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# Final Report **Clinic Management**

Swaziland Primary Health Care Project

USAID Project No. 645-0220

Ministry of Health  
Kingdom of Swaziland

Management Sciences for Health  
Charles R. Drew University  
of  
Medicine and Science

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## EXECUTIVE SUMMARY

The Swaziland Primary Health Care Project (PHCP) was a cooperative agreement between the Government of Swaziland, Ministry of Health, and United States Agency for International Development. (USAID - Project No. 645-0220). Extending from April 1986 to June 30, 1991 the Project was implemented jointly by Management Sciences for Health (MSH) and Charles R. Drew University of Medicine and Science, (Drew) in support of Swaziland's National Health Policy (1983). The Project was designed to improve and expand the country's primary health care system emphasizing maternal child health and child spacing. The project's midterm evaluation (September - October 1988) and subsequent Project Paper Amendment (May 1989), narrowed the project's original scope and re-focused activities on the following regional and clinic level areas: Clinic-based and outreach services; decentralization, planning, budgeting, financial management and health care financing; and health information system (HIS).

The clinic management associate was responsible for the non-clinical aspects of clinic based services improvement, i.e. management skills, community development and outreach activities. (Project Paper Amendment, 1989). The current associate joined the project in its final year of implementation, therefore this report covers the period January 8 - December 31, 1990. The clinic management End of Project Status (EOPS) indicators are used to summarize the main accomplishments as presented below.

### 1. Improved Service Delivery and Outreach Approaches.

#### 1.1 Outreach Sites

The outreach sites program was very successful in mobilizing communities to build structures for health activities. The intended project output of 49 sites was exceeded and a total of 84 structures received basic furnishings and equipment, such as salter scales/frames for weighing children and trunks for transporting supplies. Building materials for completing structures were also funded on a request basis.

#### 1.2 Home Visits

Data from the Health Information System (HIS) show that 2,307 home visits were made nationwide in the ten month period January - October 1990. They were distributed regionally as follows: Hhohho - 855; Manzini - 556; Lubombo - 643 and Shiselweni - 253. Of the 90 clinics submitting data, 42 of them or 47% reported making home visits. It is not possible to tell whether or not this reaches the project's target of a "40% increase" since no baseline was stated.

#### 1.3 Community Health Committees

Community health committees are mechanisms for increasing grass-roots participation in planning, implementing and monitoring health activities. Results of a survey show that of 93 clinics reporting, 47 (51%) have active committees. On a regional or sub-regional basis, the percent of active committees ranged from 100% (Hhohho South) to 21% (Manzini Sub-Region).

#### 1.4 Project - Produced Reference Manual and Drug Management System.

The proportion of clinics maintaining the drug management system and using the Drug Formulary and Clinical Reference Manual is close to 100 percent. Conversely, the Orientation Manual was available in 42 percent of clinics and is rarely used. Relief nurses receive little, if any, formal orientation to the clinic setting. According to clinic supervisors, staff shortages preclude releasing nurses for orientation prior to their clinic assignment.

## 2. Improved Skills, Conditions of Service and Supervision.

### 2.1 Improved Skills (Clinic - Based Training Follow-Up)

#### 2.1.1 Workshop Training

Most of the training in basic management skills including supervision, patient flow, drug management and community outreach activities took place prior to the project's midterm evaluation. Approximately 700 participants attended 17 workshops in these areas. Clinic and community level interventions were systematically implemented following the workshops. To review the sustainability of these previous inputs, visits were made to 17 clinics not yet involved in the clinic - based training. The clinics were effectively implementing innovations introduced by the project.

#### 2.1.2 Clinic - Based Training Follow-Up

The training methodology shifted from workshops to the clinic based model after the midterm evaluation. The Clinic Management Associate's responsibility was to follow up the management aspects of the training. As the training is done in one region at a time, most activities were concentrated in the Lubombo Region where training took place February - June 1990. Fifty seven trainees (32 staff nurses, 25 nursing assistant from 26 clinics) were visited with the clinic supervisor or designate. Nurses spoke positively about the training and in most cases were utilizing the newly acquired skills.

Although the Shiselweni Region training was completed before the Associate joined the project, visits were made to eight clinics to observe the sustainability of project inputs. The reorganization of the physical set-up of clinics remained intact (ORT Corners, Salter Frames, Filing System) but nurses stated that they often did not have time to use the ORT Corner. Visits were made with the Public Health Medical Officer, as the Matron was on study leave and the Clinic Supervisor position was vacant. Therefore, it was not possible to fully address some of the identified problems. The associate's involvement in the Hhohho Region Training was limited to assisting Clinic Supervisors make a plan for follow-up scheduled to start in January 1991.

## 2.2 Improved Conditions of Service (Upgrading of Nurses Accommodations)

This project activity was intended to improve conditions of service for nurses working in rural areas. In cooperation with the Planning Unit, Ministry of Health, and the four regions, a list of priority repair needs was established. Basic repairs were completed on 30 of the 52 houses for which requests were made. There are still critical housing problems related to structural deterioration, lack of electricity, water and plumbing which were beyond the scope of this project. The Ministry of Health, through the Planning Unit, has established goals for continuing the renovation and upgrading program.

## 2.3 Improved Supervision

### 2.3.1 Monthly Supervisory Visits

Project output indicators emphasized more frequent and positive supervisory visits to clinics. The target was stated as "at least 80% of rural clinics receiving monthly supervisory visits from regional nursing supervisors". Available information shows that there are 149 government, mission and private sector clinics. Monthly visits to 119 of these clinics would meet the project's target.

Health Information System reports were available for 89 (60%) of the 149 clinics January - October 1990. Only 5 (6%) of the 89 clinics were visited each of the 10 months. However, some clinics received numerous visits in a given month and then were not visited for one or more months. For example one clinic's report showed the following visits by months: January -5; February -4; June and July -1; and no visits the other months. These 10 visits over the 10 months period average one visit per month, but the pattern shows that this would not present an accurate picture. Some clinics consistently receive more or less regularly scheduled visits, while others are seldom visited.

### 2.3.2 Supervisory Checklist

The Supervisory Checklist served a number of purposes, including the monitoring of selected project indicators. Consequently, it was too lengthy and time consuming to be of practical use. The midterm project evaluation recommended that it be shortened and revised by the Ministry of Health with support from the project. An ad hoc group comprised of three clinic supervisors and the clinic Management Associate revised the checklist based on input from relevant personnel.

### 2.3.3 Obstacles to Supervision

The original project paper stated that one major difficulty in expanding primary health care services was a lack of effective supervision for clinic personnel. Project input increased the supervisory skills of nurses and improved clinic operational and management support systems. Foremost among remaining problems is the lack of established posts for clinic supervisors as recommended in Health Manpower Requirements FY 1988 - 89 to FY 1992 - 93.

Implementation of these recommendations would eliminate the need for a nursing sister in charge of a Public Health Unit to also supervise clinics in the region. The various other demands made on those in supervisory positions many times takes precedence over clinic visits.

## SUMMARY OF RECOMMENDATIONS

Regions use HIS data to monitor performance and set desired targets for home visiting, outreach sites activity and supervisory visits.

Matrons and Clinic Supervisors establish a realistic orientation process for clinic nurses based on policy guidelines. (Regional Personnel Management Policies and Procedure, section 6. Orientation - Ministry of Health, April 1987). The usefulness of the Orientation Manual should be ascertained.

Ministry of Health, Planning Unit, Explore alternatives to using Public Works Department and community labor for major renovation or construction of staff housing.

Matrons and Supervisors review the Supervisory Checklist at least annually and revise as indicated.

1. INTRODUCTION

The report of the Primary Health Care Project's Clinic Management Associate covers the period January 8 - December 31, 1990. The position, supported by the sub-contractor, Charles R. Drew University of Medicine and Science, provided clinic-focused inputs in the broad areas of management and outreach activities. Working collaboratively with designated counterparts, the major activities included:

- (1) Clinic-based training follow-up activities related to management;
- (2) Support/re-orientation of regional clinic supervisors and nurses to project-initiated management strategies, such as increased use of the supervisory checklist and project-produced manuals, maintenance and improvement of the drug management system and reorganization of clinics for more efficient operation;
- (3) Expansion of outreach services; and
- (4) Upgrading nurses' accommodations.

## 2. BACKGROUND

This section describes the context in which the Project was set.

### 2.1 Country Profile

The Kingdom of Swaziland, the smallest country in Africa after the Gambia, covers an area of 17,364 square kilometers (km) (6,700 square miles). It has a maximum length of 192 km from South to North and 144 km from East to West. The country shares its southern, northern and western borders with the Republic of South Africa and its eastern border with Mozambique. The 1986 census estimated the population to be 712,131, with 31,072 of that number employed as migrant workers in South Africa. In 1988, the population was estimated to be 728,800 (Schneider, et. al., 1989, p.18). The majority of the population share a common language, tradition and history.

Swaziland is divided into four geographical regions referred to as Highveld, Middleveld, Lowveld and Lubombo Plateau. Each has markedly different altitudes, climates, scenery and economic base activities.

The highveld, covering 29% of the country, is mountainous with an average altitude of 1300 meters (3,500ft) above sea level. It receives the greatest amount of rainfall of the four regions and the climate is humid and near temperate. In winter, (May-August) freezing temperatures and snow may occur. The major economic activities of the highveld are forest and wood-pulp production and asbestos mining. Swaziland's capital city, Mbabane, is the commercial support center for this region.

The middleveld covers 26% of the country and is the most developed and densely populated area. It is hilly with large valleys and an altitude of 700 meters. The climate is sub-tropical, being warmer and drier than the highveld. Good arable land makes it the most agriculturally advanced with estate production of citrus fruit and pineapple for export. Maize is the main crop but other vegetables, bananas, cotton and tobacco are also produced. Major manufacturing enterprises exist and the second major town, Manzini, and the airport at Matsapha are located in this region.

The lowveld is the largest, but least developed area, covering 37% of the country. It is hot and dry and in years of low rainfall, drought is a constant threat and crop failures are common. Yet with irrigation schemes, large capital - intensive estates produce sugar, citrus, rice and cotton. Non-irrigable areas are used for cattle ranching. A coal mine and three sugar mills are located in this region, and with soil management practices, it is considered to be the region with the greatest development potential.

The Lubombo Plateau, which borders on Mozambique, is the smallest region, covering only 8% of the country. Its altitude and climate are somewhat lower but similar to the middleveld. Subsistence agriculture and cattle ranching are the principle activities. The administrative center for this region is located at Siteki.

Swaziland has a dualistic political structure which combines the Western concept of government with the traditional, Tinkhundla system that administers Swazi Laws and Customs. The Head of State is His Majesty, King Mswati III, who is advised in the Government of the country by Cabinet Ministers responsible to a bicameral Parliament. The national development goals of economic growth, social justice, self-reliance and stability were established after the late King Sobhuza II led the country to independence from British Colonialism in 1968.

