

PD-ABC-689

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SWAZILAND

FAMILY PLANNING/MATERNAL CHILD HEALTH

(645-0236)

PID Document

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List of Acronyms

ARI	- Acute Respiratory Infections
CCCD	- Combatting Childhood Communicable Diseases
CDC	- Centers for Disease Control (U.S. Public Health Service)
CDD	- Control of Diarrheal Diseases
EPI	- Expanded Program of Immunizations
FLAS	- Family Life Association of Swaziland
FP	- Family Planning
GDP	- Gross Domestic Product
GM	- Growth Monitoring
GNP	- Gross National Product
GOS	- Government of Swaziland
IPPF	- International Planned Parenthood Federation
LDC	- Less Developed Country
MCH	- Maternal and Child Health
MSH	- Management Sciences for Health
MH	- Maternal Health
NPA	- Non-Project Assistance
ORS	- Oral Rehydration Salts
ORT	- Oral Rehydration Therapy
PAAD	- Program Assistance Approval Document
PACD	- Project Assistance Completion Date
PAIP	- Program Assistance Initial Proposal
PFA	- Patient Flow Analysis
PHC	- Primary Health Care
PROAG	- Project Agreement
PVO	- Private Voluntary Organization
RHM	- Rural Health Motivator
SINAN	- Swazi Infant Nutrition Action Network

I. The Problem

Swaziland's total fertility rate is approximately 5 and its population growth rate is about 3.4%, one of the highest in the world. At this rate, the population will double in about 21 years, imperiling the country's otherwise bright economic prospects. The importance of population issues to national development was noted by the Minister of Finance in his 1991 budget speech, in which he stated: "Despite the significant real growth in the economy...the potential for increased individual welfare is limited by our high population growth rate." In addition, infant mortality, estimated at 100/1,000, remains high, especially for a country with Swaziland's per capita GNP. Although reliable figures are not available, maternal mortality is thought to be high as well.

II. Ministry of Health Strategy.

Family planning (FP) is one of a number of basic maternal and child health (MCH) services provided by Ministry of Health (MOH) nurses. At the field level, there is no separate infrastructure or separate staff for family planning or for other activities. The MOH firmly intends to maintain this integration and even enhance it by more effectively coordinating central technical functions related to maternal health and family planning (MH/FP), immunizations (EPI), growth monitoring (GM), the control of diarrheal diseases (CDD), and acute respiratory infections (ARI) under a single, more vigorous MCH program. The Minister of Health has informed USAID that the MOH regards the integration of FP within existing programs as the only route to sustainable public-sector FP services in Swaziland.

However, FP has, in practice, received less MOH attention than other MCH services. Heavy competing demands on nurses' time, largely resulting from routine child-survival activities, plus traditional Swazi sensitivities to FP and insufficient appreciation of its health benefits have discouraged nurses from according high priority to FP during their day-to-day work. The MOH wants to change this situation and to do so in a way that decreases rather than increases demands on clinic nurses' time.

III. USAID Strategy

USAID's population strategy, set forth in its approved Action Plan, will attempt to increase contraceptive prevalence from 17% to 30% through: (1) increased availability of contraceptives at the community level; (2) increased demand for family-planning (FP) services through information, education and communications activities; (3) establishing FP programs in large private industries, and (4) strengthening the MOH's FP program, the principal source of services for the approximately 78% of Swaziland's population which is rural and among whom fertility is highest.

USAID will address element one through (a) a centrally funded social-marketing program and (b) this project. Element two is being addressed under a grant to the private Family Life Association of Swaziland (FLAS, the local IPPF affiliate), and element three will be addressed under the same grant this year. The FP/MCH Project will address element four.

Given the relative lack of attention accorded to FP to date, as well as its importance as both a powerful health intervention and a key factor in socio-economic development, FP/MCH's first priority will be the expansion of FP services. However, to do this, the project cannot deal with FP alone; it must also deal with the other things nurses do, with the system in which FP is imbedded. This is especially true for important efforts to improve field-level management systems (see IV,B,4 below) which cannot be adequately addressed by concentrating on FP alone. (E.g., the MOH obviously cannot have one supervisory system for FP and other, competing systems for CDD, etc.) Therefore, and in keeping with the MOH's perspective on integration, the project will approach FP as part of a package which includes other priority MCH services as well: FP (including closely linked maternal-health efforts in ante and post-natal care), GM, EPI, CDD, and ARI. Nurses spend a major part of each day providing these services which address by far the majority of preventable mortality in Swaziland. By assisting the MOH to improve the delivery of the priority services noted above the project will maximize the potential for both fertility and mortality reduction.

1. The Child Survival Hypothesis, i.e., that reduced child mortality is a prerequisite for lower fertility, has been debated for years and recently refuted by Maurice King (1990). Historically, fertility declines preceded significant mortality reductions in the west, an experience being repeated in some LDCs. King indicates that fertility decline requires "...changes in people's behaviors, lifestyle and standard of living".

Child-survival programs can be a part of this process of modernization. UNFPA's Executive Director notes that, "The surest way to achieve a sustained decline in fertility is to give a new priority to social' or women's resources' investments, to improving mother and child health, women's status and education and to making family planning as widely available as possible to both women and men". (UNICEF, 1991) A recent review of research (Potts and Thapa, 1990) notes that, "A smaller family size improves the prospects for child survival; similarly, improved child survival motivates couples to want to have fewer children. Research has shown these two forces interact with each other. Both these factors, in turn, lead to greater use of family planning." USAID believes that these considerations, in addition to the managerial and imperatives noted above, provide further justification for approaching FP as an integral part of MCH care under FP/MCH.

IV. The Project.

A. Goal and Purpose. The goal of the project is to help reduce, along with other elements of USAID and other-donor assistance, unwanted fertility and maternal and infant mortality. The purpose of the project is to improve and expand MOH delivery of integrated family planning, maternal and child health services.

B. Project Accomplishments: What the Project Will Do. FP/MCH will strengthen the integration of FP with other MCH services, and introduce important structural changes and management improvements to enhance the efficiency and effectiveness of priority MCH services generally. The project will, initially, employ a phased, experimental approach to overcoming key structural and management constraints to better service delivery and will replicate those solutions nationwide by the PACD. These efforts will be concentrated at the field level, where services are actually provided. FP/MCH will thus assist the MOH to systematically review the ways in which it manages its resources to deliver services to the rural majority and to modify the deployment of those resources for optimal results.

1. Integration of Services. The project will incorporate family planning components into the MOH's existing MH, EPI, GM, CDD, and possibly ARI activities, taking advantage of currently missed opportunities' to promote FP.

Linkages between FP and maternal-health efforts are obvious: antenatal care and, especially, post-natal counselling provide excellent opportunities to promote FP, and women are likely to be highly receptive to FP promotion from nurses who have assisted them through pregnancy and delivery. The project will ensure that FP counselling is routinely provided during antenatal and, especially, post-natal care.

Perhaps less obvious are the potential links between FP and child-health programs. However, one of the principal reasons Swazi women visit health facilities is to obtain services for their children, and these programs provide promising vehicles for promoting FP. Ninety percent or more of Swazi mothers bring their infants to clinics for at least one immunization; perhaps over 80% show up four to five times during the child's first nine months of life. Attendance at growth-monitoring sessions roughly approximates immunization attendance. By some accounts, up to 80% of mothers have their infants weighed monthly. In addition, GM tends to identify mothers who need family planning most: those with children who are failing to thrive, whether due to high parity, poorly spaced births, poor socio-economic status, or frequent illness.

In the EPI and GM programs, mothers visit health facilities with essentially well children in a non-crisis' atmosphere. These programs could become important vehicles for providing mothers with post-partum education, including the importance of breastfeeding and FP, especially birth spacing.

In CDD and ARI, linkages with FP are more ambiguous since mothers are at least initially pre-occupied with sick children. However, most children presenting with diarrheal illnesses in Swaziland are not seriously ill. In more severe cases, recovery can be readily apparent as oral rehydration therapy is administered, with mothers becoming more open to CDD's health education component, which includes breastfeeding promotion. In addition to the possible incorporation of an FP component into the MOH's national CDD course, the project will strengthen CDD's efforts to promote exclusive breastfeeding for at least the first four to six months as an important deterrent to diarrheas during early infancy when children are at greatest risk of death from these diseases. The resultant increased duration of lactational amenorrhea would have beneficial child-spacing effects, and infant nutrition would, of course, also benefit.

ARI accounts for about 25% of outpatient visits in Swaziland, the largest single source of primary-care pathology and a major source of nurse/mother interaction. About 80% of these ARIs are non-serious, upper tract infections for which much of the treatment consists of health education, another possible opening for FP, which could be included in the MOH's national ARI course currently being designed.

2. Structural Changes. The project will increase the provision of FP/MCH services at the community level by supporting the greater use of outreach sites and Rural Health Motivators (RHMs) to deliver basic MCH services. It will also increase the efficiency of clinic services by using RHMs in clinics and by improving patient flow.

Outreach sites are simple structures, built with voluntary community labor, which are visited, usually monthly, by clinic staff to provide basic services. There are 161 outreach sites in Swaziland. RHMs are health volunteers, mostly women, chosen by community leaders. They are trained for three months by the MOH and reside in the communities they serve. There are about 1,500 RHMs with about 500 more to be trained. (Many, however, are inactive due to their low stipend - under \$8/month, competing demands on their time and infrequent supervision.)

Outreach sites have been used primarily to provide child-health services, and FP/MCH would increase their use for FP. Although condoms are available at outreach sites, orals and injectables, the most popular methods in Swaziland, are not. This is due to MOH practice of requiring pelvic examinations, which have been difficult to conduct at these sites, prior to prescribing these methods. However, discussions with the MOH during PID design indicate a willingness to modify this practice by establishing new protocols for the prescription of orals and injectables, thus allowing outreach sites to become important sources of FP services. FP, EPI and GM are ideal services for community outreach, and the establishment of linkages at outreach sites between these services will be especially important.

The role of RHMs has been largely confined to health education, with a long-standing reluctance among many professionals to delegate service-delivery responsibilities to these personnel. However, experience in many other countries indicates that community health workers with little formal education can be trained to provide a variety of basic services, including the provision of oral contraceptives, safely and effectively. The MOH is now willing to test this approach under the project and implement it nationwide, as proves feasible.

It is widely recognized that heavy patient loads in clinics often overwhelm nurses, and, as noted above, FP has suffered as a result. At least part of this overload results from RHMs referring patients to clinic nurses for services that could be provided in communities by other personnel. Thus, greater reliance on outreach sites and RHMs would, in addition to expanding the availability of basic FP/MCH services as above, increase the efficiency of clinic services by unburdening clinic nurses, allowing them more time for FP and other priorities.

