to boys and girls. Premarital pregnancy resulted in heavy fines on the boy or girl by the peer group and it was the parents who paid the fine. The King also imposed fines on men. The regimental system also regulated the sexual behavior of men.

Attitude towards marriage

Swazi traditional marriages were uniform for the entire society. Although potentially polygyneous (one man/many wives) there were few polygamists as custom required the payment of "lobola" (bride-price). Polygyneous unions usually meant each woman bore fewer children. Custom also required the spacing of children, being 2 - 2 1/2 years. Abstinence was the norm as a woman after child birth was taboo (blood pollutes) and the husband had his own separate sleeping quarters. The introduction of Christian and civil marriages became monogamous and close-ended. The number of children for each woman in such marriages increased and a breakdown of values of such marriages resulted in bearing children out of wedlock. Though this was a social stigma in Swazi tradition and Christian marriages, it became more common and is tolerated. Unmarried mothers are a characteristic social phenomenon, and traditional sanctions are no longer enforceable. There are conflicts between two different systems of marriage.

The changing environment

The traditional peer group that regulated youth behavior in sex has died out and no alternative replaced it. Modernisation and employment patterns leave children alone while parents work. High risk young males and females are in schools or workplaces with lessened parental control. Extra-curricular activities of young persons are no longer under parental and family guidance as they move away for employment and live independently from families. A number in this young group are exposed to "loose" sexual behavior and prostitution with the growth of the local tourist industry. Swazi tradition required restraint in sexual behavior and allowed for child spacing and abstinence; all this has broken down in the changing environment.

The various religious denominations now present in the country hold different views on sexual behavior and family planning. Some strongly object to modern contraceptives, other do not and yet others will accept certain forms and reject others. This range of positions presents difficulties and confusion to individuals. Recent efforts to approach men through a program like "Mantalk" will be valuable to address the male role in family planning. Besides male education there is a need to educate Swazis on small healthy families and the economic costs

of education as traditional restraints on large families has broken down. However, as sex education and regulation of fertility are elements of Swazi tradition this cultural underpinning can provide a basis for modern family planning. The process of education and change must be handled with sensitivity but will be a useful step in changing attitudes. Chiefs and traditional healers can if approached with the right message of concern for youth and their health can also help.

G. Population Assistance

(a) USAID Assistance.

USAID long-term population family planning strategy has identified four areas of assistance. These are (1) strengthen MCH/FP within primary health care (2) expand and strengthen private NGO and commercial activities (3) assist policy and strategy development and support population and family life education. the first two are being implemented in current projects; the other two have not been implemented yet.

There is a family planning component in the PHC project as part of intergrated service delivery. The major assistance for population is the Family Health Services (FHS) Project, a four year project (1988 - 1993) with a total funding of $2.4 million. It has the purpose of strengthening the private family planning sector. It is being implemented by the Family Life Association of Swaziland, a local NGO and the Pathfinder Fund, a US based PVO.

During the first two years, the project will address strengthening FLAS' institutional capability by developing a Research and Evaluation Unit and an IEC Unit. FLAS will also be assisted in this expansion of its educational and awareness creation efforts. During the second phase, this project will undertake expansion of activities in the private (for profit) sector by promoting the establishment of family planning services in industries.

The project was authorised in July 1988 and the resident advisor arrived in February 1989. Thus there is little to report or evaluate at this stage. The role of the NGO sector in family planning will be strengthened but it would be unrealistic to expect a major role for this NGO Sector given of a number of local considerations. As the project develops the roles of FLAS and the public sector in different program areas should be evaluated and better defined. FLAS has undertaking social strengths in mobilization, IEC activities, operation of "model clinics" and promoting services in this industrial sector.

(b) Role of other Donors

Population assistance is provided principally by two other donors. The United Nations Population Fund (UNFPA) and the International Planned Parenthood Association (IPPF).

UNFPA has just concluded an assistance agreement that will provide 1 long term advisor in MCH and 3 UN Volunteers in Health Education, Statistics and Nurse/Midwifery. The agreement also provides medical equipment, commodities and vehicles. The project has an estimated cost of $ 982,000 over the next 3 years.

Assistance from IPPF has been an annual operational cash grant (about $150,000) to FLAS and commodities to GOS. No other donor assistance is envisaged in the immediate future.

Given the stage of program evolution in Swaziland, it does not appear that these inputs will be adequate for a sound program and further assistance will be needed. USAID has a significant comparative advantage in operating on a broad range of activities in the population sector and can draw on the technical assistance in program strengthening and development that exist in the U.S. In the next 2 - 3 years as the policy and program development process moves ahead opportunities for increased U.S. assistance on a broad front will arise.

H. Policy and Program Trends

(a) Policy Development

From the above assessment it is safe to expect a transition to a National Population Policy in the next 2 years. The driving force for this will be the Local Parliamentarians Group with support coming from the active African Parliamentarians Group based in Harare. The role for USAID could be to support the process as needed, especially as the centrally-funded Options Project has the technical experience to assist if required. However, it should be noted that much can be done to improve and upgrade the population/family planning activities without having to wait for the policy to be written and approved first; this is discussed in the next section.