## 2.2 Health Sector Profile

Swaziland's National Health Policy (1983) was formulated to address what it described as the "unacceptable" health status of the Swazi People. Cited among the major health problems were the high rates of infant, child and maternal mortality, an unfavourable incidence of preventable disease and nutritional deficiencies. These and other identified health problems were grouped into these three categories: (1) Maternal-Child Health and Family Planning; (2) Communicable and Environmental Disease; and (3) Nutrition. The policy statement endorsed Primary Health Care as the most effective strategy for providing accessible preventive and curative health services in the targeted areas.

Under Swaziland's decentralization policy, authority for health sector activities is delegated to the four administrative regions: Hhohho, Manzini, Shiselweni and Lubombo. Regional Health Management Teams (RHMTs) oversee a network of government, mission, private sector and traditional primary health care services.

Nationwide there are nine hospitals; nine health centers; six public health units; 149 clinics; and 161 outreach sites.

(Ministry of Health, Statistics Unit). Schneider (1989) estimates that there are some 10,000 traditional healers. (p.14).

### 2.3 Primary Health Care Project

The Swaziland Primary Health Care Project (PHCP) (USAID Project No. 645-0220) was initiated April, 1986, and scheduled to end December 31, 1990. The Project Assistance Completion Date (PACD) was extended by six months to accommodate participant training commitments and to continue the technical assistance of one team member. The Project was implemented in cooperation with the Government of Swaziland, (GOS) Ministry of Health, (MOH) through a contract with Management Sciences for Health (MSH) and a sub-contract with the Charles R. Drew University of Medicine and Science (DREW).

The goal of the project was to improve the health status of children under five years of age and women of childbearing age. The project's purpose was to improve and expand Swaziland's Primary Health Care System. The goal and purpose were to be accomplished by improving service delivery (training and instituting interventions such as ORT, prenatal risk identification and growth monitoring) and improving the management of health resources.

The original project design had eight components which were reduced in scope after the midterm evaluation. The subsequent Project Paper Amendment re-focused activities on the following regional and clinic level areas;

- (1) Clinic-based and outreach services;
- (2) Decentralization;
- (3) Planning, Budgeting, Financial Management and Health Care Financing; and
- (4) Health Information System Development.

### 3. Overview of Clinic Management

The Clinic Management Associate was one of the Project's five long term advisors. This advisor was primarily responsible for the non-clinical aspects of clinic based services improvement, i.e. management skills, community development and outreach activities. (Project Paper Amendment, 1989). Since the current Associate joined the Project in its final year of implementation, a brief summary of prior accomplishments will be given.

Prior to the midterm evaluation, workshops were used widely to train personnel in Clinic Management topics. A record of workshop activity shows that approximately 700 participants attended 17 workshops related to Supervision, Drug Management and such Community outreach areas as Home Visiting/Community Profiles, Community Participation and Community Health Committee development.

These training and follow-on activities produced a number of sustainable outputs, including the following documents: (1) Clinic Drug Formulary and Handbook; (2) Supervisors and Trainers Guide for Implementation, Maintenance, Monitoring and Evaluation of the Drug Management System; (3) Clinical Reference Manual for Clinics and Health Centres; (4) Orientation Manual for Clinics, Health Centres and Public Health Units; (5) Referral Forms; and (6) Supervisory Checklist and Guidelines.

In addition to documents, clinic level management interventions, including the drug management system and patient flow measures, were also initiated. Community development outputs included home visiting; working with Community Leaders, Rural Health Motivators and Community Health Committees; and outreach sites expansion.

The workshop approach to training was replaced by the Clinic-based model which emphasized a more task-specific, skill-oriented approach. The Clinic Management Associate's responsibility in the Clinic-based training and follow-up was for simple management interventions. (Scope of Work - Appendix A). Follow-up visits of nurses who participated in the training were to be made with regional public health nurses [trainers] and supervisors, who according to the Midterm Evaluation, were to do the planning and training. In addition to the redirection of training, the Project Paper Amendment (May 1989) and the Revised Work Plan (August 14, 1989) focused other Clinic Management activities on the priority areas described below.

### 3.1 Improved Service Delivery and Outreach Approaches

- 3.1.1 Clinic Level basic management interventions were aimed at improving such clinic operations as: drug/inventory management, use of project - related manuals and reorganization of clinics for efficiency.
- 3.1.2 Clinic/Community linkages were designed to increase access of underserved populations to health care and promote community participation in health care delivery. Major activities included: constructing or upgrading outreach shelters, increasing home visits and strengthening community health committees.

### 3.2. Improved Skills, Conditions of Service, and Supervision and Management Support.

Assumptions were made by the Project that training, (skills development) more supportive supervision and improved conditions of service, such as better housing, would optimize staff productivity and motivation.

#### 3.2.1 Improved Skills

Clinic based training follow-up emphasizing basic management interventions.

#### 3.2.2 Improved Conditions of service

Upgrading of nurses' accommodations; Supervisory Visits addressing conditions of service.

#### 3.2.3 Improved Supervision and Management Support

Monthly Supervisory Visits to clinics using supervisory checklist.

The specific EOPS related to the above areas along with relevant scope of work and work plan activities are used to organize the remainder of the report.

#### 4. CLINIC MANAGEMENT OUTPUTS

##### 4.1 IMPROVED SERVICE DELIVERY AND OUTREACH APPROACHES DEVELOPED

##### 4.1.1 Outreach Sites

Establish 49 new outreach sites, including provision of basic furnishings and equipment.

##### Number of outreach sites operational

The outreach sites program was designed to increase accessibility and utilization of Maternal Child Health services in rural areas. After successful completion of seven pilot facilities in Mankayane, Sub-region of Manzini (1987), the activity was extended to other regions. The target of 49 operational sites was met in April 1990, at a cost below the budgeted E1000 per site. In response to additional requests from nurses and communities, a total of 84 sites received assistance (Table 1) in the form of basic furniture (4 chairs, 4 benches, 2 tables and 1 examination couch); privacy and window curtains; trunks for transporting supplies; and salter frames/scales for weighing children. Building materials for already started structures were also funded on a request basis. (Appendix B - Project - Assisted Outreach Sites).

Structures are usually built of indigenous materials that can be afforded by the community. The design is simple, and the size varies from one room to several depending on community resources. Regional nursing staff from public health units or clinics visit designated sites on a scheduled monthly or in some cases, bimonthly basis. The annual schedule of visits is posted in respective clinics and a copy is given to a community leader.

Sustainability

An outreach program has existed in Swaziland since the 1960's when Mrs. N.E. Dlodlu, the first Public Health Matron started the concept of Mobile Clinics. (Interview, Mrs. Aylline Dlamini, Public Health Matron, 1972 - 79). Outreach sites are now an integral part of the PHC system and support the Ministry of Health's policy of providing access to health service within one hour's walking distance of users. (5-10km).

The outreach sites concept is institutionalized throughout the country. Data from the Health Information System (HIS) show 161 government, mission and private/industry distributed regionally in the following way: Lubombo 50; Manzini 62; Hhohho 28 and Shiselweni 21. Of the 84 project - assisted sites, 81 (96%) are reporting activity data on the HIS.

Other evidence of the sustainability of the project is the positive response of nurses and communities to the program. Many communities had official openings to dedicate their structures and express appreciation for the Project's support. (Appendix C-Speech and Newspaper Article, Lundzi Outreach Dedication).

Constraints

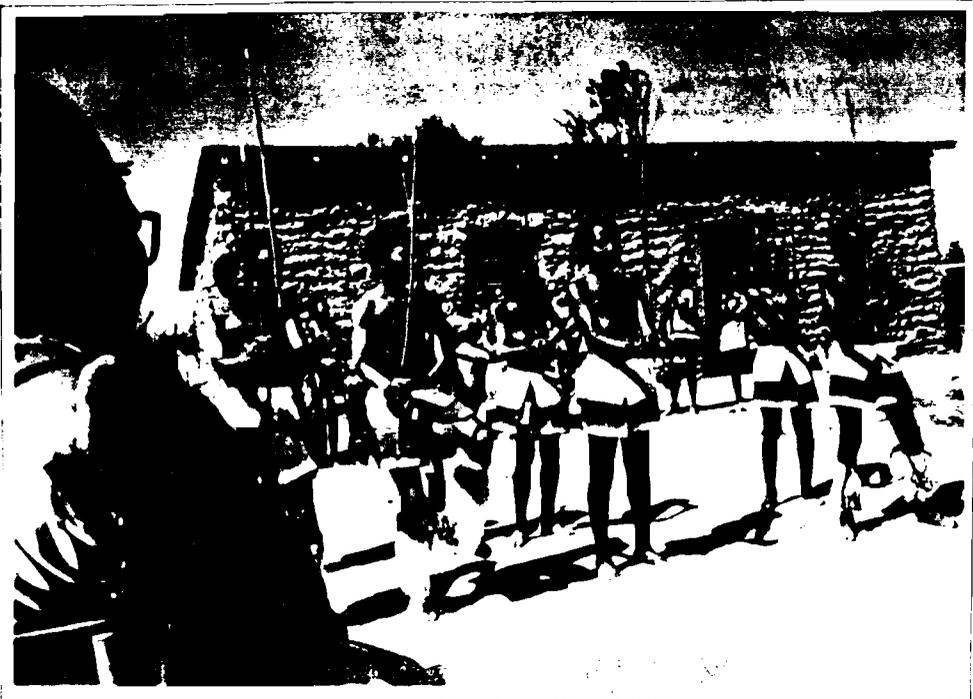
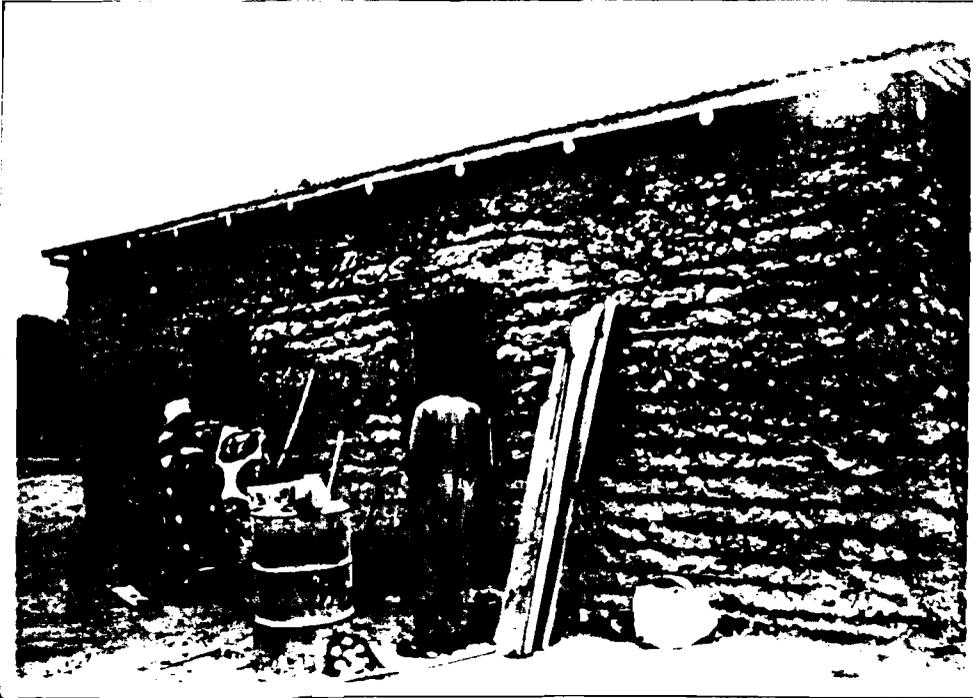
Lack of transportation, shortage of clinic staff and impassable roads during rains led to cancellation of some visits. When the one vehicle was in for repairs or otherwise not available there was no backup system. In one region, the transport was not available for three months during which time no visits were made.