In addition, FP/MCH will support the training of RHMs to work in clinics to relieve nursing staff of routine, non-technical functions such as basic health education, growth monitoring, drug dispensing, and ORT.

Finally, prior to PP/PAAD design, patient-flow analyses (PFA) will be conducted in a sample of clinics to examine the problem of too many patients and too few staff. PFA will indicate ways in which patients can be expeditiously channeled through facilities while receiving an appropriate mix of services. In this latter respect, PFA can be a tool for linking services, eg. ensuring that mothers waiting to have their children immunized, or adults being treated for STD's receive family-planning counselling as well.

PFA will probably be most useful in larger facilities with varying options for organizing staff and time, e.g. health centers and public-health units. These latter two types of facilities are especially important since outreach staff and supervisors are posted there, and freeing up these staff is a project priority (see 4,a below). In smaller clinics staffed only by one nurse and a nursing assistant, the rule in rural areas, these options are more limited, and PFA will concentrate on linkages, the organization of services to maximize the use of RHMs, and the shifting of some services from clinics to communities.

4. Management Improvements. The project will establish field-level systems to enable the MOH to (a) monitor the quantity and quality of FP/MCH services being provided, (b) identify constraints to optimal service provision at the local level, (c) respond to those problems in individual clinics, and (d) assess service impact on the population those clinics serve.

The ability to effectively manage and evaluate integrated MCH services (or any services) is crucial to ensuring that they are

implemented as desired and have their intended effect. The project will, therefore, place major emphasis on strengthening MOH capability to perform three key management functions: supervision, on-the-job training, and data collection and analysis. These three support functions will be improved across all priority MCH areas (i.e., FP, EPI, GM, CDD and ARI). The contraceptive logistics system will also be strengthened.

a. Supervision is acknowledged as a major problem for the MOH² which currently has 11 supervisors to monitor the 149 clinics and 161 outreach sites under its jurisdiction. Many clinics are only visited once or twice a year; outreach sites are rarely supervised at all. Clinic supervisors are not currently assigned in all regions, and where they are assigned, they are frequently distracted by logistical, administrative, and hands-on nursing tasks. Although insufficient vehicles are a problem, supervisors are assigned based on seniority, many senior nurses are reluctant to travel extensively in rural areas, and many do not drive. Thus, supervisors do not work full time (or even most of the time) on supervision. In addition, program managers for MH/FP, EPI, GM, CDD and ARI rarely assess field activities, a significant under-utilization of their expertise. Although clinic supervisory guidelines exist in the form of checklists, they are often not used and constitute only a first step towards a more effective, problem-solving approach to supervision. (See b. below.) There is essentially no synthesis or use of data resulting from supervision for management purposes.

The project will assist the MOH to define the content of supervision for MH/FP, EPI, GM, CDD and ARI in terms of a minimum number of key observations at both clinics and outreach sites; establish reasonable supervisory schedules and reporting formats; incorporate the use of data from the MOH's Health Information System into the supervisory process; and synthesize supervisory and HIS data for use by MOH management (see d below).

b. On-the-job training is a principal means of dealing with problems observed in the field and will be³ approached under the project as an integral part of supervision. There should be no

2. Fifty-two government clinics, 33 mission clinics, 64 industry and private clinics.

3. Given its emphasis on field-level activity, FP/MCH will not attempt to strengthen the central MOH's training division, the capability of which to design and implement training courses based on documented clinical performance is nil, or pre-service training institutions. However, USAID is considering the use of a U.S. PVO with experience in Swaziland to either upgrade this unit's capability or to assist pre-service institutions to be more responsive to the MOH's training needs.

supervision without informal, on-the-job training and no formal training without subsequent supervision and follow up. However, while supervisors and program managers should be able to detect and correct many problems during supervision, they are not trained in interactive problem solving and some may not be technically up to date in all areas of emphasis under FP/MCH. Therefore, the project will train supervisors and program managers in a problem-solving approach to supervision, including work with nurses to establish linkages, as above, between FP and other services.

Although formal, technical training will not be emphasized under the project, a small amount of project funds (perhaps 2%) will be allocated for short-term U.S. or third-country training opportunities for program managers and supervisors in areas of project emphasis. Limited support would also be available to periodically review and revise the MOH's central-level CDD and ARI courses.

c. Data-based management. In addition to supervision, the regular reporting of various service statistics, including figures on the distribution of contraceptives and FP clients by method, is an important means for MOH managers to know what's happening in the field and respond appropriately. Although a regionalized, computer based Health Information System (HIS) has been installed for this purpose, under USAID's Primary Health Care (PHC) Project, it is only about a year old and remains fragile. Quality-control checks on data are not performed, capacity for trouble-shooting the system is limited, and raw data is not analyzed or disseminated and is, therefore, seldom used by MOH managers and supervisors. The project will help institutionalize the HIS by providing in-depth training for HIS staff in relevant computer software and basic statistics; and by establishing procedures for data-quality control and for the routine analysis and use of data at varying levels of the system, including the supervisory system.

The project will conduct two population based studies on fertility, contraceptive prevalence, and a limited number of other key indicators - one at the start of the project and one near the end. These surveys, updating a 1988 survey conducted under USAID's PHC and Combatting Childhood Communicable Diseases (CCCD) Projects, will be the principal means of measuring goal attainment in FP. Alternative methods to measure infant and maternal mortality (e.g., the preceding birth technique and the sisterhood method) will be investigated and possibly adopted for routine use, with resulting data included in the HIS.

The project also will support a variety of smaller surveys and studies to document performance in areas not easily assessed through supervision or the HIS. These will be important management tools for guiding implementation as the project evolves and instilling a field-oriented, fact-finding' approach to service management in a system not currently attuned to data

based decision making. Although flexibility should be maintained to respond to situations which will only be appreciated as the project proceeds, a tentative list of topics follows below:

- estimations of the population served by individual clinics (i.e. catchment areas);
- mothers' knowledge, within catchment areas, of how to manage acute diarrhea at home and of the danger signals of ARI and how to respond;
- duration of exclusive breastfeeding within catchment areas;
- the extent to which oral contraceptives are properly used within catchment areas;
- the evaluation of RHM performance in delivering basic services, including oral contraceptives;
- the cost effectiveness of community based distribution of contraceptives;
- reasons why women prefer home delivery and avoid post-natal care;
- the etiology of diarrheas (viz. dysenteric and chronic vs. acute, watery);
- the epidemiology of maternal mortality, ARI, and diarrheal diseases
- adverse effects associated with specific traditional treatments for diarrheas and ARI; and
- determination of client satisfaction with services received and the completeness/quality of services.

Perhaps most importantly, an **Epidemiology Unit** will be established by the MOH in the National Public Health Unit to utilize data from the HIS, the supervisory system and special studies to assist program managers and higher-level MOH management to set program objectives and evaluate their attainment. Much of the data-related activity noted above will be conducted under the direction of this unit which will thus constitute the major stimulus to informed MOH decision making and program management. Assistance in setting up this unit and ensuring its optimal functioning will be a major project priority.

This unit will also absorb the MOH's current disease surveillance system and outbreak-control teams, thus assuming responsibility for monitoring and reporting on the incidence of communicable diseases. Although this surveillance and response capability could eventually be expanded to include various communicable diseases, the unit's first priority (the area on which surveillance and control are currently concentrated) will be the elimination of indigenous measles. Surveillance and outbreak data will also be incorporated into the HIS.

d. Contraceptive Logistics. MOH contraceptives are currently ordered from IPPF and USAID by FLAS. To place these orders, FLAS must estimate MOH requirements based on data, usually

incomplete and of questionable validity, received from the MOH. Although data on contraceptive distributions are supposedly included in routine HIS reports from each clinic, these reports are not monitored, and commodities consistently leave the MOH's contraceptive warehouse without documentation. A significant but unknown portion of these contraceptives end up in an unknown number of larger clinics which re-distribute them to smaller facilities for distribution to users. It is virtually certain that these commodities are counted as distributed twice. Despite the liberal bias that this should give to forecasts, stock-outs at the warehouse are common, and the system is widely acknowledged to be largely unsupervised and increasingly chaotic.

Under FP/MCH, the MOH will assume full responsibility for its own contraceptive logistics. FP/MCH will assist the MOH to install a system which monitors inventories and expiration dates at the warehouse, intermediate depots and clinics, tracks distribution to end users, forecasts annual requirements based on this data, and places timely orders with relevant donors.

C. Implementation: How the Project Will Work. The project's principal inputs will be technical assistance focused on establishing the integration, structural changes and management improvements noted above. Aside from contraceptives, there will be no large commodity inputs and no project support for MOH recurring costs. Three long-term advisors, all with prior experience in developing countries, will be provided. One will be Chief-of-Party whose principal counterpart will be the MOH's Deputy Director of Health Services. Day-to-day project implementation will be conducted in close coordination with the Chief Medical Officer for Public Health; the Senior Public Health Matron; Program Managers in FP, EPI, GM, CDD and ARI; and regional supervisors.

One long-term advisor will be a nurse-midwife, widely experienced in the delivery of FP services, who will work primarily with the FP program manager on family planning and maternal health, including the establishment of linkages between FP and other activities. It will be highly desirable for this advisor to have significant experience in EPI, GM, CDD and ARI as well. (To the extent that this is not possible, these skills will be required of the remaining two advisors.)

A second advisor will provide skills in epidemiology, data systems and survey/research design. He/she will concentrate on the further development and institutionalization of the HIS and the epidemiology unit, including the incorporation of supervisory data and disease-surveillance data into the HIS; the analysis and use of this data; the design and implementation of operations research studies; and alternative means of measuring infant and maternal mortality, as well as assisting in the design and implementation of population-based studies.

A third (probable Chief of Party) will be a health-systems management specialist, with significant experience in supervision, training and the utilization of outreach mechanisms and community health workers. This latter individual will, in coordination with the other two, concentrate on the optimal utilization of MOH and community resources at the field level to maximize the efficiency and effectiveness of FP, EPI, GM, CDD, and ARI activities.

This long-term assistance will focus on improving service delivery, not on the institutional development of the central or regional MOH bureaucracy. Although all long-term advisors will be posted in Mbabane, they will be expected to spend a significant amount of time in the field.

In addition, approximately 30 person-months of short-term TA will be required.

As noted above, most activities will be implemented in phases, starting in a small number of clinics to see what works and what doesn't prior to national implementation. This first phase of the project would last up to two years, possibly confined to approximately the six best and six worst clinics (and surrounding outreach sites) in terms of FP and other HIS performance indicators. The PP will specify the phasing and nature of these early interventions, and the criteria for judging their utility prior to nationwide replication.