(b) Program Development

The principal conclusion of this assessment is that the time is now right to move forward in expansion of program related activities. In the absence of a policy, one constraint is the definition of a focal point for the program and national leadership to oversee this process. It is important that the Government consider their options and identify the program leadership. The second constraint is the lack of a formal program framework. Until this is fully developed, the existing semi-formal co-ordinating mechanism may need to be strengthened and adapted to provide an oversight arrangement over population related activities.

The following activities can be expanded in the next few years.

(a) Improved family planning services in the Ministry of Health institutions. They will continue to provide as in most countries, the bulk of service acceptors, as they do now. They will be in part by sheer numbers of science delivery points.

(b) The operation of FLAS clinics as model clinics and training centres for service delivery. FLAS should retain its urban-based orientation with regard to service delivery.

(c) The systematic expansion of industry-based family planning service and education to the extent possible. The size of the organized sector, its further growth and the existence of clinics in industrial establishments make the potential of this outlet considerable. The exact modality of this expansion should be carefully planned so that it will over time be self-sustaining. The issue of how to encourage industry take up the cost of this service has to be studied, and a different approach may be needed from that used in other situations.

(d) The use of marketing techniques to provide more attractive products and better messages and literature. This will improve the acceptability of products and give a better image of contraceptive products. The SOMARC team after an in-depth study found that there was not a sufficient base to undertake conventional social marketing program. However, they agree that improved marketing techniques are desirable and should be included in future assistance.

(e) The expansion of population and family planning communication activities. The current efforts of the Health Education Unit, FLAS and Mantalk are limited in content and scope. An IEC task force should be established to expand and co-ordinate the program. More use should be made of the mass media to creat awareness as the policy evolves.

(f) Planning should begin for the introduction of Family Life Education and Population Education into school curricula. This is essential for the future parents but is also needed because of the incidence of teenange preganancies and sexual activity at relatively early ages. The climate for the introduction of such a program appears to exist. Within community-based activities, a program for out of school youth could be introduced as there is a high drop out after primary school.

(g) The establishment of a single national data base for family planning service data is essential. There is a need to reach agreement on the focal point for this data base. The existence of two separate focal points in the Ministry of Health and in FLAS should be resolved to provide a viable.long term solution. This will include how a Program Research and Evaluation Division will operate.

(h) A program to build national consensus through programs directed to leadership groups, political leaders, traditional leaders and other target groups should be planned and executed. This should be done to support the development and implementation of a national policy. This program should include presentations of the RAPID type.

(i) It is premature to consider social policies to influence fertility behavior at the present time. An environment for this does not exist and will risk a possible backlash. Such policies have been introduced in other programs but this may not be needed here for several years.

Conclusion and Recommendation

The crucial question to answer is whether a significant expansion of USAID effort in this sector is needed. It is recommended that such an expansion be undertaken as the local environment and the current status of activities justifies further expansion.

USAID has a comparative advantage in population program assistance because of its ample global experience and technical resources available in all program areas. The potential for "real" overlap with UNFPA, the only other significant donor in this field is small.

This assistance for population should be broad based and cover not only service delivery for family planning and related MCH services but also areas such as population education, research and evaluation, policy formulation and implementation and program development and management. The scope of this assessment does not allow time to define the exact content and size of this assistance and the strategies for its implementation. However, any expansion of this assistance must pay attention to style and image of how the assistance is given.

IV. FUTURE USAID STRATEGIES

Review of options for future USAID assistance

A. Introduction

In the preceding two sections a review of the health population and nutrition sub-sectors was done. The review described the status of these sub-sectors, the related sub-sector policies and the assistance provided. On the basis of this review, this section of the report will examine the intent of those options posed in the scope of work and discuss possible implications for the GOS and for USAID. After discussion of the three options, the report will identify the preferred choice and offer a justification for that choice.

There are in terms of the study two core issues. First USAID has made major investments in several areas of health, especially primary health care and in institutional development over the past 10 years. How should future assistance in health be implemented and what are the implications of the content and mode of that assistance. The second issue arises from the concern over continued high rates of population growth which is eroding prospects for sustainable development, the pace and scope of US proposed assistance in population and whether the environment exists for expansion. The assessment team was advised that the recommendations on health assistance and on population assistance should each be treated on its own merits. However, the health-population linkages are also discussed in this section.

To this extent population assistance is a constant under all three options, and will be discussed only once later in the paper. The scope of population assistance is not a dependent variable on the directions of health assistance.