Table 1

Regional Outreach Sites Supported by Primary Health Care Project

Region	Health Care Facility	Number of Sites
Hhohho	Piggs Peak PHU	8
	Mbabane PHU	14
Manzini	King Sobhuza II PHU	10
	Mankayane PHU	11
Lubombo	Siteki PHU	7
	Good Shepherd	9
	Sithobela HC	9
	Ndzevane Refugee	2
	St Philips	3
Shiselweni	Hlatikhulu PHU	7
	Nhlangano PHU	4
Total		84

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LUNDZI OUTREACH SITE

Shelter Construction  
and  
Celebration

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HLANE OUTREACH SITE - LUBOMBO REGION

Maternal-Child Health Services

4.1.2 HOME VISITS

Proportion of rural clinics from which nurses make regular home visits increased by 40% during project life.

Proportion of clinics doing regular home visits.

Home visits, like the outreach sites program, expand Maternal Child Health and other Primary Health Care Services to rural populations. Where feasible, clinic nurses visit homesteads within their catchment area to identify health problems, give health education messages and follow-up specific clients, for example, defaulters. Prior to the midterm evaluation, the Primary Health Care Project sponsored workshops on home visiting/community profiles for nurses in all four regions. These sessions included field experiences in conducting visits, developing community profiles and estimating and mapping clinic catchment areas. Participants were expected to initiate a home visiting program in their respective clinics using the Ministry of Health's Household Health Folder, which was revised during the training. On clinic visits made by the Clinic Management Associate, there was evidence that a number of clinics continue to make visits, maintain the record system and update and display their catchment area maps.

Baseline data on the proportion of clinics conducting home visits before the inception of the Primary Health Care Project were not available. It was not stated how many additional clinics should make home visits in order to reach the target of a 40% increase by the end of the project. However, data obtained from a survey of clinics in the Lubombo Region (March 1990) and reports from the Health Information System give the status of activity in this area. The major findings related to the project output indicators are presented below.

#### Home Visit Survey - Lubombo Region

The brief questionnaire shown in Appendix D was designed to collect data on a number of indicators, including home visits. Of the 29 clinics surveyed in Lubombo, 11 or 38% of them reported making home visits. Two of the eleven clinics stated that their visits were made by Rural Health Motivators. The other 18 clinics, 62%, did not make visits due to "shortage of staff" or "clinic is too busy". Two additional clinics later reported making visits, therefore, 45% of the clinics (13 of 29) in the Lubombo region made home visits.

#### Health Information System(HIS)-Home Visit Data-January-October 1990

Home visit reporting is now integrated into the HIS. The graphs on pages 18 - 21 show the number of visits reported by each of the four regions in the 10 month period January - October 1990.

The Hhohho Region, for example, reported the following number of visits: 19, 10, 92, 141, 105, 96, 138, 107, 106, and 41, for a total of 855, or an average of 86 visits per month.

The line and bar graphs on pages 22 and 23, respectively, compare the regions with each other. For example, in May, Manzini reported 143 visits, while Hhohho, Lubombo and Shiselweni reported 105, 76 and 28, respectively. Total home visits and range of visits by region are shown in Table 2. A total of 2,309 visits were made throughout the country during the period, or an average of 231 visits per month. The monthly average by regions is as follows: Hhohho - 86; Manzini - 58; Lubombo - 64 and Shiselweni - 25.

#### Range of Visits

Hhohho, Manzini and Lubombo made the lowest number of home visits (10, 6, and 0, respectively) in the months of January and February, while Shiselweni made the lowest number, 7, in September. Regions made the most visits April - June as follows: Hhohho (April) - 141; Manzini (May)-143; Lubombo (March and April) - 130; and Shiselweni (June) - 36. While it is beyond the scope of this report to present a detailed analysis and interpretation of data, regions could use the HIS data to plan realistic targets and address factors related to changes in home visit activity.

Table 2

Total Home Visits and Range of Visits by Regions  
January - October 1990

-----

<u>Regional</u>	<u>Total Visits</u>	* <u>Range</u>
Hhohho	855	10 - 141
Manzini	556	6 - 143
Lubombo	643	0 - 130
Shiselweni	253	7 - 32
Total	2,307	

- \* Range - represents a month when the lowest number of visits were made in that region and a month when highest number of visits made. Example: Manzini's lowest number of visits was 6 (February) while the highest number was 143 (May).

In addition to regional data, individual clinic home visiting performance can also be obtained from the HIS. Of the 90 clinics that submitted information, 42 (47%) of them reported making home visits. The percent of clinics making visits in each region/subregion is shown in Table 3 and the complete list appears in Appendix E. The Table shows that 75% of the clinics in Hhohho South make home visits, followed by Mankayane sub-region - 73%; Shiselweni - 63%; Hhohho North - 57%; Lubombo - 34% (Earlier Survey - 45%); and Manzini sub-region - 21%. It should be emphasized that the results are based on available data for months of January - October 1990.

Table 3

Percent of Clinics Making Home VisitsJanuary - October 1990

Regions/Sub-Regions	* Total Clinics Reporting	No. Clinics Making Visits	% of clinics making visits
<u>Hhohho</u>			
South	8	6	75%
North	7	4	57%
<u>Manzini</u>			
Manzini	19	4	21%
Mankayane	11	8	73%
<u>Lubombo</u>	29	10	34% * *
<u>Shiselweni</u>	16	10	63%

90

42

\* Not all the clinics reported (nationwide - 47% of clinics make visits)

\* \* Data reported earlier on survey was 45%

### Summary

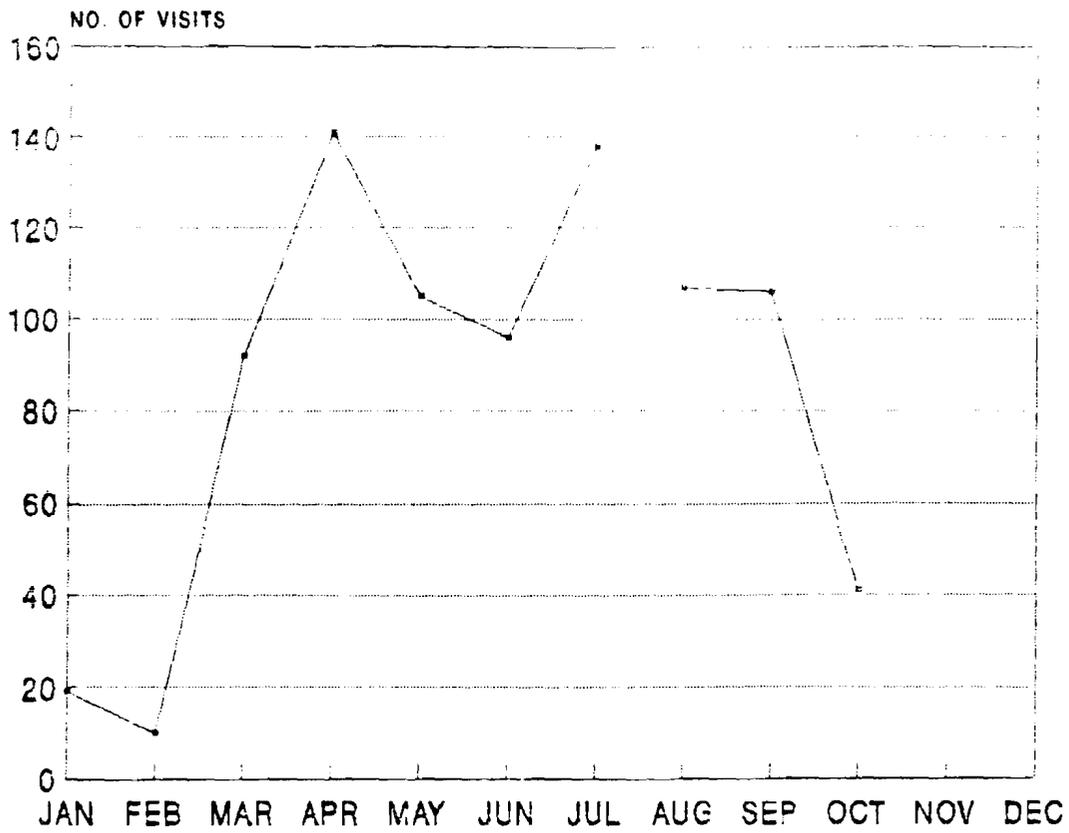
With 90 clinics reporting, 42 of them (47 %) are making home visits. On a regional/sub-regional basis, the percent of clinics making visits ranges from 75% (Hhohho South) to 21% (Manzini sub-region). The Primary Health Care Project indicator of "a 40% increase in the number of clinics during the life of the project," did not have a stated baseline. Therefore, it is not possible to determine whether or not the target was reached. Shortage of staff, heavy patient loads and great distances between clinics and homesteads are among the deterrents to more frequent visits.

### Sustainability

There is a system in place to sustain and support home visiting as an important outreach component of Primary Health Care. Where it is not practical for nurses to make visits, Rural Health Motivators can supplement this activity. As described by Dr. Makhubu in the booklet, Nurses' Guidelines for Working with Rural Health Motivators, the community-based workers "follow up defaulters when asked to do so by nurses in cases of T.B., Family Planning, Immunization and other services that are provided in clinics" (p17).