A summary of project activities, per section B above, follows below, followed by a brief sketch of how they will be managed.

1. Under Integration of Services, the project will:
 - a. Establish linkages between FP and EPI, GM, CDD and ARI;
 - b. Strengthen breastfeeding promotion.

This will be the principal responsibility of the MOH's program manager for MH/FP, and other program managers, with the assistance of the nurse-midwife advisor. Initial attention will focus on establishing linkages between FP and EPI and GM, leaving the more problematic CDD and ARI programs for later, after some experience with linkages has accumulated. Initial linkage strategies will inform the development of new health-education materials for use by clinic staff at outreach sites and by RHMs, possibly in conjunction with professional staff seconded from the MOH's Health Education Unit. Activities relating to breastfeeding and growth monitoring will be conducted in coordination with the Ministry of Agriculture's A.I.D.-supported "Weaning Project" and with the Swaziland Infant Nutrition Action Network (SINAN), a small PVO devoted exclusively to breastfeeding promotion.

2. Under Structural Changes, the project will:
 - a. Increase the use of outreach sites for the provision of FP services;

- b. Expand the role of RHMs beyond health education to include the delivery of basic services, starting with the expanded provision of condoms and introducing the provision of oral contraceptives;
- c. Utilize RHMs to provide routine clinic services; and
- d. Conduct patient-flow analysis (PFA).

Items (a), (b), and (c) will require the formulation of new protocols for the provision of oral contraceptives and other services and an evaluation of their implementation. This operations research will be conducted by the MH/FP and other program managers, and regional supervisors with the assistance primarily from the nurse-midwife and research design advisors.

In addition, items (a) and (b) will require increased MOH supervisory and logistical inputs. The possibility of using community-health nurses for expanding the MOH's outreach capability, including the provision of services at outreach sites and the training, supervision and supply of RHMs, will be explored during PP development. These personnel, distributed among six Public-Health Units (and elsewhere) and theoretically responsible for (and trained for) community-health, have become swept up in a trend towards clinic-based care and have become largely facility bound, providing essentially the same kind of care as their curative counterparts. Many recent community-health graduates are eager to reverse this trend. The Senior Public Health Matron will work with regional matrons, the nurse-midwife advisor and the supervision/training advisor to phase outreach activity over to Public-Health Units.

Initial PFA will be conducted by CDC under the CCCD Project during PP development, and subsequent work in this area will be conducted entirely through short-term TA under the general guidance of the Chief of Party and the Deputy Director of Health Services. Changes indicated by the initial PFA will be implemented in a few clinics, fine-tuned, re-assessed and expanded to additional clinics under the project.

3. Under Management Improvements, the project will:

- a. Improve supervision by defining key observations, establishing supervisory schedules and reporting formats, using HIS data for supervision, and synthesizing HIS and supervisory data for use by MOH management.
- b. Train supervisors and program managers in an interactive, problem solving approach to supervision; provide short-term training; and assist the MOH to refine its national CDD and ARI courses.
- c. Train HIS staff; establish routine data-quality-control and data-analysis procedures; incorporate the use of HIS data in supervision; conduct operations research, two population-based studies of FP impact, and pilot efforts to assess maternal and infant mortality; oversee disease

surveillance and control activity, with an emphasis on measles; and establish an Epidemiology Unit.

d. Establish an effective contraceptive-logistics system.

Items a and b will be the principal responsibility of the Senior Public Health Matron, clinic supervisors and public-health unit staff working with the long-term supervision/training advisor, assisted by short-term TA. In May/June 1991, a training-needs assessment will be conducted under CCCD to document, by observing clinical practice, specific skills which need improvement in EPI, GM, CDD, and ARI. This assessment will include a separate, three-week review of family-planning practice and will form an important analytical base for determining the initial focus of an improved supervision and training system (and for informing the content of the MOH's national courses in CDD, ARI and FP).

Data-related functions (item c) will be conducted by the Epidemiology Unit in coordination with the MOH Statistics Unit and assisted by the epidemiologist advisor and short-term TA. This unit will be directed by an epidemiologist recently returned from USAID-sponsored training, who would report to the Chief Medical Officer for Public Health. EPI's Operations Officer will work with the Unit to help improve surveillance and outbreak-control capability. Technical assistance is scheduled under the PHC Project to develop a preliminary design for improving and possibly expanding the existing surveillance system. The Chief of the Statistics Office will return from advanced training in the U.K. in 1992, one additional epidemiologist is currently in training and a second will depart in September.) and a third USAID participant in computer science (BA) will return in June. Thus the MOH should have ample trained personnel for data related functions. Project TA will season these still inexperienced staff in the design and implementation of field studies and the practical use of data for program management.

Improvements in contraceptive logistics (item d) will be implemented very largely through short-term TA under the overall guidance of the Chief Medical Officer for Public Health, and the long-term Chief of Party. In late May 1991, assistance will be provided under CCCD to review the logistics system and recommend improvements which will be implemented under the project. The desirability of utilizing the regular MOH drug-supply system (or perhaps EPI's effective vaccine distribution system) to supply contraceptives, and abolishing the current vertical system, will be explored, as will the usefulness of regional depots.

V. The Ministry of Health.

The MOH is a small institution with serious difficulties largely relating to shortages of qualified staff. A substantial brain drain, mostly to South Africa, low salaries, and poor housing

and working conditions, especially in some rural areas, play a significant role in the Ministry's difficulty in attracting and retaining good people. While Swazi nurses, the backbone of the system, are mostly dedicated and hard working, their supervision and support is poor. Their thinking, naturally enough in light of their training, tends to be clinic rather than community oriented, and the MOH suffers from a serious lack of an epidemiological perspective. As a result planning and decision making tend to be intuitive and ad hoc rather than based on data and analysis. The outlook of the nursing profession tends to be conservative with respect to change in general and the delegation of what are considered to be professional responsibilities to non-professional personnel.

Overall management capability is weak, and the ability (or inclination) of the center to assume a strong role in setting and implementing program objectives and in evaluating their attainment can be pronounced. This may be due in part to the value Swazi culture places upon extensive discussion, non-confrontation and consensus (as opposed to innovation) as well as a current lack of high-level staff with significant training and experience in public health. In the absence of a strong central MCH coordination function, the EPI, CDD, ARI and FP managers have often operated independently, and lines of authority between program managers, other MOH personnel and the nursing hierarchy in general are often blurred.

The MOH's program managers for FP, EPI, GM, CDD and ARI do not occupy formally established posts. Rather, they are temporarily 'seconded' from other MOH positions. The position of FP is especially precarious in that the FP Program Manager, a key individual in the implementation of FP/MCH, is only seconded half-time for FP and works the other half as chief nurse at a large urban clinic. Regional HIS personnel are also seconded from other duties. (One is a janitor trained to enter data in dBase, a notable success story if a permanent HIS position could be established for her.)

VI. Experience with Similar Projects.

USAID has had considerable recent experience with the MOH through the PHC and CCCD Projects. This experience is marked by both successes and failures. Under CCCD, successes have included the EPI Program, which has attained complete immunization rates of over 80%, and the CDD Program which is providing good quality, effective diarrheal-disease training. CCCD has also worked effectively with the malaria program, contributing to an increased sophistication in the monitoring of drug and insecticide resistance, in strengthening entomological capability and in the design and execution of health education campaigns. Initial signs point to a well designed and well implemented ARI program.

The PHC Project was, in its first three years, plagued by a

variety of problems relating to an overly ambitious project design and to difficulties within both the MOH and the MSH/Drew University technical-assistance team. Its accomplishments during that time were minimal. However, its final 18 months have seen the installation of a functioning, albeit fragile and as yet unused, health information system, an important breakthrough. Innovative, week-long programs of clinic-based training under PHC have been well received, especially at the regional level, and seem to have improved rural nurses' performance. They have certainly heightened MOH awareness of the need to design and conduct training activities based on actual field conditions.

On the down side, a major PHC emphasis on what in retrospect seems a poorly conceived and poorly implemented attempt to decentralize the MOH has largely failed. All four people trained to the Master's level under PHC to implement this scheme have since left the MOH. Clinic based training for nurses, while it has gained increasing acceptance within the MOH, has been highly dependent on contractor assistance for its design, organization and implementation. Efforts to strengthen the existing supervisory system have made some improvements, but major structural and technical problems persist in this crucial area. Although long-term training under PHC has provided a good base of qualified personnel at the MOH's Health Education Unit, attempts by both CCCD and PHC to improve the unit's output (especially of FP materials) have been largely unsuccessful.

VII. Differences between FP/MCH and Previous Projects

FP/MCH will be USAID's first significant attempt to strengthen MOH capabilities in FP. CCCD has no FP component at all, and PHC's involvement in FP has been extremely limited. Although PHC assisted in the construction/renovation of 84 outreach sites, neither PHC nor CCCD focused to a significant extent on the content or management of outreach services, and neither involved RHMs in service delivery. Although CCCD has conducted limited (and useful) operations research (OR) over the past year, PHC had no OR component. In FP/MCH, OR will be a significant means of evaluating the effectiveness of pilot interventions prior to national replication.

PHC contained significant components related to central-MOH institutional development (decentralization, planning, budgeting, finance, et al.); FP/MCH will provide no such support. PHC devoted major resources to formal training in a variety of subjects; FP/MCH training will be almost entirely on-the-job and concentrated on highly specific service-delivery constraints. Even in its more focused final years, PHC undertook a large number of activities. (Its final workplan contained over 90 items.) FP/MCH will be considerably less ambitious. PHC had a significant long-term training component; FP/MCH contains none. PHC had an expatriate staff of five, and

CCCD's technical officer brought the total to six. FP/MCH will have half that number of full-time expatriates. Both PHC and CCCD expended considerable effort to develop the Health Education Unit; FP/MCH will probably expend none.

CCCD focused on the development of separate entities for EPI, CDD and, less so, malaria. Limited inputs have recently been provided for ARI. Except for EPI's outbreak-control teams and the disease-surveillance system, CCCD has tended to concentrate at the central level. FP/MCH will concentrate on the implementation of MCH activities in the field and will stress linkages among priority services.

Although support will continue under FP/MCH for the HIS and to improve supervision, the nature of that support will be different. CCCD and especially PHC established, with considerable effort, an HIS which now routinely produces raw data. FP/MCH will concentrate on the quality control, analysis and use of that data for program management. PHC devoted, with questionable results, considerable attention to clinic management and supervision, concentrating in its final years on the generation of a largely unused supervisory check list and following up participants in clinic-based training. Both activities were conducted under the serious constraints noted above relating to MOH supervision. FP/MCH would operate with significantly increased MOH and project commitment to supervision (see below).