The team is fully aware in presenting its findings that the issue of future directions in the HPN sector has been extensively discussed and there are strongly held views that have been excellently presented by different officials. The team has also heard from several Swazi officials and other knowledgeable persons and from the donor community and resident advisors under different programs. The judgement of the team are based on the information from these interviews and from a study of over 35 documents and extended team discussions on the best option available. The team brought to it their technical backgrounds and experience elsewhere and applied it to the local situation; it is based on technical considerations within the context of the time constraints of a three week Mission

B. Discussion of Option I

Option I proposes that USAID should:

1. Phase out AID support for intergrated primary health care interventions as the current portfolio ends and to the extent other donors can match gaps in assistance after phase-out.

2. No new bilateral health programs.

The implications of this option will be:

1. The phase out of the large predominately technical assistance efforts including PHC, RWBDC, CCCD and Project Hope projects at end of projects

2. The Ministry of Health will have at end of project, the institutional capability in planning and management and the ability to sustain the activities without significant external support. (It is unlikely from our discussions that the size and scale of current USAID will be picked up by other donors).

3. GOS will have sufficient additional local resources to sustain the activities and the improvements in the various health indicators gained as a result of priority PHC programs.

C. Discussion of option II

Option II proposes that:

1. USAID should continue to provide selected support for priority areas in health with modest bilateral assistance and centrally funded support as identified.

2. Utilize mechanism of assistance to provide less direct project assistance support from the USAID/Swaziland Mission by using US based PVO mechanisms.

3. Provide selected short-term and long term assistance to targeted technical areas

The implications of this option are:

1. USAID continue to play a useful catalytic role in the health sector in the future and at the same time coordinate US sector assistance within a more modest program.

2. The assistance is selected and targetted to identify technical areas of special need in close dialogue with GOS.

3. The selection of PVOs to provide TA support has to be done carefully as only a limited number have in-depth capability in HPN technical assistance.

4. The Ministry of Health will continue to draw on the long association with USAID and US based expertise and institutions. The USAID/GOS health link will therefore not be weakened.

5. The Ministry of Health will have gained the institutional decision making capability and increased its confidence in defining the directions of its programs and their needs for donor support

6. The Ministry of Health can request from other donors supplements to their programs, in the face of reduction/shifts in USAID assistance.

D. Discussion of Option III

Option III proposes that:

1. Continue approximate current levels of support for PHC efforts in areas where AID has a comparative advantage. It is assumed there will be maintenance of a major bilateral health program (including use of PVOs).

2. The focus and content of these programs may change but it would be assistance to institutional development in support of Primary Health Care.

The implications of this option are:

1. There will continue to be a strong technical assistance component, in the priority areas as defined by the MOH and USAID in the current projects.

2. The continued high level of technical support will delay the long term process of assumption, by Swazis of decision making and full responsibility for the planning and direction of their own programs.

3. There is a limited role for other interested donors, given the absorptive capacity of the MOH.

E. General discussion and choice of option

(a) Past achievements of USAID

Large scale USAID health projects have been provided over the past 5 - 6 years through predominantly bilateral programs in the areas of Primary Health Care, Rural Water and Sanitation, Childhood Communicable Diseases and Nurse Training projects. The goals were to reduce infant and child mortality and develop institutional capability to manage programs in priority areas to provide basic health services, especially for the rural population. The approach used was to provide a strong component of external technical assistance to the MOH, Nurse training school, Rural Water Board and other institutions. This high impact, energetic, aggressive approach was directed to the development of MOH institutional management capability at the central and regional levels and to priority programs in immunization, MCH/FP, water supply and sanitation and breastfeeding.

The progress of projects to date has been impressive. Although a strong data base does not yet exist to confirm the consensus is that the prevalence of immunizable diseases among children has decreased with a decline in childhood mortality. Water supply and sanitation facilities and their use have expanded to more than 30% of the population, MCH/FP services have expanded with half of the deliveries now being done in hospitals. Breastfeeding and other health education messages have effected changes in behavior to some extent.

Project systems support for CCCD, MCH/FP, WS&S, and pre-service and in-service nurse training has strengthened GOS capabilities in planning, management and monitoring of programs. The development of management information clinic based management, logistic and drug supply and other systems have developed structure for the support of priority programs. In-service training, for the Regional Health Management teams and clinic staff has strengthened capabilities in program management.

Concurrent with the project activities and despite economic trends over the years GOS has continued to allocate approximately 8% of the national budget to health sector. It has increased support to preventive services each year as part of its budget allocation policy. At the same time there are factors outside the MOH's direct control,(e.g. of higher paying jobs elsewhere) that have diminished the gains of the sector. The gains have been impressive, the GOS capabilities have improved to the extent that USAID is at the stage of an in-depth examination as a basis for future directions of USAID assistance.

(b) Balance between large scale technical assistance and selected strategic inputs.

The balance must be struck between the short and long term gains of continued high levels of technical assistance. With the high levels of infusion of technical assistance specific project indicators will show strong progress indicating short term achievements. However, the long term gains may be delayed if the technical assistance continues to allow a larger share of program and project direction to outside experts. In that case Swazi capability will be slowed.