# HOME VISITS - 1990

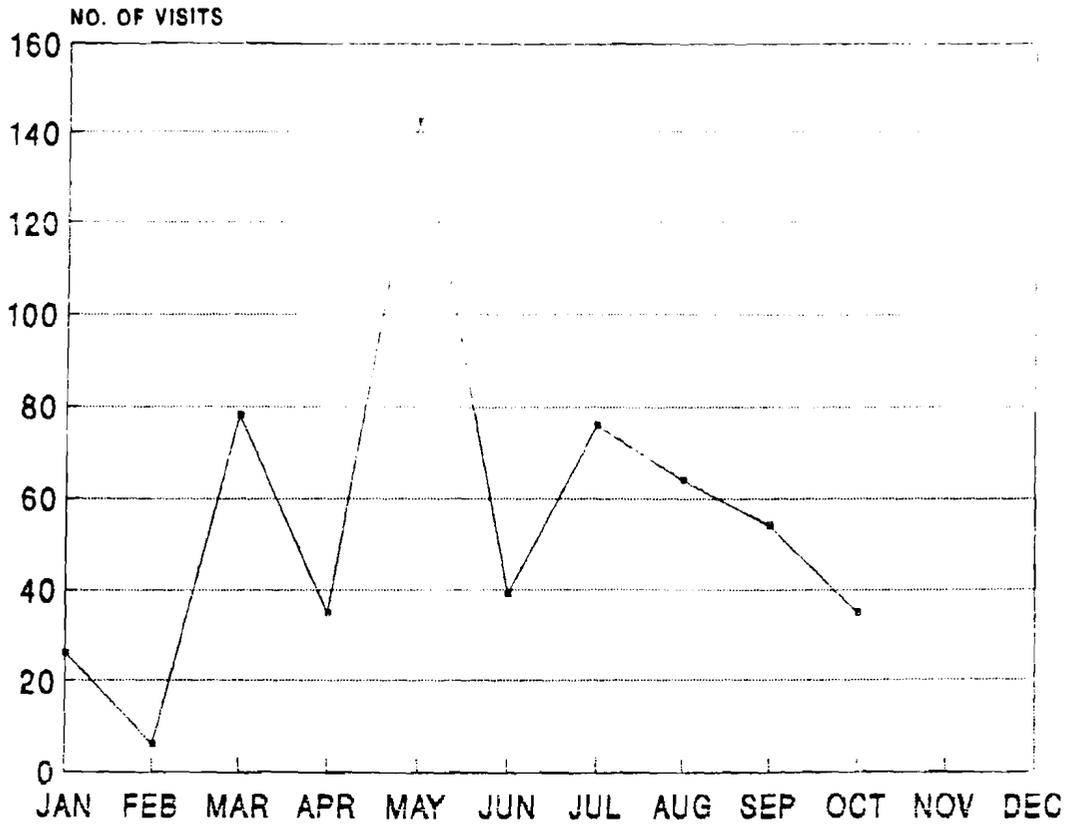
## HHOHHO REGION



MOH (Stats unit)

# HOME VISITS - 1990

## MANZINI REGION

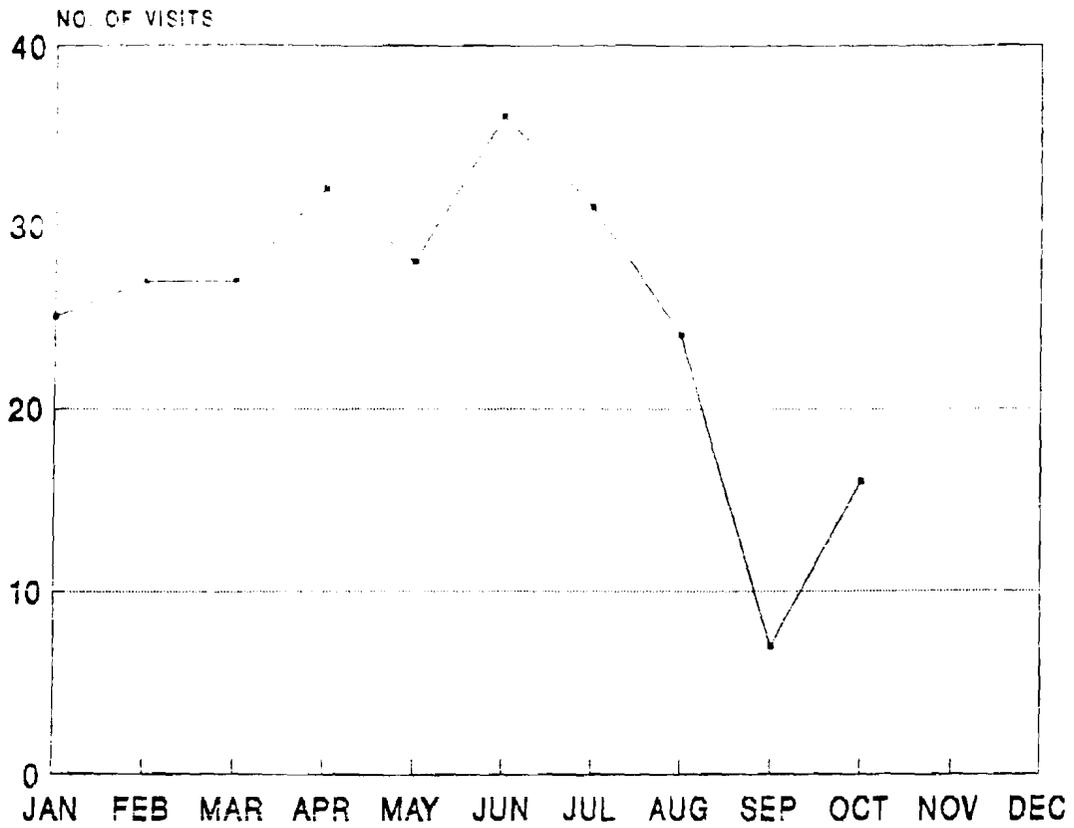


MOH (Stats unit)

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# HOME VISITS - 1990

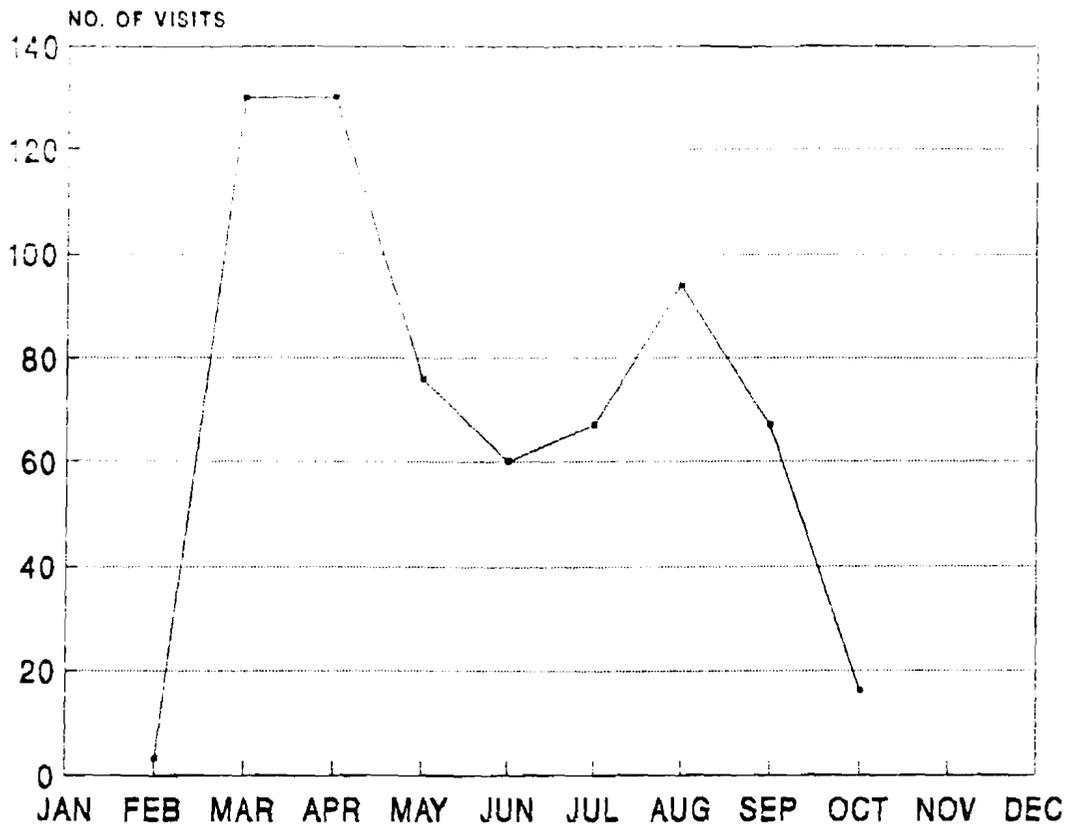
## SHISELWENI REGION



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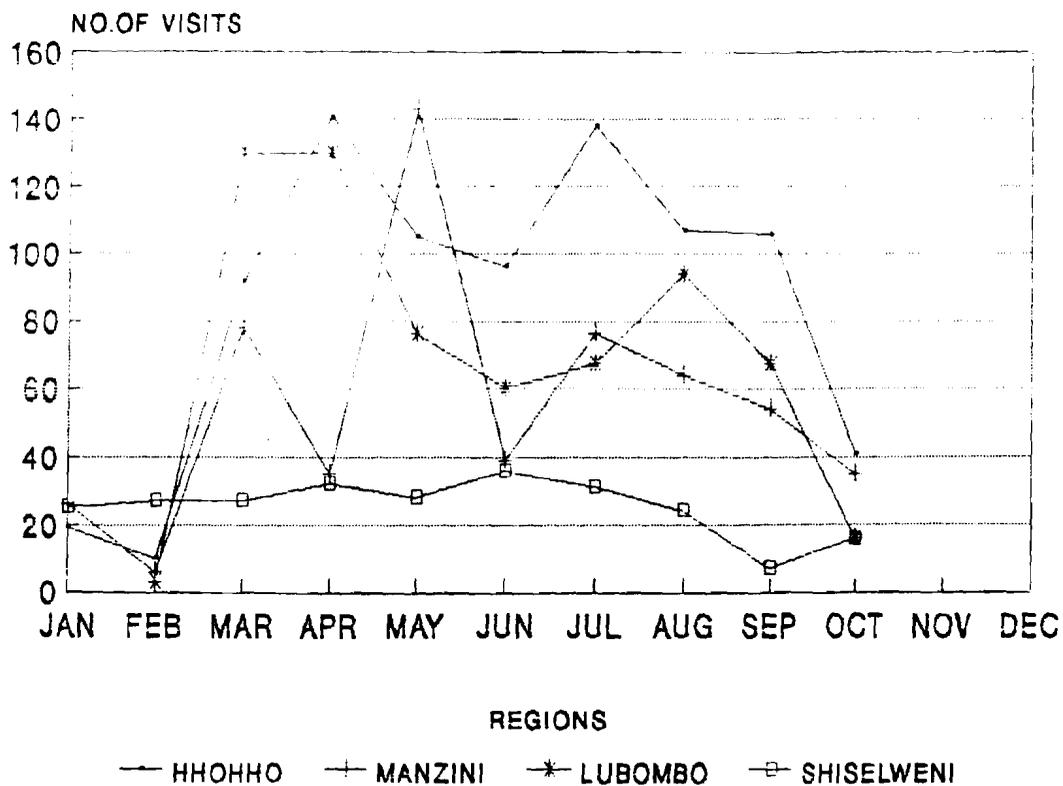
# HOME VISITS - 1990