VIII. MOH Potential

The problems noted above notwithstanding, USAID believes that a strong MOH commitment to FP/MCH could result in a significant African success story. Swaziland is a small, ethnically homogeneous country with a strong sense of national identity and community. Communications are excellent by African standards; one can easily traverse the entire country by car in a day. A sizeable network of accessible clinics and outreach sites and a large number of RHMs could, if properly managed, extend basic health and family-planning services throughout the nation. USAID's relations with the MOH are good, and the Ministry is highly desirous of continued USAID assistance. MH/FP, EPI, GM, CDD and ARI program managers are dedicated, experienced, capable individuals. The return in August from a WHO assignment of the Deputy Director of Health Services and the recent return from advanced training of the Medical Officer for Public Health and the Senior Public Health Matron could provide the necessary leadership for a strong MCH program. If properly utilized, the new MOH Epidemiologist, statistics chief and computer scientist could be major assets. Establishment of the HIS, the success of EPI and the emerging success of CDD and ARI, and the degree to which regional staff have received and been influenced by clinic-based training testify to the dedication of many MOH personnel and the results which can be achieved by TA focused on specific, field-level activities.

Further basis for optimism is the two-day USAID/MOH retreat (following on the participatory approach used to develop USAID's Small Business Development Project) at which this PID was discussed. In this meeting, MOH support for FP as the central theme of FP/MCH was confirmed, and participants discussed strategies for linking FP with other MCH services. GOS and USAID policies presented, and small groups of participants examined the progress and problems encountered in previous projects. Presentations also included an examination of the health impact of family planning and a review of innovative urban and rural community-based distribution projects in Nigeria. These discussions were particularly useful in establishing a common base from which to discuss FP/MCH.

IX. Conditionality

Several MOH positions must be either created or filled and some key policy determinations must be made for FP/MCH to succeed. These conditions are built into a non-project-assistance component (NPA, see XIV below and Annex 1) of the program, and technical assistance will not begin until the following initial conditions are met.

- 1) The MOH will assign a qualified person to work full-time as MH/FP Program Manager at the National Public Health Unit.
- 2) The MOH will assign a sufficient number of qualified persons to work full-time as clinic supervisors and provide them with required transportation. (The number of positions required will be determined during PP development; however, there are currently 11 clinic supervisors, and this may be a more than sufficient number of full time individuals.)
- 3) The MOH will establish an Epidemiology Unit within the National Public Health Unit, under the direction of a trained epidemiologist reporting to the Medical Officer for Public Health.
- 5) The MOH will issue a policy statement to the effect that it intends to (a) utilize outreach sites to provide condoms, pills, and injectables and (b) conduct field trials to investigate the feasibility of trained RHMs distributing condoms and orals without prior examination by a nurse, both according to protocols to be developed and tested under the project.

X. Other-Donor Activities

Aside from IPPF, whose primary input is general operating support for FLAS and some contraceptive support for FLAS and the MOH, the only other family-planning donor of consequence in Swaziland is the United Nations Fund for Population Activities (UNFPA) which is currently providing technical training and follow-up in family planning for nurses. Eighty have been trained so far, and 16 more are slated for training before the

project ends in February 1992. This project has provided, and continues to expand, an important core of technically qualified FP service providers. An extension of this project is currently under discussion with the GOS, and FP/MCH thus does not contain a technical-training component in FP. UNFPA has also recently initiated discussions with the GOS on a multi-sectoral population-policy project.

The World Health Organization provides a small amount of assistance for training and occasional short-term TA in various areas. A topic of continuing MOH/WHO interest is an initiative to identify and train Traditional Birth Attendants (TBAs), a possible area of interest to FP/MCH. However, initial work has been unable to determine the extent to which TBAs exist and function as an definable group in Swaziland, an issue which needs to be resolved prior to considering a program in this area. WHO is a major partner in Swaziland's AIDS-control program, through the Global Program on AIDS, and maintains a full-time AIDS advisor in-country.

UNICEF provides the MOH with significant commodity support (including all vaccines for the EPI program and packaged ORS for CDD), occasional technical assistance and training and study tours, all related primarily to child survival programs. It is not involved at all in family planning, but is becoming interested in safe motherhood. Initial indications are that this will be pursued through the Ministry of Education and a local adult-literacy program. UNICEF has also provided significant support, again mostly commodities and local costs, for the Ministry of Agriculture's Weaning Project, a nutrition-education/growth monitoring effort implemented in close conjunction with the MOH. UNICEF has supported the RHM program for a number of years, principally with local-cost support for training RHM trainers and for the basic training of RHMs themselves. There is essentially no UNICEF input for RHM supervision or to utilize RHMs to deliver basic services.

Britain's Overseas Development Agency (ODA) is planning a project to upgrade the MOH's secondary and tertiary levels of care, and to assess and improve services in peri-urban areas, thus complementing FP/MCH's emphasis on rural areas and primary care. The ODA project will improve the referral process from primary to higher levels of care, improve hospital management, and provide training for health technicians, and administrative personnel. ODA is also planning a project to improve MOH financial management, following up on work initiated in the final year of USAID's PHC Project.

The Republic of South Africa (RSA) provides specialty training in South Africa to MOH personnel, confers regularly with the MOH on the control of communicable diseases, and has been a major supporter of the MOH's malaria unit, the latter in the form of a resident advisor, commodities, some facilities construction and local-cost support. Support for the malaria program is scheduled to be significantly phased down during 1991. The RSA

is also involved in a population initiative with Swaziland and Lesotho aimed at the formulation of population policy, generating political commitment for population issues and compiling existing demographic data. The RSA is not involved at all in the provision of family planning services.

XI. Social Considerations

A. Socio-cultural Context

Swaziland is a small country with a population of approximately 805,000 people. According to the 1986 Census, 78% live in rural areas, a percentage which is declining due to increasingly rapid urbanization, and 98% percent are ethnic Swazis.

Economically, the country is relatively well off with real GDP growth averaging 4% per year over the past six years. GNP per capita is \$848, and the World Bank classifies Swaziland as a middle-income country. Income distribution, however, is believed to be skewed with the rural majority having significantly lower incomes. At the household level, most families have cash income from wage employment or income-generating activities in addition to the in-kind income they receive from agriculture. The high rate of population growth (3.4%), however, threatens to overwhelm Swaziland's reasonably healthy economy, and the health status of the population as measured by infant mortality and life expectancy is lower than that of countries with similar income levels.

Traditional Swazi culture and governance remain strong influences in the society. The King is head of both traditional and modern government structures. In rural areas, the traditional government, led by chiefs, has considerable impact on peoples' daily lives. Modern government influence is primarily through the provision of education, health and agricultural extension services and infrastructure.

The importance of traditional culture is especially evident in the health sector. Some 10,000 traditional healers provide advice and treatment for a wide range of illnesses. These healers are widely consulted, and they have considerable influence in their communities. Recognizing this, various efforts to improve understanding and cooperation between traditional healers and modern health workers have been undertaken.

B. Beneficiaries

The purpose of the FP/MCH Project is to improve and expand the delivery of integrated family planning, maternal and child health services. Project activities will be concentrated in rural areas, and the primary beneficiaries will, therefore, be

rural families, women of child-bearing age and children under 5.

According to the 1986 Census, there are 100,000 children under 5 and 110,000 women between the ages of 15 and 44 living in rural areas. These figures will have increased in the last five years, due to high fertility and the young age structure of the population. Thus it is safe to say that the potential beneficiary population exceeds 200,000 people.

In addition, substantial indirect benefits for the population as a whole would result from reduced population growth. (See XII, A below.)

C. Participation

To date, project design has been a collaborative effort between USAID and MOH officials. This is an important accomplishment since previous projects have been criticized for not involving the "implementors" at the design stage. Participants in a two-day design conference recommended that similar meetings be held as design progresses. This will be essential to ensure full commitment to the project by MOH staff, not just senior officials but also the mid-level staff that will actually implement the project.

It is more difficult to identify means for the primary beneficiaries to constructively participate in project development, but chiefs and community health committees, where they exist and are active, will be consulted in the process of delegating service-delivery functions to RHMs (eg., prior to community level distribution of oral contraceptives). RHMs themselves, or at least a select group of them, should be consulted during the PP design.

D. Socio-cultural Feasibility

FP is a sensitive subject in Swazi society, and rural women, who tend to have more traditional viewpoints, have a substantially lower contraceptive use rate than their urban counterparts (13% vs. 28%). While attitudes are changing, there are still cultural barriers and knowledge gaps that inhibit the use of family planning. During the PP design, the social-science analyst should review a recent study of family planning knowledge, attitudes and practices (P. McLean, "Swaziland: Perceptions and Attitudes of Men and Women Towards Family Planning", 1990) and identify issues for consideration by the design team.

The social-science analyst should explore the willingness of nurses to act as FP providers. A recent study of attitudes of service providers indicates that while nurses generally accept their role as providers of FP, there may be some problem areas that need to be addressed during project design.

The acceptability of having RHMs provide services, especially FP, in communities, clinics and outreach sites should be explored from the point of view of health professionals, rural women, the RHMs themselves, and the chiefs in whose communities the RHMs operate. It is also possible that an expanded role for RHMs will cause traditional healers to view them as competitors and thereby create ill feelings. The acceptability of having RHMs sell contraceptives should also be investigated.

E. Impact and Sustainability

The impact of the project will be measured in terms of reduced fertility and infant and maternal mortality. Such reductions would clearly contribute to A.I.D.'s goal of meeting basic human needs through equitable and sustainable growth. Lower fertility produces smaller families which generally mean improved standards of living for family members, mothers and children in particular. Reductions in infant mortality could help foster the trend towards smaller families. A reduction in maternal mortality obviously improves the standard of living for women and allows families and society as a whole to benefit from women's productive contributions for a longer period of time.

The sustainability of project interventions will be an important issue during project development. Past experience has shown that it can be difficult for the MOH to sustain activities initiated with heavy reliance on expatriate advisors. Although the MOH will seek staff positions required to sustain FP/MCH interventions, and this is a step in the right direction, project designers must ensure that these interventions are appropriate to both the experience and quantity of MOH staff.

XII. Financial and Economic Considerations

A. Economic Justification

The negative impact of high population growth on economic development is generally accepted by development professionals and most government representatives. The Swazi Minister of Finance stated in his 1991 Budget Speech that "despite the significant real growth in the economy ..., the potential for increased individual welfare is limited by our high population growth rate.... High population growth also poses a difficult challenge to public finance because resources which could otherwise be used to deepen our investment in human productivity are taken up in the effort simply to maintain current services.... If we care about investing in the next generation, we should adopt a population approach based on full respect for the individual and full information on birth control options." The Minister's statements provide a compelling argument for investing \$8 million in FP/MCH.