The time has come when the MOH should take on the projects and make them their own and, to an ever increasing extent, assume the responsibility and exert the authority to direct their programs at the central and regional levels.

To a large extent, USAID supported projects have developed the past manpower and systems needed as a base for this process. USAID can now plan its future assistance to assist the process toward full Swazi program development. This process will no doubt encounter difficulties and setbacks but it will have longer term benefits.

It is essential that planning for long term sustainability of projects needs to be considered at the health project development stage. This is not always done in the face of critical needs. This principle apply to all sectors. Therefore, the population sub-sector's proposed program expansion should undergo the same careful planning, review and decision making process. This will moderate any impulse to expand the program at all costs.

(c) Shifts in areas of assistance in the future.

In the planning for future health programs it should be recognized that the USAID health projects as a whole have provided a large technical assistance component with comparatively small levels of input for construction, commodities and equipment. In the future, the MOH also needs to address the concerns of limited supplies, transport, health facilities, staff housing and salary incentives. Unless these are provided it will make it increasingly difficult for GOS to sustain the programs already built up and allow the staff to implement the skills learned.

(d) Role of PVOs/NGOs in HPN assistance

A limited number of international PVO's have the in-depth technical capability to provide specialized technical assistance to the health sector. It is a little better for family planning. PVO's such as technical assistance Pathfinder, Project Hope, provide specialized technical assistance and in many respects operate similarly to contractors/consulting firms. The potential for expansion of PVOs to assume a major role in Health/Population/Nutrition is therefore limited.

PVOs generally specialize in logistics, food distribution and other essentially vertical assistance type of programs and can be considered by USAID to fill a defined gap.

In the consideration of the use of local PVO/NGOs, it should be recognized that they are developing and can complement public sector coverage to a certain extent. As they are energetic and flexible they can be at the cutting edge of new and sensitive areas and can carry out pilot projects that can later be expanded by the public sector. The commercial sector, can provide specialized vertical assistance to specific areas of need. Their coverage, however, will remain smaller than that of the public sector, they cannot be a substitute for the public sector though they could take on a larger share of work than at present.

(e) Dialogue with GOS

USAID may choose in the future to focus HPN resources on selected priorities, but these should be decided in concert with the GOS. Due consideration should be given to an effective dialogue and to the overall needs and priorities in the planning and implementation of program/projects. It is important to avoid competition among projects for the same manpower and technical resources among different programs thus, in effect, returning to the vertical programs of the past.

(f) Strengthening management at all levels.

The expansion and maintenance of community based health systems require attention to the strengthening of the different levels of management support. World wide, the early PHC/community health workers programs were developed with insufficient attention placed on the management structure and support needed. Later health assistance provided broad based institutional development/management support which was distant to the operations at the periphery. In the future, attention should be given to structure the management system support at each level.

(g) Population - Health linkages

In the discussion of options, population has been considered as a constant component in each. The assessment of the need and potential for expansion of population activities has been discussed in the population section. However, it is appropriate to clarify the linkages between health and population which should be better understood for the development of future health and population assistance.

There has been considerable debate over the years about health and population linkages. The past and current evidence is that selected health development can reinforce attitudes and the practice of family planning as well as the desire for fertility moderation. In this respect reduced infant and child mortality is a major consideration. In the context of Swaziland, the falling but still high infant and child mortality needs to be addressed. The practice of delivering family planning within maternal and child health programs is also fairly standard practice and mutually reinforcing.

Not all health programs impact on family planning practice; equally there are other non-health factors (eg literacy, women's development) that are important and influence attitudes to family planning practice. A balance of these variables should be present to jointly influence fertility trends.

Experiences elsewhere have also shown that there is no magical threshold level that health or other social indicators must reach before family planning acceptance can take place. Efforts to improve health status should go hand in hand with population program efforts so that population growth and rate does not go up. Selected health programs and population programs reinforce one another in their benefits.

(h) Other considerations

Among the other considerations beside these in the general discussion above are the following:

1. The team has assessed that the USAID projects which provide large scale technical assistance have been vital to the development of institutional capability and specific technical expertise of Swazi nationals. The assessment has further recognized that the Ministry of Health is a stronger institution with increased self confidence and maturity and the capability to increasingly assume the direction and management of its own programs.

2. Both Ministry officials and others interviewed have indicated the need for continued support in selected areas that are identified as priorities by a good policy dialogue between USAID and GOS officials.

3. The mechanism of assistance would be balanced with the use of PVOs and other mechanisms in specific areas of expertise. The team assessed that USAID coordination and oversight through the HPN office serves an important function in providing the framework for a consistant approach within which various intermediaries can provide assistance to Swaziland.

4. It is assessed by the team that other donors, who have played a comparatively smaller role in the health sector to date, may increase their assistance. They should also dialogue with the MOH and jointly define increased support in areas of need, so that total health system needs are met.