## LUBOMBO REGION



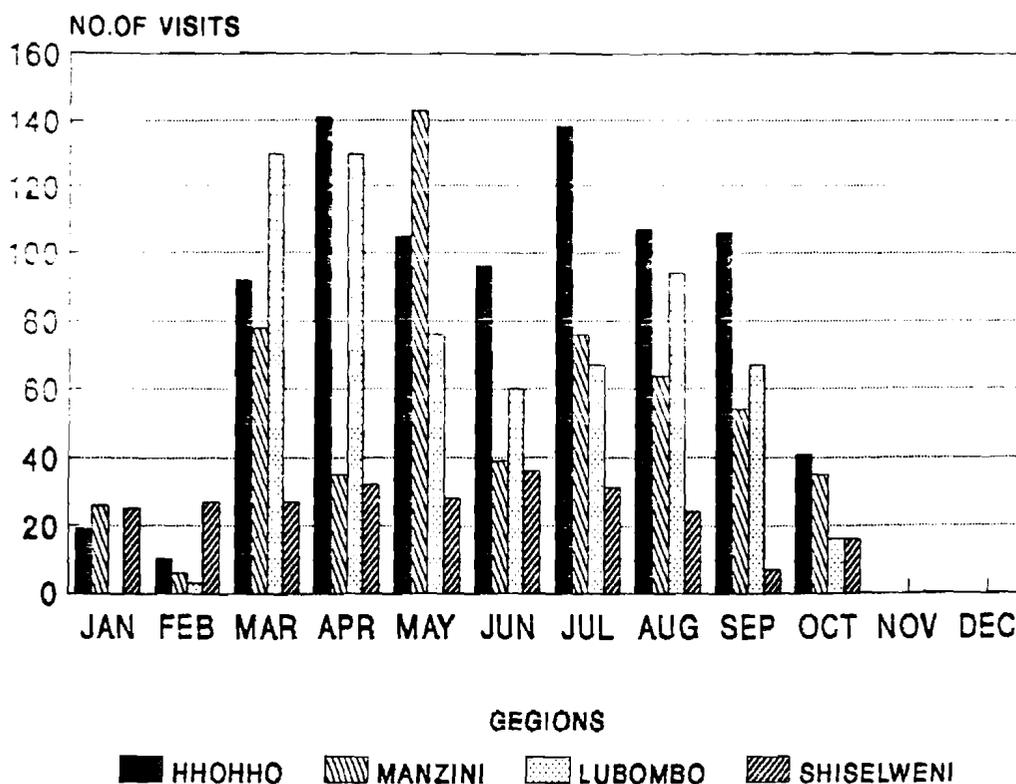
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## HOME VISITS - 1990 BY REGIONS



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## HOME VISITS - 1990 BY REGIONS



MOH (Stats unit)

#### 4.1.3 COMMUNITY HEALTH COMMITTEES

Proportion of all clinics with functioning community health committees increased by 40% during life of the Project.

Proportion of clinics with functioning community health committee.  
(Document Only).

The community health committee is an advisory body which served as a communication link between the community and the rural clinic on health-related matters. In Swaziland, these committees are well-established structures for mobilizing community participation in Primary Health Care activities. The recommended Terms of Reference established by the Ministry of Health, state that the main purpose of such committees is "to educate the people on sound health practices and motivate them to take actions which will improve the health of the community." (Guidelines for the Future Operation of Health Services in Swaziland 1986, p.84).

While community health committees are an integral part of Swaziland's Primary Health Care System, their activity level varies considerably. At the time of the Second Annual Review of Primary Health Care (1987), committees were functioning in only one-third of the 30 clusters sampled. Of those committees sampled, 10% met weekly, 27% met monthly, 20% met as needed and 43% had never met.

In the early stages of the Primary Health Care Project, substantial support in the form of workshops was given to strengthening community development activities, including community health committees. Over 1,000 persons attended 15 Community Participation, Community Health Committee and Community Leader workshops. A survey of health committee functioning was also done at a Basic Management Workshop (1988, February 7-12) and a list of active and inactive committees was obtained, but there was no evidence that the results were tabulated or used in any way. The same Survey Form was used to document the current functioning of health committees. Additional information was obtained from Africa Magongo, Health Education Unit, who conducted a survey of committee functioning in the Lubombo South clinics.

Survey results are shown in Table 4 below and the list of active committees are included in Appendix F. The percent of active committees by region/subregion are as follows: Hhohho South - 100%; Hhohho North - 78%; Mankayane - 55%; Shiselweni - 50%; Lubombo - 45% and Manzini - 21%. Of the 93 total clinics reporting, 47 (51%) of them have active community health committees.

Table 4  
ACTIVE COMMUNITY HEALTH COMMITTEES  
1990

Regions/Sub-Regions	Total Clinics Reporting	No. Clinics With Committees	% of clinics with Committees
<u>Hhohho</u>			
South	9	9	100%
North	9	7	78%
<u>Manzini</u>			
Manzini	19	4	21%
Mankayane	11	6	55%
<u>Lubombo</u>	29	13	45%
<u>Shiselweni</u>	16	8	50%

Total all Regions                      93                      47

Overall Percentage of Clinics with  
 Active Health Committees = 51%

The baseline that the Primary Health Care Project was using the measure a 40% increase in the functioning of health committees was not stated. Therefore, it cannot be determined whether or not the target was met. However, it is evident that health committees are institutionalized and functioning well in many of the clinics. Data such as presented here can assist region to set desired targets for this activity in their annual action plans.

#### 4.1.4 Reference Manuals and Drug Management System

Proportion of clinics at which staff use project-related manuals and protocols to effectively diagnose and treat patients is  $\approx$  50%.

Proportion of clinics using manuals developed and implemented by the Primary Health Care Project (Drug Formulary, Clinical Reference Manual, Clinic Orientation Manual).

Number of clinics with drug management system operational.

The following manuals were produced with technical and financial support from the Primary Health Care Project: Clinical Reference Manual (April, 1987); (2) Orientation Manual (April, 1987); (3) Drug Formulary (February, 1989) and Supervisors and Trainers Guide - Drug Management System (December 1989). The Clinical Reference Manual provides diagnosis and treatment protocols for the most common health problems seen at rural clinics. The Drug Formulary accompanies the Drug Management System and provides guidelines for safe practices in ordering, storing, prescribing and dispensing essential drugs. The Supervisors and Trainers Guide - Drug Management System, as the name implies, is an instructor's manual for orientation, in-service or on-the-job training in drug management. The manual was distributed in September 1990 and there is no evidence of its use as yet.

The Orientation Manual was developed to assist newly assigned and relief staff adjust to work in the rural clinic setting. It is a tool for addressing the problems of high turnover and frequent rotation of clinic staff. (Midterm Project Evaluation, October 1988). The document was to be used in conjunction with a proposed two week orientation period for nurses being posted to rural clinics.

### Use of Manuals

The proportion of clinics using the Clinical Reference Manual, Drug Formulary and maintaining the Drug Management System is close to 100%. Only two of over 50 clinics visited needed assistance with proper recording on the tally sheet and establishing minimum/maximum stock levels. Occasional breakdowns in the system occur when new staff are not properly oriented to the system. Through the office of the Senior Public Health Matron, 250 copies each of the Drug Formulary and Clinical Reference Manual were reprinted.

The Orientation Manual was available in 4 of 29 clinics (14%) in the Lubombo Region and 2 of 8 clinics (25%) in the Shiselweni Region. In the Hhohho South and Mankayane sub-regions 16 clinics (Hhohho South -5; Mankayane -11) had copies of the manual. Nurses stated that they read it on their own as there is no formal orientation program. Although about 42% of the clinics visited have orientation manuals, they were rarely used. (Clinics in Hhohho North and Manzini Sub-regions were not visited). There is no system in place for reviewing and updating the orientation manual nor for absorbing the cost for reprinting.

### Recommendation

Each Regional Health Management Team devise a strategy for orienting clinic nurses to their job responsibilities and work environment based on established policies. (Regional Personnel Management Policies and Procedures - Section 6 Orientation (Ministry of Health, April, 1987, P.17).

Review the orientation manual's usefulness and revise accordingly.

4.2 Improved Motivation of Health Workers Brought about by Improved Skills, Improved Conditions of Service and Improved Supervision.

4.2.1 Training

At least 80% of clinic nursing staff trained in priority Primary Health Care service areas, as well as in basic clinic management skills.

Number of nurses trained in Clinic Management including drug management.

Workplan Activity: Provide clinic - based training to clinic nurse in basic management skills including supervision, patient flow, drug management, community profiles and outreach.

Prior to the midterm evaluation, the project used workshops to train nurses in the above management topics. Project records show that nearly 700 participants attended 17 workshops in the areas of drug management, clinic management and outreach activities. These workshops were followed by the systematic implementation of related clinic and community level interventions. Monthly and quarterly project reports indicate that the training target in terms of absolute numbers was reached before the midterm evaluation.

To review the sustainability of those workshop trainings and management inputs, visits were made to five clinics in Hhohho South and twelve clinics in Mankayane. These 17 clinics were found to be effectively implementing the drug management system as well as other innovations introduced by the project. The five clinics in Hhohho South and eight of the twelve clinics in Mankayane also have well functioning ORT Corners established by the National ORT program. Likewise, the ORT Unit at Mankayane Hospital was properly maintained.

After the midterm evaluation, training methodology shifted from workshops to the clinic - based model. This strategy emphasized small, regional training with timely follow-up in the participant's own work setting. The Clinic Management Advisor's responsibility was to assist the clinic supervisor in monitoring and reinforcing the management aspects of the training by using the Supervisory Checklist.

In the original plans for clinic-based training, a module on clinic management was to be included "to reinforce the knowledge and use of the supervisory checklist." (Paper-Clinic Level Training Programme in Shiselweni, 29 August 1989). The program was to integrate training and supervision by mobilizing in one program the key figures or primary health care at the clinic level. Although a separate management module was not developed relevant content was integrated in the training and was the focus of the follow-up visits. A form (condensed version of supervisory checklist) was developed (Appendix G) to record observations related to the following content covered during the training:

1. Reorganization of clinic for efficiency.

- a Proper positioning of the EPI refrigerator, ORT Corner, growth monitoring equipment (Salter Scales/Frames) and consulting room set-up
  
- b Arranging paperwork according to the filing system established by Dr. Joret (memo - V. Joret to M. Edmondson - March 10, 1990). The project supplied files, filing cabinets, where needed, and built-shelves for more efficient organization of record keeping materials. The Clinic Management Associate and clinic supervisor assisted with the implementation of the system and in some cases (Lubombo Region) delivered files to clinics in the interval when there was no Training Backstop-for the project.