A substantial reduction in fertility will require vigorous promotion of family planning to the group with the highest fertility - rural couples. Approximately three quarters of the Swazi population live in rural areas where virtually the only source of FP services is the MOH. Therefore, an increased use of FP among the rural majority depends on the MOH. As noted above, although FP is available at MOH clinics, it has not been a priority. Now the MOH is ready to promote family planning more vigorously as a basic component of maternal and child health care, an approach that makes sense in a society where family planning is a sensitive topic.

B. Economic Benefits

The benefits of the proposed project are many. Short-term benefits include improved health status leading to higher levels of productivity, more efficient delivery of MOH services and better preventive health care leading to savings in health care costs, and an improvement in equity since the majority of project beneficiaries are rural people who tend to be poorer than urban residents. Longer term benefits of a lower population growth rate include a more economically productive population and savings in education and health-care costs. (Education already claims the largest share, 33%, of the GOS recurrent budget; health care is second at 10%).

C. Merits of Project Design

The project is designed to improve service delivery to rural people. It is focused at the field level and to the maximum extent practicable, avoids activities focused on the central MOH. Training of clinic staff will be an important means of accomplishing project objectives. The training will take place on the job in clinics, conserving staff time and reducing the cost of the training (hotel-based training provided under previous projects was more expensive and less effective than clinic-based training). Long-term, out-of-country training is inappropriate for accomplishing the project's objectives and will not be supported.

Long and short-term technical assistance will be the principal A.I.D. input. While long-term assistance is expensive, the cost is justified when a significant transfer of knowledge and skills takes place, thereby enhancing the prospects for sustainability of project achievements. It is, therefore, incumbent on the project designers to ensure that appropriate counterparts are available and committed to the project.

D. Economic Analysis for the Project Paper

The PP should include a least-cost economic analysis of the proposed project. A least-cost analysis is appropriate given

the non-quantifiable nature of some of the project's benefits. Other benefits such as potential long-term savings in health care and education costs should, however, be quantified. In addition, the near-term recurrent-cost implications of sustaining project activities should be assessed.

The economic analyst will consider ways of maximizing the internal efficiency of the project, including the use of local PVOs and other institutions to provide some types of training and develop health education materials and the use where possible of local or regional technical assistance.

XIII. A.I.D. Support Requirements

USAID's Health and Population Office consists of one USDH, one FSN Program Assistant, a vacant USPSC position and one secretary. This office will be expected to manage a portfolio consisting of the following, starting in October 1991: the FP/MCH Project, a \$2.4 million Family Health Services (FHS) Project with FLAS (including an AIDS-prevention component implemented in coordination with AIDSCOM), a centrally funded social-marketing project, and two centrally funded grants to Project HOPE. In addition, the USDH will spend approximately eight weeks a year on regional responsibilities in Lesotho and Botswana. The office currently manages a similar project portfolio.

USAID plans that the USDH HPN officer will manage the technical aspects of FP/MCH and FHS directly and rely on the Program Assistant, whom the Mission is grooming for higher level responsibilities, to manage SOMARC, HOPE and AIDSCOM under his guidance. The Program Assistant will handle administrative matters for all activities, as she currently does. USAID is currently reviewing work-load and staffing requirements in the HPN office to determine if the vacant USPSC position should be filled.

XIV. Estimated Costs and Methods of Funding

The total project budget is \$8.0 million. A.I.D. will contribute \$6 million, \$5 million in project funds and \$1 million in non-project assistance (NPA, see Annex 1). The GOS will contribute \$2 million (approximately 5.2 million Emalangeni at the current exchange rate), half of which will be an addition to the MOH's capital budget for constructing or renovating staff housing and clinics in rural areas.

Table 1 shows an illustrative budget for the A.I.D.-funded portion of the project. Technical-assistance costs include all benefits, fringes, contractor overheads and other fees, home-office support costs and in-country project office staff. Commodities include \$200,000 for contraceptives, eight computers, health-education materials, three project vehicles and project-office equipment and furnishings. Research, monitoring and evaluation includes local costs for operations research, two contraceptive prevalence and fertility surveys (one at the beginning and one near the end of the project), a mid-term and final evaluation and two non-federal audits. A small amount is budgeted to support SINAN, a local PVO that promotes breastfeeding.

Table 1

ILLUSTRATIVE A.I.D. PROJECT BUDGET
(U.S. Dollars)

Technical Assistance		4,030,000
Long term: 15 person years	3,367,000	
Short term: 30 person months	663,000	
Training		97,000
Short term: 15 person months	60,000	
Workshops, materials	37,000	
Commodities		346,000
Research, Monitoring and Evaluation		502,000
Support to SINAN		25,000
NPA		1,000,000
	TOTAL	6,000,000

The GOS's contribution to the project will include, in addition to capital funds for construction, the salaries and per diems of all staff involved in project activities, housing and office space at the National Public Health Unit for long-term advisors, sufficient vehicles for supervision, and approximately 50% of the oral contraceptives and condoms required by the MOH from 1992 through 1996. USAID intends to phase out funding for contraceptives in Swaziland completely at the end of FP/MCH.

XV. Design Strategy.

A. Schedule. USAID anticipates a first-quarter FY92 obligation, although a fourth-quarter FY91 obligation may be possible, depending on the progress in PP/PAAD design and final negotiations with the MOH/GOS. Therefore, work on the Project Paper should be initiated by June 15, 1991, allowing two months to complete the project design.

B. Documentation. The resource documents noted in Annex 2 will be provided to the technical sub-group (see below) in advance for reading prior to arrival in Swaziland.

C. Design-Team Composition. The PP/PAAD team will include a USAID Project Development Officer, an economist with experience in NPA, a contract Social-Science Analyst, and a three-to-four person Technical Sub-Group. (The economic and social analyses need not be completed at the same time as other PP components.) The Technical Sub-Group would comprise individuals with the following qualifications:

Experience in family-planning program design (clinic and community-based), implementation and evaluation;

Clinical experience in reproductive health and family planning;

Experience in epidemiology, the development and use of data systems, operations research, and

Experience in managing local service-delivery networks (clinics and outreach mechanisms, including community-health workers) with substantial experience in supervisory and on-the-job-training systems.

These skills may be found in different combinations of individuals. An established technical reputation will be highly desirable in working with organized nursing on controversial medical issues (eg., the non-prescription distribution of oral contraceptives and use of RHMs). Prior experience in Swaziland is desirable.

Members of the Technical Sub-Group should be together in-country for six full weeks. Their contracts should allow up to four preparation days prior to arrival to review the documentation noted above. A six-day work week should be authorized, and two rental cars should be provided.

The estimated cost of project design is \$120,000. This amount is available and programmed in USAID's FY91 PD&S budget.

D. Participation. The momentum of the PID-development workshop should be maintained during PP development. Participants in that workshop should continue to be involved in project design, along with other important MOH officials who could not attend, and the PP team should follow-up on the workshop discussions and recommendations that may lead to important new initiatives under FP/MCH. If possible, the MOH's Deputy Director of Health Services should be temporarily released from her consulting duties with WHO to participate fully with the technical sub-group. The PP should include provision for annual workshops to review progress and discuss implementation problems and solutions to sustain a sense of project ownership.

E. Design Issues

1. Source of Technical Assistance. USAID has amended the CCCD Project, implemented by CDC, to conduct analyses which will lead into FP/MCH (training-needs assessment, patient flow analysis, an initial review of contraceptive logistics). In addition, CDC has access to a wide variety of well qualified technical expertise required for FP/MCH as well as considerable experience in Africa in general and Swaziland in particular. One option will be to take advantage of this experience by implementing FP/MCH under a Mission-funded PASA with CDC rather than embark on a competitive process. (Alternatively, CCCD could be extended to run until new TA is in place.) The PP will compare TA needs with areas of CDC expertise as a basis for a decision in this regard.

2. CDD and ARI. The design team should carefully examine the feasibility linking FP with the CDD and, especially, ARI programs, including the addition of an FP component to the MOH's national CDD and ARI courses.

3. MOH Capability and Resource Requirements. A major emphasis in PP/PAAD design will be an analysis of MOH ability to effectively implement the project components described in Section IV, B above, especially supervisory and outreach components, including the use of RHMs. The PP will not try to answer questions better left to operations research under the project or attempt the level of implementation detail more appropriate to annual workplans. The design team will, however, analyze systemic constraints to implementing each project component, specify how these constraints will be overcome, set forth an implementation plan and reasonable targets of achievement, and estimate the MOH resources required for successful implementation.

The principal MOH resource likely to be required under the project is staff. Staff requirements and responsibilities should be clearly established in the PP, especially for the supervision of clinics, outreach sites and RHMs, and the availability of sufficient staff should be confirmed prior to project authorization. The feasibility of using public-health unit staff for outreach activity, including RHM supervision, will be thoroughly investigated.

4. Health Education. New materials on FP and its linkage to other MCH interventions will be needed by clinic staff, RHMs, and the general public. In the absence of a productive MOH Health Education Unit, the PP should seek other approaches to meeting these needs. FLAS is developing a major new IE&C effort, and, although it will focus only on family planning (not on linkages with other services), FLAS' materials should be carefully considered for adaptation and use in FP/MCH. In

addition, the design team and the MOH should consider the feasibility of seconding individual staff from the Health Education Unit to individual programs for the production of materials related to FP/MCH.

5. Epidemiology Unit. The staffing requirements of this unit and means of coordinating its work with that of the MOH's Statistics Unit and Planning Unit should be examined to specify a reasonable demarcation of responsibilities among these units and ensure the maximum effective use of the HIS.

6. Contraceptives. The design team should investigate the feasibility of phasing down USAID's provision of contraceptives over the life of the project to ensure the sustainability of the MOH's FP activities.

7. Collaboration with Other GOS Agencies. Continued liaison with the Ministry of Labor and Public Service's Management Services Division and the Department of Economic Planning and Statistics (DEPS) will be essential. Labor must approve all positions required for the project, and final approval for the project will rest with DEPS, which will sign the PROAG on behalf of the GOS. DEPS has emphasized that MOH efforts at "systemic improvement" should be evident in FP/MCH in the form of specific targets of achievement. The verifiable indicators in the project logframe along with the proposed conditionality noted above provide an initial listing of such targets.