5. The team also judges that USAID and the GOS will need to continue to maintain close linkages in health and will benefit mutually from the option recommended.

(i) Recommendation

On the basis of the general discussion and the other considerations referred to above the team has concluded and recommended that the option for the next phase of USAID assistance that will be appropriate is Option II.

F. FUTURE U.S. ASSISTANCE IN POPULATION

The section on population of this report discussed the demographic situation and future trends and then outlined the prospects for population policy and program development. The in renewing future USAID plans it was noted that the broad lines of USAID strategy to strengthen MCH/FP work in the private sector, assist policy and strategy development and support population/family life education are still valid. However, present assistance focuses on the first two areas and expansion to the other two areas and the general increase in explicit population support is appropriate.

The sector report earlier further concluded, given the urgency of the situation and the changing socio-cultural environment to population and family planning that the time was ripe for expanded assistance to the sector. Population and family planning continue to be sensitive in certain quarters and profile and style in working in the sector are important at this stage. The areas of assistance that could be pursued by USAID in the future in an expanded USAID assistance are:

1. Assistance for policy and program development;

2. Increase of commodity support consistent with the rising demand;

3. Assistance in improving and expanding the quality of family planning services provided within primary health care and through the private and industrial sector. This will include innovative marketing approaches and expansion of the private sector.

4. Support to educational efforts at the Community and leaders through FLAS and other local NGOs.

5. Assistance for introducing population education and family life education to those in school and out of school.

6. Assistance for the rationalization of the population and family planning data collection and analysis arrangements.

The overall directions of future expansion are more fully discussed in the population section of the report.

It is important that the pace of the population support should be measured and should not be seen as directed and managed from the outside. To this extent the use of NGOs will be a useful vehicle but the final effort in population will involve both public and private sectors. The Government however, can be expected to exercise an oversight and lead role. There is little doubt that in the next two to three years significant changes will take place and AIDs assistance for the sector will need to increase.

LIST OF INDIVIDUALS CONTACTED

1. MINISTRY OF HEALTH

Dr. Fannie Friedman	Honourable Minister
Chris Mkhonza	Principal Secretary
E.M. Hlophe	Undersecretary
Dr. John Mbambo	Director of Health Services
Maggie Makhubu	Chief Nursing Officer
Paul Thompson	Budget Officer
L.B. Dlamini	Deputy Chief Nursing Officer
Nester Shongwe	Principal Officer Institute of Health Sciences
Frank Martin	WHO Advisor Sanitarian
Pitnera Mthembu	Senior Health Educator
Paul Thompson	Financial Controller

2. MINISTRY OF EDUCATION

M.J. Nsibande	Principal Secretary for Education

3. MINISTRY OF ECONOMIC PLANNING AND STATISTICS

Phindile Mkhonta	External Assistance
Cindie Mabuza	Economic Planning - Health

4. US EMBASSY

Ambassador Mary Ryan	Ambassador

5. USAID

Roger D. Carlson	Director
Harry Johnson	Deputy Director
Alan Foose	Regional HPN Officer
Mary Pat Selvaggio	Assistant Regional HPN Officer
Anita Henwood	Health Population Nutrition Specialist
Lalit Kraushaar	Assistant Officer CCCD
Allan Reed	Regional Program Officer
JCJohnson	Assistant Regional Program Officer
Doug Wear	Somarc Assessment Team
Albert Katsande	Somarc Assessment Team

6. CONTRACTORS

Dan Kraushaar	PHC Project Chief of Party
Mary Kroeger	PHC/MCH Nurse Midwife
Margaret Price	PHC/Clinic Management Advisor
Bill Hoadley	RWBDC Engineer
Tom Kenyon	Project Hope Director
Agatha Lowe	Project Hope Nurse Coordinator
Ailene Duvale	Project Hope Nurse Educator
Faye Richardson	Project Hope Nurse Educator
Tom Fenn	FHS Advisor

7. FAMILY LIFE ASSOCIATION OF SWAZILAND

Khetsiwe Dlamini	Director FLAS
Nomcebo Manzini	Deputy Director FLAS

8. NON-GOVERNMENT ORGANIZATIONS

Dr. G. Douglas	Occupational Health Services/ Mantalk
William Msibi	Save the Children Fund

9. DONOR AGENCIES

Joseph Cavallie	UNDP Representative
Dr. Q. Qhobela	WHO Representative
Nossisa Mohammed	UNFPA Representative
Rodney Phillips	UNICEF Representative
Dr. R. Mwaikambo	UNFPA/IPPF Advisor
Graeme Gibson	British High Commission