2. Management of drugs and supplies to support selected patient Care Areas

- a. Immunization (EPI)  
Adequate supplies of vaccines, needles and syringes, properly functioning cold chain system.

b. Oral Rehydration Therapy (ORT)

Management of ORT Corner; maintenance of equipment and supplies; instructions to caregivers; and record keeping - review of Assessment and Treatment Form where participants had attended National ORT training.

Most of the follow-up activities were concentrated in the Lubombo Region where participant training took place from February - January 1990. Fifty seven trainees (32 staff nurses; 25 nursing assistants) from 26 clinics (Appendix H) were visited with the Clinic Supervisor or designate. Some clinics were visited two or more times due to the late arrival of ORT and weighing equipment which in some cases, delayed the implementation of skills learned in the training. Once equipment was in place, clinics were re-visited to observe trainee skills, reinforce teaching and respond to questions or problems.

The clinic - based training and follow-up were completed in the Shiselweni Region before the Associate joined the project. However, visits were made to eight clinics with the Public Health Medical Officer to observe the sustainability of project inputs. The physical clinic innovations (ORT Corners, Filing System) were in place, but it was not possible to ascertain the degree to which skills were being implemented. Nurses did state that they often do not have time to observe the ORT Corner. At the time, the Regional Matron was on study leave and the Clinic Supervisor post was vacant so it was possible only on a limited basis to redress problems areas.

Involvement in Hhohho participant trainings which started in October, was limited to orienting the Acting Regional Matron and Clinic Supervisors to follow-up activities for which a schedule was made.

#### 4.2.2 UPGRADING OF NURSES' ACCOMMODATIONS

33

Improved Conditions of Service for Rural Clinic Staff, including Provision of Limited Furnishings for Nurses' Accommodations.

Number of Nurses Accommodations Upgraded.

The lack of adequate housing and facilities is well documented as a major constraint to the posting and retention of rural clinic staff. The upgrading of nurses' houses was the Primary Health Care Project's effort to improve the conditions of service and ultimately provide an incentive for nurses to work in rural areas. On reconnaissance visits to clinics the overall housing situation was found to be less than desirable except where there were newly built structures. Lack of routine maintenance has led to serious structural deterioration of some facilities well beyond the scope of this Project to address. Nor do community groups, in most cases, have the skilled manpower to cope with the extensive renovation needs of some of the houses. Besides the structural problems such as leaking roofs, falling ceilings and cracking walls, many houses are without stoves, refrigerators or an adequate water supply. In many instances, nurses are sharing a very small facility leading to extremely crowded conditions and lack of privacy.

The method of work used to approach this activity was first to hold a series of meetings with the then Assistant Health Planner, Planning Unit, Ministry of Health, to review the status of housing repairs occurring under the Rural Clinics Renovation Project (RCRP) and identify the best use of project funds.

Secondly, a detailed, prioritized list of basic repair requests with cost estimates was obtained from the regions. Finally a planning meeting was held with Project and Planning Unit representatives responsible for this activity to establish a mechanism for implementation.

The original plan for Project assistance in this area was to supply materials only with the local communities providing the labor. (Midterm Project Evaluation). It was later decided that the extent of the repairs and the subsequent maintenance needed, required the skilled manpower of the Public Works Department (PWD). However, attempts to coordinate this activity with PWD proved futile and led to delays, except in the Shiselweni Region where the Regional Health Administrator and the Public Health, Medical Officer spent considerable time working with PWD on this activity. The Project hired part-time carpenters and painters to do work in the other regions.

At the end of the Project, basic repairs have been completed on 30 of the 52 houses for which requests were made. (List of Accommodation Upgraded - Appendix I). Basic renovations included repair of roofs, gutters, broken windows, doors, installation of locks and painting. The Project also provided: Curtain materials for about 20 houses; kitchen cupboards where nurses were sharing facilities; and a water tank for one clinic where the water shortage was critical.

In spite of the tremendous Project input into upgrading nurses' accommodations, there are still acute housing problems. It was beyond the scope of the project to deal with plumbing, electrical and appliance needs, which also need urgent attention.

The Government is aware of the housing situation at rural clinics and has a plan for its improvement. One of the program priorities designed to strengthen rural clinic services during the Fourth National Development Plan period (1983/84-1987/88) was to construct 74 staff houses. More recently, the Health Sector - Development Plan 1990/91 - 1992/93, reaffirmed the Ministry of Health's commitment to continue its major clinic renovation and upgrading program. Priority will be given to "the renovation of rural clinics throughout the country" and "construction of staff housing at clinics for nursing staff who are currently forced to share rooms or sleep on clinic floors". (Health Sector - Development Plan - 1990/91 - 1992/93, p.88).

#### 4.2.3. CLINIC SUPERVISION

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

Proportion of clinics receiving monthly supervisory visit from nursing supervisor (using checklist).

The effective implementation of the Government's National Health Policy and the Primary Health Care Project's input are both dependent upon adequate clinic supervision. To this end, early project support included a number of workshops aimed at improving the management/supervisory skills of matrons, clinic supervisors and nurses. In addition to training, the project supplied one supervisory vehicle for each of the four regions and sponsored driving instructions for three supervisors in order to alleviate transportation constraints. In most regions, clinic supervisors are functioning in a dual capacity. They are responsible for the supervision of a Health Center or Public Health Unit as well as a number of widely dispersed clinics. To confound the problem, the Regional Public Health Matrons were on educational leave for the greater part of the year, adding more responsibilities to an already overburdened cadre.

There are eleven Nursing Sisters or Staff Nurses serving as clinic supervisors as follows: Hhohho - 5; Manzini - 3; Lubombo - 2; and Shiselweni - 1. All supervisors make an annual schedule of their planned monthly clinic visits. However, other priority commitments often lead to cancellations.

According to the job description for Nursing Sister - Clinic Supervisor, visits are to be made monthly to Government and Mission clinics and more often if there are special problems. Supervisors are also expected to visit private and industry facilities to provide EPI and Family Planning Supplies/Information and to follow-up on health statistics record keeping.

There was no documentation on the total number of clinics nor the percent receiving monthly supervisory visits at the time the project's target of 80% was established. Therefore, the figures in Table 5 will be used to discuss the status of supervisory visits. The table shows that there are 52, 33 and 64 Government, Mission and Private/Industry Clinics, respectively, for a total of 149. Monthly supervisory visits to 68 of the 85 (52 and 33) Government and Mission Clinics and 51 of the 64 Private/Industry Clinics or a total of 119 clinics nationwide would meet the project's target of 80%.

Table 5

Government, Mission and Private Sector Clinics

<u>Region</u>	<u>Government</u>	<u>Mission</u>	<u>*Private</u>	<u>Total</u>
Hhohho	9	9	17	35
Manzini	15	12	35	62
Lubombo	12	9	12	33
Shiselweni	<u>16</u>	<u>3</u>	<u>-</u>	<u>19</u>
Total	52	33	64	149

Source: Ministry of Health, Statistics Unit and Regional clinic lists.

Note: Public Health Units and Health Centres are excluded.

\*Private Sector includes all private, company and non-governmental organization clinics.

Health Information System reports were available for 89 (60%) of the 149 clinics, January-October 1990, as shown in Table 6. The clinics in the Lubombo and Shiselweni Regions have the highest reporting rate while less than half of the clinics in the other two regions are reporting.

Table 6

Regional Clinics Supervisory Visits

<u>Region</u>	<u>Total Clinics</u>	<u>Total Reporting</u>	<u>Percent Reporting</u>
Hhohho	35	16	46
Manzini	62	28	45
Lubombo	33	29	88
Shiselweni	<u>19</u>	<u>16</u>	84
Total	149	89	

Data Available for 89 of 149 Clinics = 60%

The graphs on pages 42 to 47 show the number of supervisory visits by regions as well as a comparison among regions. A total of 623 visits were made during the 10 month period as follows: Hhohho - 176; Manzini - 263; Lubombo - 104 and Shiselweni 80. This averages about 62 visits per month with each region contributing as follows: Hhohho -18; Manzini -26; Lubombo 10, and Shiselweni -8.

A review of the individual clinic data sheets showed that only 5 (6%) of the 89 clinics were visited each of the 10 months January - October. However, a number at clinics received several visits in a given month and then were not visited for one or more months. (Appendix-J Individual clinic supervisory visits).

Table 7 shows that supervisory visits ranged from 0-30, with 43% of the clinics being visited 1-5 times in the 10 month period. Clinics visited in the 21 - 25 and 26 - 30 categories represent the five clinics (6%) that were visited monthly.

Table 7

Supervisory Visits - January - October 1990Frequency Distribution of Supervisory VisitsJanuary - October 1990

<u>No. of Times Visited</u>	<u>No. of Clinics</u>	<u>Percent</u>
26 - 30	4	5
21 - 25	1	1
16 - 20	3	3
11 - 15	9	10
6 - 10	24	27
1 - 5	38	43
0	<u>10</u>	<u>11</u>
Total	89	100%

If clinics received 10 or 11 visits in the 10 months period, it might be assumed that this averages a visit per month over a 10 month period. This is not the case, however, as illustrated in the following example of one clinic's report; January - 5; February - 4; June and July - 1 visit each; and no visits the other months. Conversely, clinics reporting 12 - 30 visits in the period, have received a number of consecutive visits monthly (one clinic - 9 visits in one month) usually since March.

The Primary Health Care Project has succeeded in increasing the supervisory skills of nurses and in improving the operational management of the supervisory support system. There are still a number of system factors, such as the lack of official posts, that must be addressed before the project's impact can be fully realized. The Ministry of Health is aware of the problems related to clinic supervision and addressed some of them in the report, Health Manpower Requirement FY 1988 - 89 to FY 1992 - 93. Clinic supervisors were recognized as "the critical element in the Ministry's plan to improve the management and productivity of the nationwide clinic network" (p. 31). The report recommended a specific number of new supervisory posts per region based on workload, or the number of clinics to be visited, and other factors such as distances between clinics. The plan was designed to eliminate the need for a Nursing Sister in charge of a facility to also supervise clinics in the region.