XVI. AID Policy Issues Possibility of an NPA component (see Annex 1).

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Annex 1

Proposed Non-Project Assistance Component

I. INTRODUCTION

During review of the initial draft PID, the Mission was struck by the magnitude of the policy reforms needed to implement the project. The emphasis on family planning, use of RHMs and the revamping of the supervisory system, for example, are fundamental and still controversial shifts in MOH policy and priorities. At the same time, the Mission was concerned that, unless a substantial effort was made to improve the difficult conditions of service under which rural nurses work, brain drain would become such a serious problem that the impact of a technical assistance project would be limited. The design team decided that an NPA component of \$1 million, leveraging an equivalent contribution from the GOS, would provide the MOH with a powerful incentive to follow through with the proposed reforms. The additional resources would enable the GOS to initiate a major rural health infrastructure development campaign, thus addressing the conditions-of-service issue as well. The idea was discussed with the Minister of Finance and the Principal Secretaries of the MOH and the Department of Economic Planning and Statistics, and all responded enthusiastically.

Presented below is our rationale for adding an NPA component to the project activity proposed in the PID. Although we realize that the following does not comply completely with the draft Africa Bureau NPA guidance, we request the Bureau to consider whether it is consistent with NPA requirements and seems worth pursuing further. If so, we propose to develop these ideas, along with project elements contained in the PID, more thoroughly in a PAAD. We anticipate a need for technical assistance in NPA programming from AID/W in this regard.

II. ECONOMIC FRAMEWORK

A. Macroeconomic Setting

Swaziland's economic growth, measured by real GDP, has averaged 4 percent per year during the last decade, and estimates for 1990 are for growth at the same level. An upturn in investment since 1986 has made manufacturing the lead sector, with a share of GDP exceeding 20 percent. Agriculture and government services are the second and third most important sectors.

Both exports and imports have grown rapidly since 1985, and the trade balance has fluctuated between small deficits and surpluses. Although sugar and woodpulp account for almost half of exports, growth in non-traditional exports is encouraging at an average of 36 percent of exports by value from 1985-89 and 41 percent in 1989. However, as the Minister of Finance noted in

his 1991 budget speech, exports are not growing as rapidly as imports, indicating an underlying weakness in the trade account that could eventually throw the overall balance of payments into deficit. Surpluses have been recorded in the current and capital accounts from 1986 onward, largely as a result of substantial official transfers and capital investment.

Swaziland's currency, the Lilangeni, is unofficially pegged to the South African Rand and has recently experienced modest depreciation against major currencies following a severe depreciation in 1985-86. The depreciation has had a positive effect on export earnings but has exacerbated inflation and increased the country's moderate debt service burden (total debt was \$289 million in 1989; debt service was 4.8 percent of exports). Swaziland's international-reserve position is excellent with approximately four months worth of import cover.

Due to the unofficial link with the Rand, Swaziland has no distinct monetary policy. This has generally served the country well but has also resulted in the importation of "cost-push" inflation of about 15 percent per year from South Africa. There are indications that South Africa is trying to lower its inflation rate, and this should improve the situation in Swaziland as well.

Although the macroeconomic picture for Swaziland is fairly bright, there are concerns about the country's economic future. Swaziland has benefited substantially from the political and economic isolation of South Africa, primarily in the form of foreign investment, but also in lower export prices due to the weakness of the Rand, and hence the Lilangeni, against major currencies. However, this situation is beginning to change. The European Community plans to lift sanctions in several key areas, and others are sure to follow. Swaziland's ability to compete for new investment with a new South Africa and other countries in the region, for new investment is increasingly questioned.

This concern is particularly relevant because Swaziland has failed to keep pace with the demands that new investment and a growing population have placed on its infrastructure. There is some evidence that investors have either pulled out or been discouraged from locating in Swaziland due to inefficient transport and chronic problems with electricity, telecommunications and other services. A 1990 report on problems in GOS capital-budget implementation states that "the weaknesses in Swaziland's economic infrastructure are sufficiently serious that they constitute a barrier to continued development."

The GOS is aware of the fragility of the economic situation. The Finance Minister stated in his 1991 Budget speech that "the Government must support supply-side policies to encourage more output in the export sector and to diversify the sources of our exports." The GOS is also well aware of the fact that it must address infrastructure problems immediately in order to retain current investment and attract new investment.

B. Public Finance

The GOS has run a budget surplus for each of the past four years. Revenue (excluding external grants) grew an average of 31 percent per year during the same period. Corporate taxes generated by a larger, more productive private sector have been a key component of higher revenues. Receipts from the Southern African Customs Union (SACU) are still the Government's largest source of revenue, but the proportion has dropped below 50 percent in recent years.

Total expenditures have increased by an average of 21 percent per year over the last five years, with increases in recurrent spending averaging somewhat less. A 10 to 15 percent inflation rate accounts for some of this fairly rapid increase. Recurrent expenditure jumped substantially in the most recent fiscal year due in large part to rising personnel costs resulting from a retroactive pay increase for civil servants.

The government's budget surpluses are attributable in part to its inability to implement its capital spending program. The rate of implementation has fallen from 80 percent in the 1986/87 fiscal year to 66 percent in 1988/89, and reports for the first half of the most recent fiscal year indicate that capital spending had reached only 28 percent of the budget.

GOS difficulty in implementing its capital program and recommendations for improving the process were the subject of a four-month USAID-funded consultancy. The problem is complex and involves both planning and budgeting processes and deficiencies in the Ministry of Works and Communications, particularly in terms of technical staff able to supervise projects. Some changes have been made as a result of the study, and others of a more substantive, long-term nature are under consideration.

C. MOH Budget

The health sector (including family planning which is integrated into the MOH's primary-care program) receives the second largest share of the GOS's recurrent budget (education is first). The MOH's recurrent budget for FY 1991/92 is approximately \$20 million (\$1 = E2.60), which represents 11 percent of the GOS total recurrent expenditure budget. Personnel is the largest expense, accounting for 35 percent of the MOH budget. It has not been possible to determine the portion of the current budget devoted to primary care, but actual expenditures on PHC were estimated at 19 percent of the FY 89/90 budget.

MOH projects in the most recent GOS capital budget amount to \$6 million, 4.8 percent of the total budget. Clinic renovation and construction of staff housing at several sites are included in the capital program, but much more needs to be done, and as the Ministry of Works and Communications is to undertake the projects, one questions how much will be accomplished.

The MOH recovers very little of its costs through user fees: 3 percent of recurrent expenditures in 1989/90. The Ministry has little incentive to do better since any fees it collects must be turned over to the Treasury. The Ministry is, however, planning a pilot project in which it would keep some portion of collected fees, and this could be an incentive to better cost recovery. USAID's PHC Project recently initiated a system to routinely determine the unit cost of health services, and the MOH is considering modest increases in user fees, on a sliding scale that would encourage service delivery at lower levels of the system. This would further boost cost recovery. The Minister of Finance has publicly endorsed these cost recovery initiatives; it remains to be seen how they work in practice.

D. Relationship Between Population and Economic Development

The goal of the proposed program is to reduce unwanted fertility and mortality. The dampening effect of high population growth on economic growth is generally accepted. Swaziland's population growth rate of 3.4 percent is perilously close to the real GDP growth of 4 percent, implying that per capita GDP is barely increasing. If even some of the potential macroeconomic problems noted above materialize, the country could be in a situation where population growth exceeds GDP growth. A rapidly growing population also puts a severe strain on public-sector resources. Rather than using higher revenues to improve the quality of education, health and other vital services, Swaziland will have to increase resource allocations to maintain the status quo, negating the possibility of an improved quality of life for a large portion of the population.

Reduced maternal mortality could be important to economic development because women of child-bearing age are among the most productive (if not the most productive) members of society. In Swaziland, 75 percent of microenterprises are owned by women, women fill more than 60 percent of all professional positions in the public sector and they also occupy the majority of professional/technical jobs in the private sector.

III. CONSTRAINTS TO THE INCREASED USE OF FAMILY PLANNING

Swaziland's population is approximately 805,000 with nearly half under age 15 and a doubling rate of about 21 years at current fertility. Modern-contraceptive prevalence is estimated at 17% nationwide: 13% in rural areas and 28% in urban areas. Traditional methods of fertility control, including breastfeeding, are declining.

There are two primary constraints inhibiting fertility reduction: family-planning services are not sufficiently accessible and demand for these services is relatively low.

A. Demand. The PID notes that traditional Swazi attitudes

towards family planning, especially in rural areas, are conservative. Contraception is seen as an invitation to promiscuity and at odds with the value placed upon large families. There is widespread misunderstanding of the basic physiology of reproduction and accompanying myths about dangers associated with family planning (e.g., if a condom comes off inside a woman, it will move to her heart and kill her; pills cause sterility, STDs and birth defects). There is limited knowledge of how to choose among various contraceptive methods and the advantages and disadvantages of each. Men especially are often opposed to contraception, and many husbands forbid their wives to use family planning. (A major reason for the popularity of injectable contraceptives is that husbands often don't know their wives are using them.)

Perhaps most importantly, there is as yet very little in the way of systematic attempts to change this situation. Family planning is not vigorously promoted in Swaziland, and educational materials are few and usually of poor quality. There are two organizations in Swaziland which could change this situation. One is the MOH, which, as noted in the PID, did not in the past accord a high priority to family planning and which has a largely ineffective health education unit. The second is the private Family Life Association of Swaziland (FLAS) which operates three urban clinics and is beginning, with USAID assistance, to place greater emphasis on information, education and communications (IE&C) activities.

B. Accessibility. Aside from a slightly wider availability of condoms, contraceptives are available from three sources in Swaziland, all basically clinical: the MOH (including mission clinics supervised and staffed by the MOH); FLAS, which provides 20 to 30 percent of family planning services in Swaziland; and private and industrial clinics. Oral contraceptives are currently available only after an examination by a physician or, much more typically, a nurse. This is the usual pattern in developed countries, deriving primarily from the risks of cardiovascular problems among some women using the pill (mainly smokers over 35 using older, high-estrogen formulations). However, very few Swazi women smoke, and it is virtually certain that the dangers associated with pregnancy in Swaziland are considerably greater than those posed by the wider availability of modern, low-dose orals for younger women. It is almost a foregone conclusion that more maternal (and child) deaths would be prevented by liberalizing access to orals than are currently prevented by restricting their availability to clinics.

For rural people, who comprise 75% of the population, virtually the only source of services is an MOH nurse working within the MOH system, and access to contraception in rural areas is constrained by the current limitations of that system. These limitations are noted in the PID and expanded upon below.

1. Insufficient and insufficiently trained staff. A shortage

of nurses to serve in rural facilities is an extremely serious problem. The incentive of salaries three times as high in South Africa attracts nurses and other health professionals, leading to significant "brain drain". The problem is expected to worsen as South African hospitals are racially integrated, with fear that white nursing staff will retreat to private hospitals, creating a shortage in the public hospitals that will be filled, in part, by nurses from neighboring countries such as Swaziland.

The country's three nursing education programs add about 35 to 40 nurses and 45 nursing assistants to the pool each year, but many young nurses refuse to accept rural assignments due to the difficult conditions of service noted in Section V of the PID. While nurses are generally dedicated and hard working, they are poorly supervised, overworked and are often insufficiently trained, especially in curative care and managerial skills.