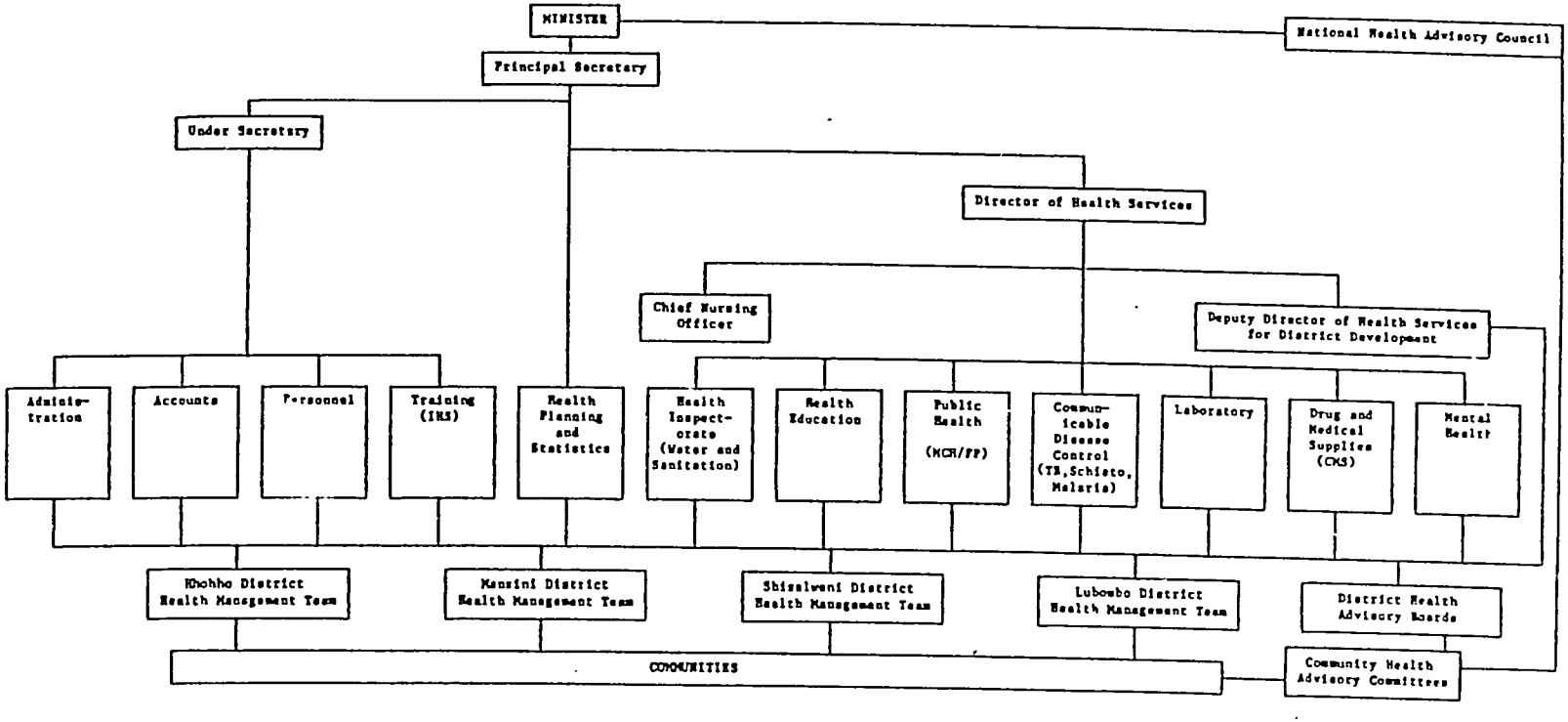
10. SWAZILAND FEDERATION OF EMPLOYERS

Peter Dodds	Executive Director SFE

FIELD VISITS

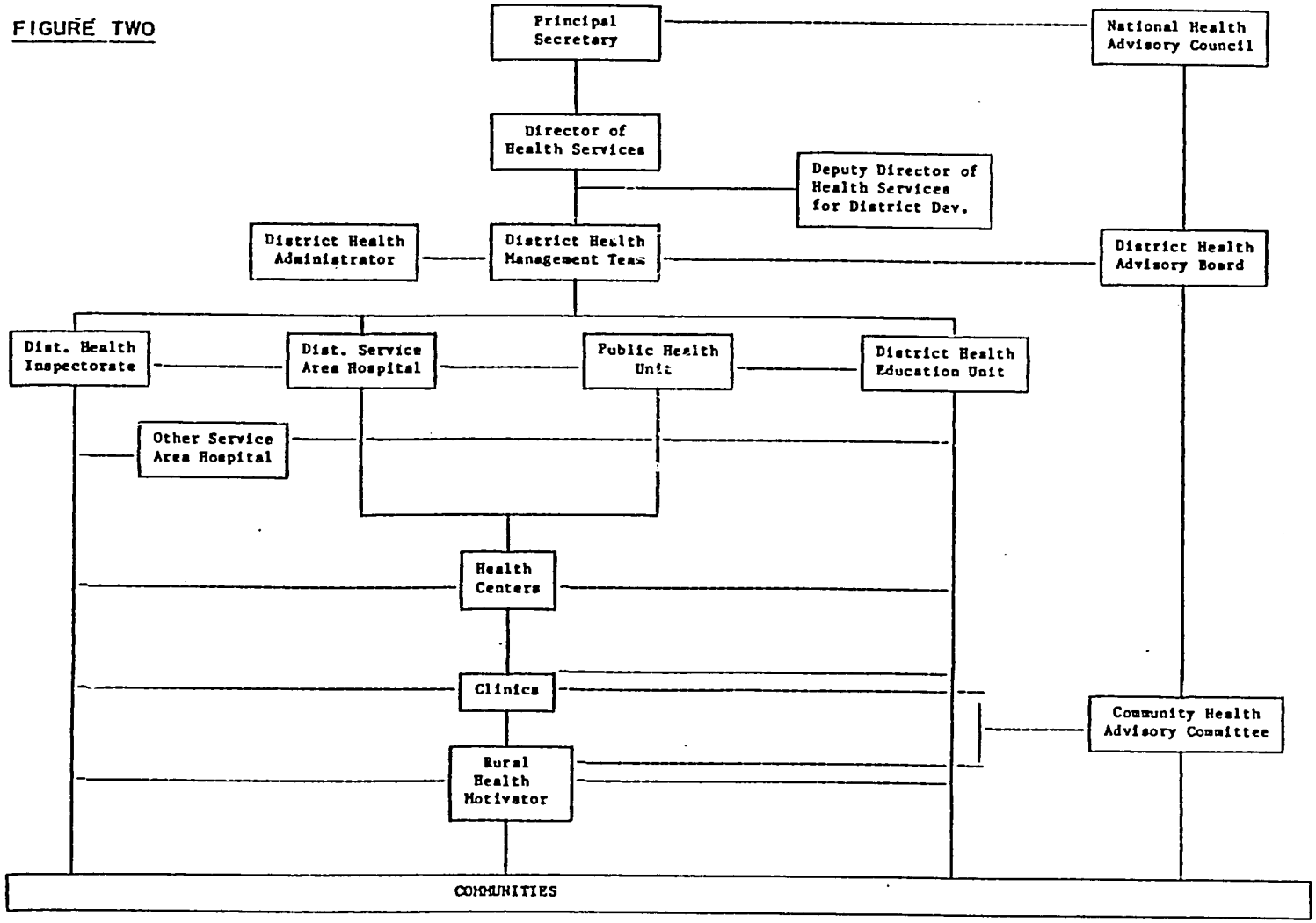
Family Life Association Clinic, Manzini
Swazican Health Clinic, Malkerns
Raleigh Fitkin Memorial Hospital, Manzini
Public Health Unit, Manzini
Public Health Unit, Mbabane
Public Health Unit, Piggs Peak
Regional Hospital, Piggs Peak
Ngonini Peatitalia Industrial Clinic

FIGURE ONE



Annex II

FIGURE TWO


Principal Secretary
National Health Advisory Council
Director of Health Services
Deputy Director of Health Services for District Dev.
District Health Administrator
District Health Management Team
District Health Advisory Board
Dist. Health Inspectorate
Dist. Service Area Hospital
Public Health Unit
District Health Education Unit
Other Service Area Hospital
Health Centers
Clinics
Community Health Advisory Committee
Rural Health Motivator
COMMUNITIES

SCOPE OF WORK FOR HPN SECTOR ASSESSMENT

1. Background

To improve the health status in Swaziland, the USAID/Health, Population and Nutrition program during the last decade has assisted the GOS to increase the capacity of the Ministry of Health to deliver quality health services in the rural areas. USAID assistance has focused on health manpower development, planning and management, disease prevention and basic service delivery, and rural water supply and sanitation. This program focus has been on improving and expanding the supply of modern health services through the public sector. AID has been the leading donor, although there are other donors who will probably continue to provide resources in high-priority areas (e.g., child survival, maternal health).

USAID has assisted in another aspect of the HPN sector -- the demand for modern health services -- in a more limited way through activities involving health education, community participation in rural water and sanitation, health communications, and most recently, support for private-sector family planning efforts.

Swaziland's high population growth rate continues to be the key development problem. Creative ways are needed to increase the use of modern contraceptive methods, and eventually to decrease the growth rate. Additional health benefits for both mothers and children will also result.

The linkages and interrelationships among the three subsectors are also important to consider in any future AID support. This is especially true since increasing the utilization of health services will likely form the basis of any future efforts in the sector, and the methods of increasing demand are likely to be the same for all three areas. At the same time, most HPN services are delivered as an integrated package, and this should be reinforced to insure the effective use of available services.

As in any sector where donor assistance is significant, sustainability in the HPN sector is an important consideration for both donors and the GOS. Much of AID's assistance thus far has been directed toward self-sustainability -- especially manpower development, improvement of planning and management systems, and the use of simple, effective technologies. However, it is important that future donor assistance should be designed to maximize sustainability and/or decrease GOS budgetary requirements in the HPN sector.