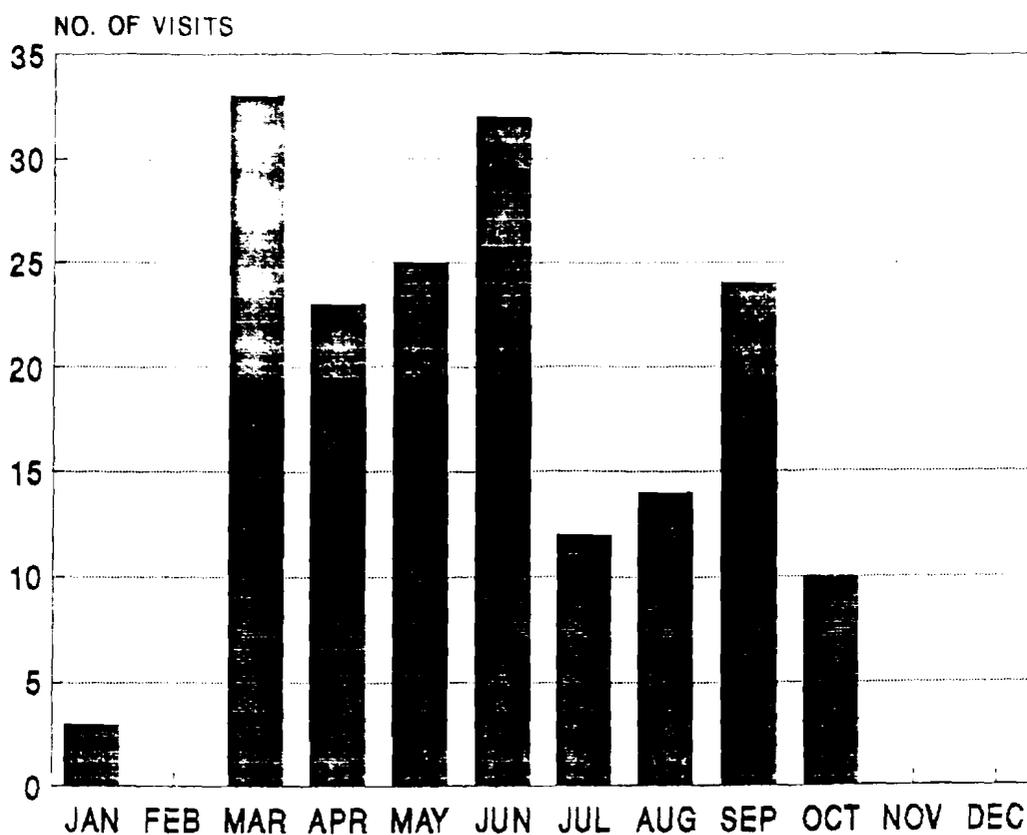
Recommendations

Review and update recommended posts for clinic supervisors as stated in Health Manpower Requirements FY 1988 - 89 to FY 1992 - 93.

Examine system factors (training, meetings, other duties) that interfere with scheduled supervisory visits.

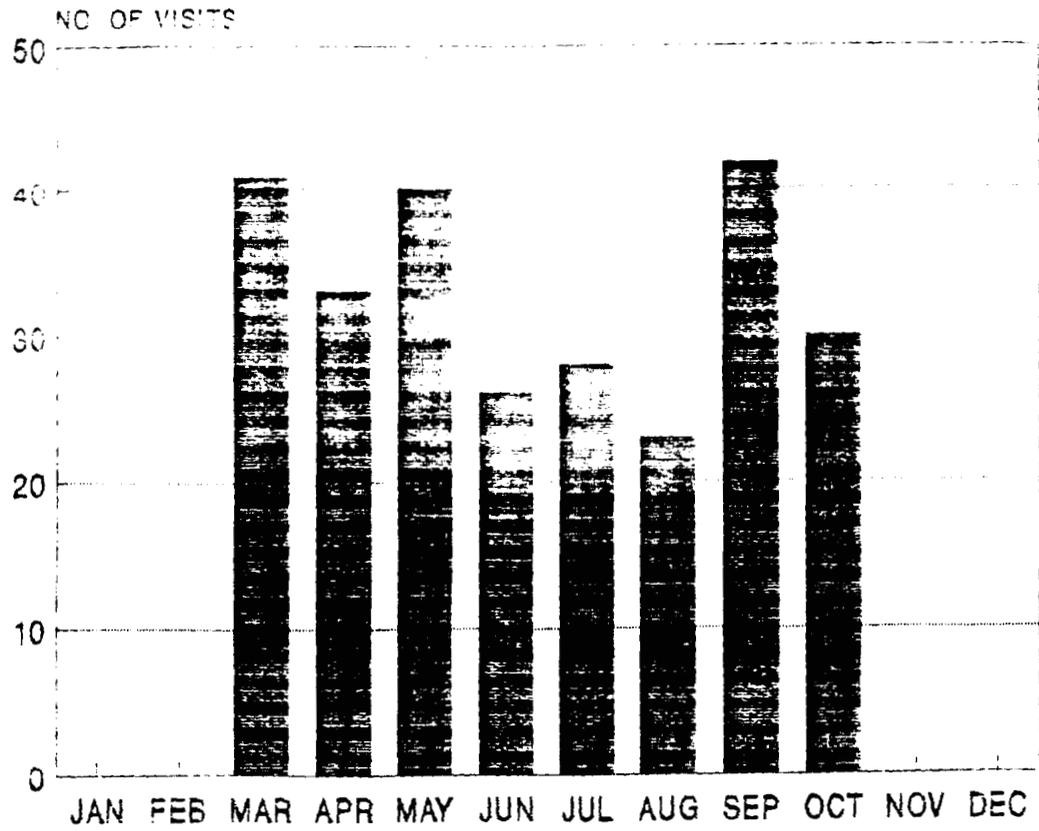
Analyze factors related to the inequitable pattern of supervisory visits, whereby some clinics are visited more frequently than others.

# CLINIC SUPERVISION VISITS - 1990 HHOHHO REGION



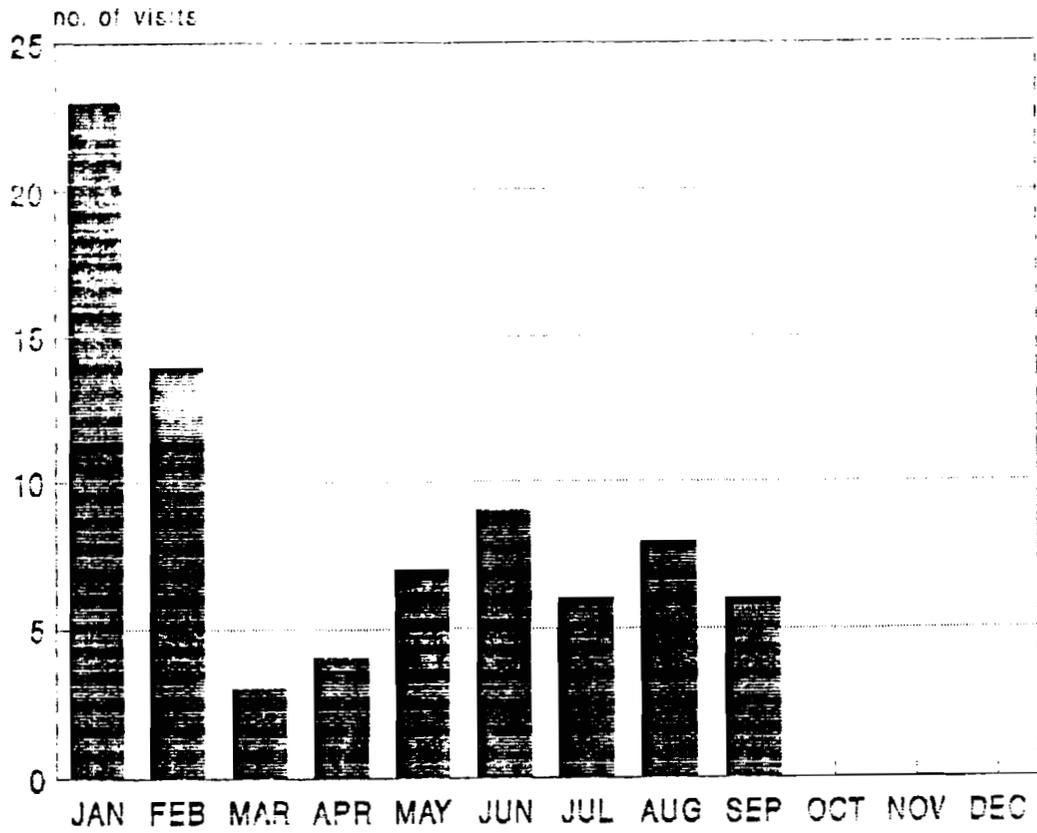
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# CLINIC SUPERVISION VISITS - 1990 MANZINI REGION



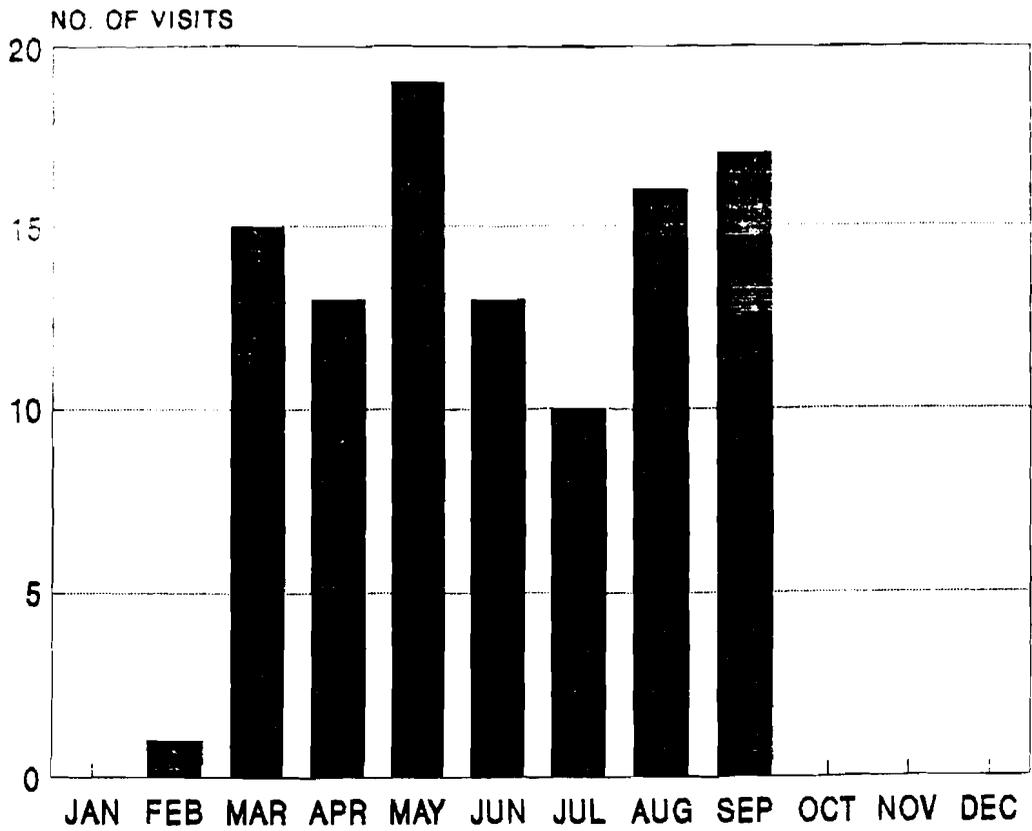
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# CLINIC SUPERVISION - 1990 SHISELWENI REGION