2. Poor physical infrastructure. Related to the shortage of nurses noted above is a serious shortage and deterioration of the MOH's physical infrastructure in rural areas. The most serious problems relate to either lack of or very poor accommodation at clinics. These conditions are a significant factor in the MOH's difficulty in attracting and retaining nursing staff in rural areas. Families may be asked to share a single unit, while single nurses may not get housing at all. At clinics that do have housing, it is often in a bad state of repair and lacks amenities such as electricity and running water.

Many of the older clinics are in need of upgrading, and many still lack electricity and running water. The presence of these amenities would not only improve working conditions but enhance the efficiency and quality of clinic operations.

3. Poorly informed management and inadequate supervisory systems. As noted in the PID, MOH planning and decision making tend to be intuitive and ad hoc rather than based on data and analysis. Data, from both routine service statistics and on-site supervision, are required to define problems and determine appropriate solutions. The Health Information System installed by the MOH with assistance from USAID's PHC Project is still in its infancy and requires continued support and development to realize its potential. Inadequate (or non-existent) supervision adversely affects the quantity, quality and mix of FP/MCH services, including the priority accorded to family planning.

4. Inefficient delivery of FP/MCH services. Heavy patient loads in clinics often overwhelm nurses, and FP, in particular, suffers as a result. Part of the patient overload results from Rural Health Motivators referring clients to clinics for services that could be provided in communities and MOH reluctance to delegate simple, routine professional responsibilities to non-professional personnel.

5. Ineffective contraceptive logistics system. Consistent

availability of contraceptives at all clinics is obviously key to achieving a sustained increase in contraceptive prevalence. However, clinics frequently run out of supplies and remain out for extended periods of time. Stock-outs at the central warehouse are not uncommon; there are no IUDs or injectables at this writing. The MOH's system for monitoring stock levels and forecasting requirements is in urgent need of review.

IV. STRATEGY IDENTIFICATION

As noted in Section III of the PID, USAID's strategy in population consists of four elements, two of which are addressed by the proposed project. These elements are designed to overcome constraints to the availability of and demand for family-planning services noted above. USAID will address constraints to availability by instituting a social marketing program; by improving the MOH's MCH-service delivery capability, including the use of community-health workers and outreach sites for family planning; and by establishing family-planning programs in large private industries. We will address demand constraints through improved IE&C programs.

A. Demand Generation

Demand generation will be addressed primarily through our Family Health Services (FHS) Project with FLAS. Given the unproductive nature of the MOH's Health Education Unit, FLAS's role in IE&C becomes paramount. USAID has provided and will continue to provide technical assistance to enable FLAS's IE&C Unit to produce a variety of IE&C materials based on extensive qualitative market research conducted last year. They will include method-specific information sheets and counselling materials (including myths and misconceptions about family planning) designed for use in FLAS clinics, but which can be easily adapted for use by the MOH. In addition, FLAS will revamp its two national radio programs according to a more effective audience participation format and will introduce radio spots on significant questions/problems raised by the research. FLAS will also continue its program of family-life education in schools and communities as well as its Leadership Awareness Program of seminars for influential groups (chiefs, teachers, etc). Convincing men of the value of FP will be a significant part of FLAS's IE&C efforts.

B. Improved Accessibility

USAID strategy for improving accessibility is to (1) make family planning available outside clinics and (2) increase the priority accorded to family planning in the clinic setting.

1. We will pursue two means of making family planning more accessible at the community level: social marketing and community outreach.

a. Social marketing could substantially increase the availability and use of contraceptives by putting orals and condoms in shops nationwide, thus making contraception a visible and easily available option. The commercial advertising which is key to the success of these programs will have a powerful demand-generation effect as well. This alternative to clinics is important; many people, especially young men, don't want to go to a clinic or to FLAS and wait in line for contraceptives (and maybe a lecture), often in the presence of their neighbors.

In addition, social marketing generates revenue. SOMARC research indicates that a program in Swaziland linked to other programs in the region (e.g., Lesotho, Zambia, Malawi) could be self-sustaining in 5 years. The MOH has approved in principle a social marketing program which will initially sell condoms only, but which will systematically explore the possible sale of orals as well. (USAID's intention to substantially reduce its supply of contraceptives to the MOH during FP/MCH and cease it entirely after the project should encourage the development of a vigorous social marketing program.) TA for initial project preparation is scheduled for late May.

b. Community outreach The use of Rural Health Motivators and outreach sites, to be pursued under FP/MCH, is a second means of liberating family planning from clinics. RHMs could be trained and supervised to distribute orals and condoms in rural areas. RHMs' effectiveness in FP might be considerably enhanced if they became agents for the provision of other MCH services as well, e.g. oral rehydration therapy, growth monitoring, sources of chloroquine for malaria. However, the role of RHMs has been limited to health education, and there has been long-standing reluctance (beginning to break down) to utilize these personnel as service providers. Phase one of FP/MCH will systematically study the feasibility and effectiveness of RHMs as service providers, as a basis for an MOH decision on their use nationwide.

It may, eventually, be possible to link the social marketing and RHM activities by making RHMs rural sales agents. This would (i) provide RHMs with extra income, thus addressing RHM frustration with their low MOH stipend and make them more enthusiastic promoters of family planning; (ii) it could increase the proportion of contraceptives sold, thus lessening reliance on the MOH's free-distribution system and reducing MOH costs; and (iii) it would free RHMs from reliance on the MOH for supply and supervision for family planning, relying instead on the private-sector for these functions.

2. Increasing the priority accorded to family planning at the clinic level will be accomplished under FP/MCH and the FHS project with FLAS.

a. FHS. Starting with the assignment this June of a full-time advisor provided by the Pathfinder Fund, FHS will develop an industry based family-planning program, starting in three large

agro-industries with thousands of workers living in company villages and served by sizeable medical departments. However, family-planning has not been a substantial part of the services provided by industry, and IE&C services have been notably lacking. FHS will tailor a package of family-planning services to the needs and desires of each firm, implement the package on a pilot basis, and, once their effectiveness has been established, sell these services to the initial three industries and to new industries as well. (A community-based distribution program, making services readily available in company villages, will probably be a part of this activity.)

b. MOH. The PID describes activities designed to increase the priority accorded to family planning by the MOH, and to improve its capability to deliver FP services more effectively, including the greater use of rural health motivators and outreach sites. The 85 government and mission clinics under government supervision constitute a sizeable rural infrastructure that is essentially the only source of family planning services for most rural people. (According to a 1985 estimate, 70 percent of the population lives within five miles of a service-delivery site.) It is important that this infrastructure be used to the maximum for family planning.

Although the potential of social marketing has been noted above, this program should not be viewed as a substitute for MOH services. Social marketing programs have never been designed to replace public-sector programs, but to compliment them by providing additional channels of distribution for those who wish to use them. Social marketing programs tend to concentrate in urban and semi-urban areas which are supplied and supervised with relative ease. Larger outlets, which generate greater volume and profit, are preferred over small rural shops. The MOH, on the other hand, serves rural areas which may be under-served by social marketers. In addition, although experience shows that many poor people in developing countries will gladly pay for contraceptives, many people at the bottom of the economic ladder, those who need family planning the most, may not. The MOH will continue to serve these people.

Although USAID would very much like to see RHMs become a part of the social marketing program (as described above), this will not happen quickly. The MOH must first be satisfied that RHMs can distribute orals safely and that social marketing can be relied upon as a cooperative, effective, culturally acceptable and safe partner in the provision of FP services. Thus both the social-marketing effort and work with RHMs under FP/MCH will probably be necessary precursors to bringing this linkage about.

C. Non-Project Assistance

The NPA component of FP/MCH will be directed toward policy changes and other actions that improve the capability of the MOH to deliver MCH services, particularly family planning. The

effectiveness of the FP/MCH Project will be limited unless the MOH is willing to initiate substantive changes in its approach to the delivery of services in the clinics and communities. The major policy reforms proposed are: 1) the establishment of a competent cadre of supervisory personnel operating without serious time and resource constraints; 2) the use of outreach sites for family planning and of RHMs as family-planning service providers in communities and as non-medical assistants in clinics; and 3) the establishment of an Epidemiology Unit and regional HIS positions with appropriate responsibilities relating to MOH policy and planning.

The proposed NPA in the amount of \$1 million would be matched by an equivalent local-currency contribution by the GOS. The local currency equivalent of \$2 million would be added, in tranches the amount and timing of which would be specified in a PAAD, to the MOH's capital budget. The MOH anticipates using the additional resources to finance a campaign to construct and/or rehabilitate clinics and staff housing to dramatically improve the conditions of service under which nurses work and contribute to better quality service delivery.

The release of the first tranche of NPA will be conditioned on the following:

- 1) The assignment of a qualified nurse mid-wife, posted at the National Public Health Unit in Mbabane, to serve as full-time manager for the MOH's Maternal Health and Family Planning Program. Subsequent tranches will be conditioned on the formal establishment of this position.
- 2) A clear MOH policy statement that basic preventive, services should be provided at the community level whenever possible and that Rural Health Motivators should be used to deliver these services. This will include a clear statement of intent to study, in the first year of the project, the feasibility and safety of using trained RHMs to distribute oral contraceptives without the client seeing a nurse or physician first. Subsequent tranches will depend on progress in training and assigning, with project assistance, additional RHMs as family-planning-service providers.
- 3) A clear MOH policy statement that outreach sites should be used to provide oral contraceptives, injectables, and where facilities permit, IUDs according to protocols to be developed in the first year of the project. Subsequent tranches will be linked to the number of outreach sites providing these services as well as the quantity of services being provided.
- 4) The establishment of an epidemiology unit, headed by an epidemiologist and with sufficient support staff, in the national public health unit under the supervision of the Medical Officer for Public Health. Subsequent tranches would be linked to the delineation of responsibilities

among the epidemiology unit, the statistics unit and the planning unit and to the formal establishment of HIS positions in each region.

5) The assignment of a number of supervisors (to be determined during PAAD development) to work full time on clinic supervision and the provision of transport for their exclusive use. Subsequent tranches would depend on increases in the number of supervisory visits to each clinic, on progress in revising the supervisory function under the project and on establishing formal supervisory positions and filling them with qualified individuals.

The idea of a construction/rehabilitation campaign has generated considerable interest in the MOH and the central ministries, and the GOS has indicated that it is willing to match A.I.D.'s NPA funds as a contribution to the campaign. As noted in the constraint analysis, poor conditions of service are a serious impediment to the MOH's ability to retain staff. The MOH recognizes that this situation must be reversed to prevent the 'brain drain' to South Africa from becoming a flood.