2. Scope of Work

The Contractor will perform an assessment of the HPN sector in Swaziland during a three-week period in March 1989. The assessment team will be composed of three members, as described below. The Population/Family Planning Specialist will be provided through an AID/Washington-funded project rather than the

Within the general framework described above, and based both on USAID and GOS program achievements to date and on the changing health environment in Swaziland, the assessment team will analyze the impact of the following range of options for future AID assistance to the HPN sector:

-- Phase-out Option:

Phase out AID support for integrated primary health care interventions as our current portfolio of projects terminates (Primary Health Care, Combatting Communicable Childhood Diseases, Rural Water Borne Disease Control, Project HOPE) and other donors are prepared to provide needed resources; but support innovative new program(s) of assistance to decrease the population growth rate.

-- Selected Support Option:

Provide modest project/program support for community-based service delivery and/or outreach activities, through PVO mechanisms (ranging from OPGs to centrally-funded matching grants, as appropriate). Provide selective inputs for targeted policy issues, but not in an institution-building approach (perhaps through OPEX-type assistance). Support innovative new program(s) of assistance to decrease the population growth rate.

-- Continuity Option:

Continue approximate current level of support of PHC efforts in those areas where AID has a comparative advantage (including the appropriateness of PVO mechanisms); and support innovative new program(s) of assistance to reduce the population growth rate.

To accomplish this, the team will review and analyze relevant documents, conduct interviews, and obtain other information as necessary. In order to analyze fully the options above, the team should consider the relevance of at least the following issues:

-- Likely availability of GOS funds in future years, and implications for each option.

-- Actual MOH expenditures in relation to priority programs and service delivery (e.g., curative vs. preventive, rural service delivery).

-- The GOS policy environment in the HPN sector, and potential areas for policy dialogue.

-- Alternative financing mechanisms and options that could provide extrabudgetary support in the sector.

-- Expected other-donor support in relation to perceived needs, as well as its complementarity with potential AID support.

WB

-- Issues related to health facility utilization and areas for improving community and family health.

-- Effective approaches to communications and education in the sector, and strategies for their development and implementation.

-- Given the policy environment in the HPN sector, options for expanded private-sector HPN services.

-- The need to expand and improve health motivation and increase service utilization, especially among the large, rural population; and the issues related to the traditional sector that may be inhibiting improvement in health status.

-- The role of traditional healers in the HPN sector, and ways in which modern and traditional health services can be coordinated to improve overall health status.

-- The potential for changes in health behavior by utilizing community-level resources and the traditional sector in Swaziland.

-- GOS capability to handle catastrophic health problems.

USAID/Swaziland has also arranged for a contraceptive social marketing (CSM) feasibility study to be carried out as part of the overall HPN sector assessment. This CSM study is intended to assess the feasibility of contraceptive social marketing in Swaziland, as an important potential component of an overall Pop/FP strategy. Since the CSM study requires specific additional inputs beyond the scope of the broad HPN sector assessment, it is being carried out in parallel. Although the CSM feasibility study will begin before the HPN assessment, it is expected to overlap with the HPN assessment. The Contractor will debrief with the CSM team, and will incorporate relevant findings and recommendations from the CSM study in the overall HPN Sector Assessment Report.

3. Team Composition

Team Leader (Health Care Management/Policy Specialist): Person should have broad experience in dealing with health care management and policy issues in developing countries.

Population/Family Planning Specialist: Person should have broad experience in the development and implementation of innovative programs that have been effective in conservative environment in developing countries. [This specialist will not be provided by the Contractor, but rather will be provided through an AID/Washington-funded project.]

Anthropologist/Sociologist: Person should have specific Swaziland experience including a knowledge of the traditional sector.

4. Relationships and Responsibilities

The assessment team will coordinate its work through the USAID/Swaziland Regional Health and Population Officer.

The Team Leader will have overall responsibility for conducting the assessment and assuring that its objectives are met, including responsibility for the work of non-Contractor team members.

5. Report

The Contractor will provide a final draft report (15 copies), and will make an oral presentation of the report to USAID/Swaziland officials prior to departing Swaziland.

6. Terms of Performance:

Work will commence in Swaziland on or about March 6, 1988. A six-day work week is authorized. The assessment, including submission of the final draft report, should be completed on or about March 24, 1989.

7. Work Days Ordered

Team Leader (Health Care Management/Policy Specialist): 17 work days plus travel.

Anthropologist/Sociologist: 17 work days plus travel.

8. Miscellaneous

Duty Post: Swaziland

Language: English

Access to Classified Information: None

Logistical Support: USAID/Swaziland will make available all pertinent reports and other documents related to the assessment. Limited office space will be provided for team use. The Contractor is expected to arrange for all incountry secretarial and clerical assistance as well as transport for the assessment. USAID/Swaziland will assist in making appointments with GOS and other officials, and hotel and rental car reservations if requested.

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