During PAAD development, minimum physical standards for nurses' housing and rural clinics will be established, and the GOS will commit itself to bringing all these facilities up to standard, through either renovation or new construction, in stages, by the PACD. This work would be performed by private firms under contract to the GOS. USAID would not be involved in monitoring or managing any construction and would only certify that required improvements have been made prior to releasing subsequent tranches of funds.

D. NPA Mechanisms.

USAID expects that the dollar tracking requirements in Section 575(a) of the FAA and current draft NPA guidance will be followed. Foreign exchange transactions are administratively controlled in Swaziland. Import licenses are required. Strict limits on exchange for travelers and expatriates are in place. Requests for foreign exchange are presented for approval either to an authorized commercial bank (for small amounts) or to the Central Bank (for larger amounts), and there is no auction system.

As the MOH achieves specific policy changes and related actions as spelled out in the PAAD, US dollars will be disbursed to a special account in a Federal Reserve Bank. It is not possible at this time to determine what uses of dollars will be most appropriate. The design-team economist will study this issue which will be fully discussed in the PAAD. The equivalent local currency, along with the matching GOS contribution, will be simultaneously deposited in a separate account in the Central Bank of Swaziland. The amount in the Central Bank account will then be transferred to the MOH capital budget account to support

a major health infrastructure development campaign, including construction and rehabilitation of rural clinics and nurses' housing.

The recent Mission General Assessment confirmed that the Ministry of Finance and Central Bank can track and report on local currency expenditures. No further tracking will be done by the Mission.

Annex 2

Background Documentation for PP/PAAD Design

- 1) Swaziland Primary Health Care Project: End of Project Evaluation, 1990
- 2) Final Report, Clinic Management; M. Edmondson, 1991
- 3) Final Report, Maternal Health and Family Planning Activities, M. Kroeger, 1991.
- 4) Final Report, Improvement of FLAS Clinical Services, M. Kroeger, 1991.
- 5) Report on MOH Contraceptive Logistics System, CDC, (consultancy scheduled for May 1991)
- 6) Report of Training Needs Assessment with an Emphasis on Family Planning, CDC, (consultancy scheduled for May 1991)
- 7) Report on Patient Flow Analysis, CDC, (consultancy to be scheduled)
- 8) Perceptions and Attitudes of Men and Women towards Family Planning, P. McLean, 1990
- 9) Swazi Secondary and High School Students: Sexual Behaviors, Attitudes and Communications Habits, P. McLean, 1990
- 10) In-Depth Interviews with Service Providers, P. McLean, 1990
- 11) National (Vertical) Health Programmes in the Decentralized Health Services in Swaziland, Peter Shipp, 1990
- 12) Guidelines for the Operation of Decentralized Health Services in Swaziland, September 1990
- 13) Swaziland Family Health Survey, 1988
- 14) Project HOPE Matching Grant Evaluation, 1990
- 15) Breastfeeding Practices in Maternity Wards in Swaziland, SINAN, 1988
- 16) Report on a Workshop on Clinic management, M. Price, 1986
- 17) Clinic Management Study, D. Promu, 1985.
- 18) Preceding Birth Technique Surveys in Five Ante-natal clinics, R. Tangerman, 1990
- 19) Health Seeking Behavior Study, R. Wilson, 1990

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- 17) Clinic Management Study, D. Promu, 1985.
- 18) Preceding Birth Technique Surveys in Five Ante-natal clinics, R. Tangerman, 1990
- 19) Health Seeking Behavior Study, R. Wilson, 1990

- 20) Evaluation of RHM Program (draft), UNICEF, 1989
- 21) Trip Report on Epidemiology of Diarrhea, L. Lee, 1989
- 22) Field Assessment of Diarrheal Training Program, N. Rafeh, 1990
- 23) Swaziland ARI Problem Statement, 1990
- 24) MOH FP Service Statistics, from FLAS Management Information System
- 25) Clinic Based Training Modules in ARI, CDD, EPI, GM, and antenatal care/breastfeeding
- 26) In-Patient and Out-Patient Data from HIS, 1990
- 27) HIS User Guides for In-Patient and Out-Patient systems, plus monthly tally forms.
- 28) Proceedings of FP/MCH Project Design Workshop, 1991

Annex 3

INITIAL ENVIRONMENTAL EXAMINATION
OR
CATEGORICAL EXCLUSION

Country: Swaziland

Project Title: Family Planning/Maternal and Child Health

Project Number: 645-0236

Funding: FY 1992 \$2,000,000
LOP \$6,000,000

Categorical Exclusion Prepared by: Susan Fine, Environmental
Officer, USAID/Swaziland

Environmental Action Recommended:

Positive Determination _____
Negative Determination _____
Categorical Exclusion X

Categorical Exclusion:

This activity meets the criteria for a Categorical Exclusion in accordance with 22 CFR Section 216.2(c) and, subject to Section 216.2(c)(3), may proceed without further environmental review, based on Section 216.2(c)(2)(i) which states that education, technical assistance or training programs, except to the extent that they include activities directly affecting the environment (such as construction, etc.), are not subject to the provisions of Section 216.3. Since this project will provide the Ministry of Health with technical assistance, training, a limited amount of commodities and non-project assistance for policy reform, and does not include activities that directly affect the environment, USAID/Swaziland has determined that the proposed project meets the criterion specified in Section 216.2(c)(2)(i) for a Categorical Exclusion.

APPROVED: _____
Bureau Environmental Officer

DISAPPROVED: _____
Bureau Environmental Officer

DATE: _____

Clearance: RLA/SA _____ Date _____
Concurrence: AFR/GC _____ Date _____

NARRATIVE SUMMARY
VERIFICATION

VERIFIABLE INDICATORS
MEANS OF ASSUMPTIONS

Goal:

To reduce unwanted DHS Surveys fertility and infant and maternal mortality. b) Preceding birth technique traditional healers Sisterhood method	a) Decline in total fertility from a) a) People will utilize available 5 to 4 services. b) Decline in infant mortality from b) No contravening practices by 100/1,000 to 80/1,000 c) 20% reduction in maternal c) mortality
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Purpose:

E.O.P.S.:

To improve and expand the staff in rural delivery of family-planning areas maternal and child health services by the MOH. FP, EPI, GM, CDD, ARI activities HIS surveillance reports DHS surveys, OR studies, supervisory reports Supervisory reports	a) National contraceptive preva- a) DHS surveys a) MOH can maintain lence increased from 17% to 30% b) Basic MOH capability to sustain is sustained c) Indigenous measles eliminated.c) d) Increased, proper use of ORT tod) treat acute childhood diarrheas. e) Increased, proper treatment of e) acute respiratory infections among children.
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NARRATIVE SUMMARY
VERIFICATION

VERIFIABLE INDICATORS
MEANS OF ASSUMPTIONS

Outputs:

1) Integration of Supervisory reports: family-planning into observations	1 a) Clinic staff use MH, EPI, 1 a) a) MOH will establish required GM, CDD, ARI to promote FP supervisory & HIS posts and
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MH, EPI, GM, CDD and possibly ARI programs.

fill them with qualified people

b) Observation

b) FP included in MOH curricula and manuals on EPI, GM, CDD, possibly ARI FP

tional resistance to emphasis on

c) Supervisory reports, observations comensurate supervision

c) Supervisors regularly assess, MOH commitment to use RHMs as advise local staff on, and service providers and provide report on FP components of MH, EPI, GM, CDD, ARI

d) MOH can coordinate central MH/FP, EPI, GM, CDD, ARI functions with each other and with regional authorities in pursuit of project objectives

2) Increased delivery HIS reports of basic FP/MCH services at the community level

2 a) Number of outreach sites providing oral contraceptives and injectables; number of clients served

HIS reports, supervisory reports, operations research

b) Number of RHMs properly providing oral contraceptives and other basic services; number of clients served

NARRATIVE SUMMARY VERIFICATION

VERIFIABLE INDICATORS MEANS OF ASSUMPTIONS

3) More efficient service a) Patient Flow Analyses Delivery

3 a) Patient waiting time decreased

Patient-flow analyses, supervisory reports

b) Appropriate mix of service provided to all patients

c) Supervisory reports, observations

c) Number of clinics appropriately using trained RHMs for routine functions

4) Improved field-level management of priority FP/MCH services as evidenced by:

a) Effective Supervision

a i) Sufficient numbers of

qualified	4 a. i) Observation supervisors assigned
defined	a ii) Content of supervision a ii) review of supervision based on observation of
guidelines and practices	performance in MH, FP, EPI, GM, CDD, ARI activity
iii) supervisors reports, observations,	a iii) Routine use of HIS data for a supervision interviews
iv) Review of synthesized data, interviews with managers	a iv) Supervisory data synthesized a and transmitted to higher management
supervisors' reports	a v) Clinics visited at least a v) every three months

NARRATIVE SUMMARY
VERIFICATION

VERIFIABLE INDICATORS MEANS OF
ASSUMPTIONS

b) Effective on-the job i) Training completed and evaluated by observing performance	b, i) Supervisors trained in and b, engaged in interactive problem solving in clinics
ii) Supervisory reports	b, ii) Changes in types of problems b, reported by supervisors
c) Data Collection/ c, i) Observation Analysis	c, i) Epidemiology Unit established and functioning
ii) Review of procedure and data	c, ii) HIS quality-control systems c, in place
c,iii) Observation, interviews with staff	c,iii) HIS staff can trouble-shoot software and produce customized data analyses
Review of analyses produced, interviews with managers, supervisors	c, iv) Standard data analyses c, iv) developed and used by management and supervisors
	c, v) Operations research conducted

c, v) Research reports, interviews
 with managers in key program areas; results
 used for program management

NARRATIVE SUMMARY
VERIFICATION

VERIFIABLE INDICATORS
MEANS OF ASSUMPTIONS

<p>d) Improved contraceptive i) Review of records and Logistics System forecasts prepared</p>	<p>d, i) Accurate distribution and stock records kept and used to re-supply facilities and forecast requirements</p>
<p>ii) HIS reports, supervisory contraceptives</p>	<p>d, ii) All clinics always supplied, with sufficient reports, observations</p>

<p>Inputs (in \$000) USAID: 15 person/yrs long-term TA \$3,367 30 per/months short-term TA \$ 663 Short-term training \$ 60 Commodities \$ 346 Research, monitoring and evaluation \$ 502 Support for SINAN \$ 25 NPA \$1,000 TOTAL \$6,000</p>	<p>Project records</p>
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GOS;
 MOH staff
 TA Housing and Office Space
 Housing for Clinic Nurses GOS Budget
 Transport MOH records
 Commodities (contraceptives)
 NPA matching contribution

TOTAL \$2,700