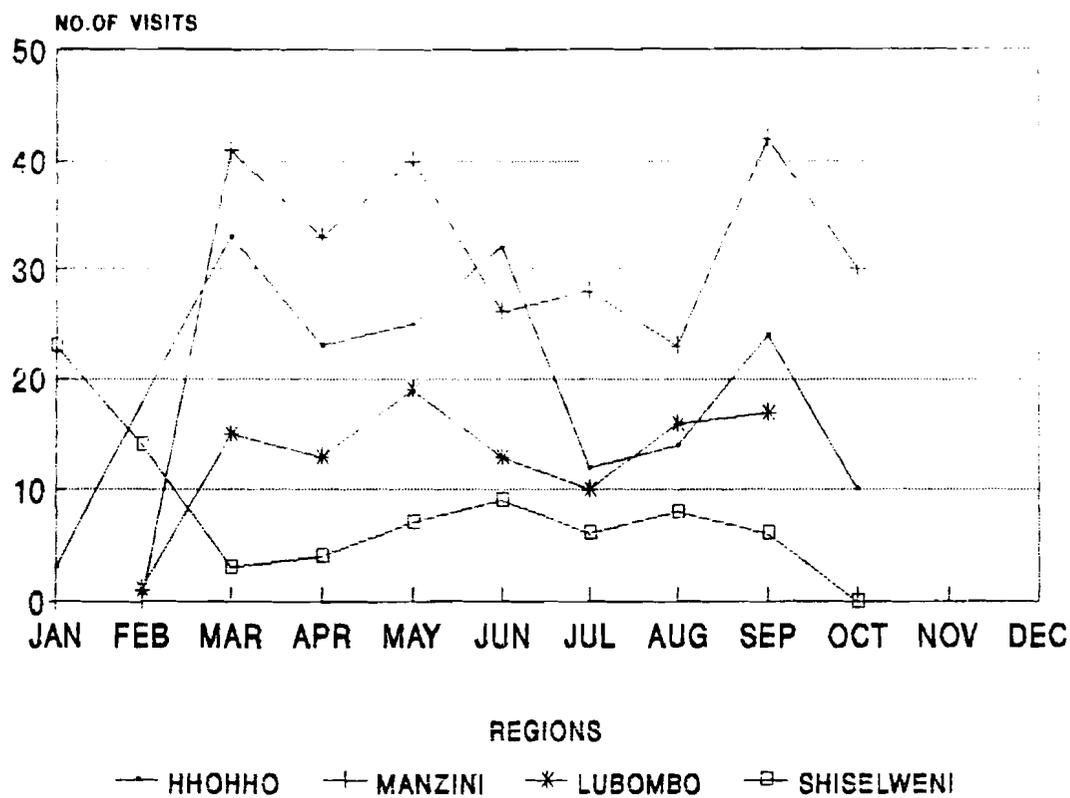
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### CLINIC SUPERVISION - 1990 LUBOMBO REGION



MOH (Stats unit)

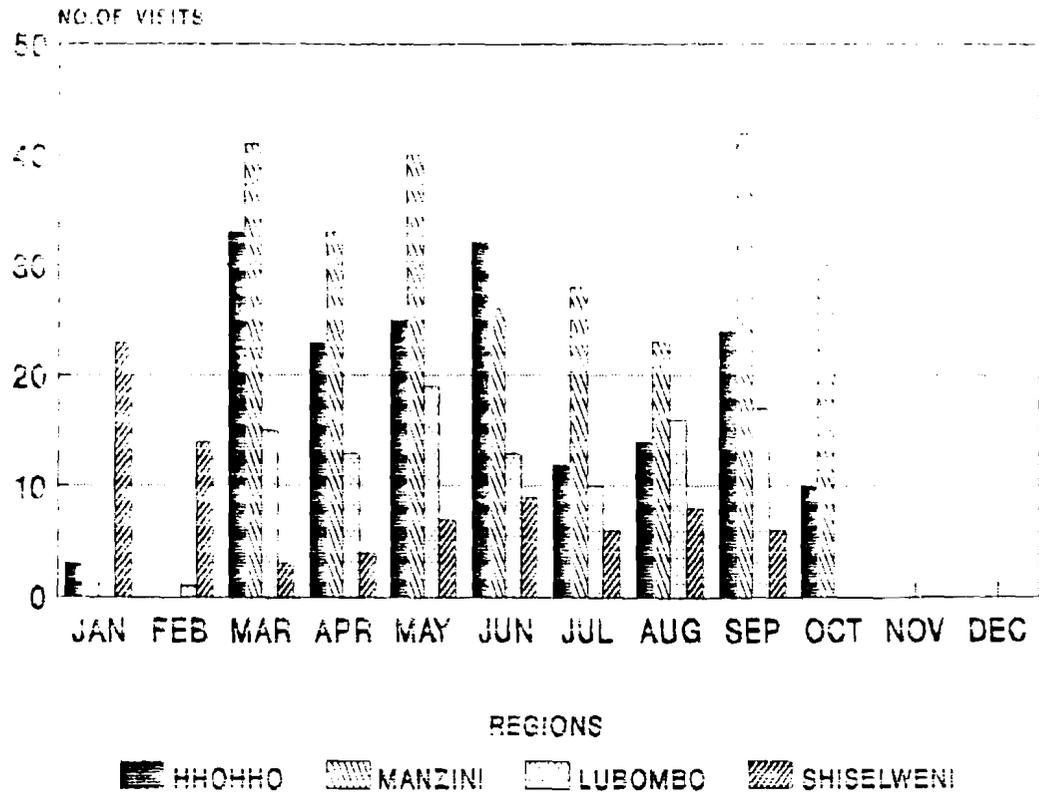
## CLINIC SUPERVISION VISITS - 1990 BY REGIONS



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## CLINIC SUPERVISION VISITS - 1990 BY REGIONS



MOR (Stats Unit)

#### 4.2.4. Supervisory Checklist

Mid-Project Recommendation: Supervisory Checklist be revised by Ministry of Health with project support.

The Clinic Supervisory Checklist started as an Action Plan at the first supervisors meeting in January 1987. It was pretested at six clinics in the Lubombo Region and updated at a June 1987 Supervisory Workshop. Based on identified shortcomings, it was again revised (January 1989) and the accompanying guidelines were developed. The tool was to be used for evaluation, training needs assessment and supervision. It was also to provide the basis for Annual General Meeting and Regional Health Management Team reports and for awarding the "Best Clinic" trophy. Additionally, it was the designated source of data for a number of Project indicators.

These numerous intended uses resulted in an eleven page tool accompanied by a nine page set of guidelines for completing the checklist. There were 24 areas with sub-areas related to: (1) Patient Care Management MCH/FP, Child Welfare (Immunization, Growth Monitoring/Nutrition) child diseases - ARI Diarrhea (ORT) and communicable disease. Repetitions under each area related to patients seen in the previous month, record-keeping, patient-retained cards and equipment/commodities; (2) Outreach/collaborative activities - home visiting, RHM supervision, health committee functioning and relationships with various specialists health care personnel; (3) clinic environment - sanitation; (4) clinic organization/management - clinic schedules, patient flow, health education and (5) clinic staff issues.

Checklist Revision Process

1. Completed checklists from Lubombo, Shiselweni Region and the Mankayane sub-region were reviewed. Discussions were held with supervisors to identify problem areas.
2. Input was obtained from matrons and other participants attending a management course at the Institute of Development Management; Clinic Supervisors; Program Coordinators; and PHC Project team members.
3. An ad hoc committee composed of three clinic supervisors and the clinic management associate drafted, then finalized the revision based on input.

The revised checklist (Appendix K) is five pages in length with an additional page for open-ended comments related to actions taken, strength and weaknesses and staff discussions. Six key indicators with sub areas address the following; Maternal Health/Family Planning; Child Welfare; Childhood Disease; Health Education/Counselling; Recording/Reporting; Inventory/Drug Management; and Inter-Intra Professional/Community Activities. The checklist has been distributed and additional copies are obtainable from the office of the Senior Public Health Matron.

Recommendation

Matrons and Supervisors periodically review and revise the checklist as indicated.

5. DEBRIEFING

Throughout the year, status reports on key clinic management activities were given at the regularly scheduled meetings of already constituted groups such as: RHMTs in Shiselweni, Hhohho and Lubombo; monthly meetings of Matrons Supervisors and Program Heads; and the Chief Nursing Officer's Quarterly National meeting with administrative nursing personnel.

Preparations for the end of project status report (debriefing) and handover activities started several months before the project completion date. A series of planning and orientation meetings were held with Sr. Harriet Kunene, Acting Matron, Hhohho, who also assumed specific tasks of Public Health Matron I since that position is vacant.

In consultation with Dr. Lahla John Ngubeni, Public Health Medical Officer, Sr. Kunene and the Clinical Management Associate planned a national debriefing meeting which was held December 3, 1990, and attended by 25 participants. (Agenda and Participant List-Appendix L). Highlights of the meeting related to the continuation of specified project activities included the following:

Sr. Hope Msibi, Clinic Supervisor, Hhohho South, and Staff Nurse Matilda Jele assumed responsibility for following through on unfinished tasks related to distribution of outreach sites furniture and feedback on revised checklist, respectively.

Robert Shongwe's report given by the Clinic Management Associate related to setting up an on-going communication mechanism between the Planning Unit, Ministry of Health, and Regional nurses on housing needs.

Matron E. Mnzebele, Manzini Region, gave a report on the eight month Management Course recently attended by matrons and its applicability to strengthening management and supervision in Swaziland.

Dr. Harriet Kunene and Hhohho North personnel used their annual work plan to illustrate how Primary Health Care Project inputs could continue to be monitor by that document.

In addition to the above national debriefing meeting, final conferences were held with Mr. Ephraim Hlophe, Undersecretary, Ministry of Health and Mr. Jay Anderson and Ms. Anita Henwood, Officer of Health/Population/Nutrition, USAID.

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# APPENDIX A

Pos ition Description  
Project Outputs

clinagnt

## POSITION DESCRIPTION

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CLINIC MANAGEMENT ADVISOR  
Swaziland Primary Health Care Project

TITLE: CLINIC MANAGEMENT ASSOCIATE

DUTY STATION: MBABANE, SWAZILAND

SUPERVISOR: CHIEF OF PARTY

DURATION: JANUARY 1 - DECEMBER 31, 1990

COUNTERPARTS: The Clinic Management Advisor is expected to work in a counterpart relationship with and through the Regional Health Administrators, designated Clinic supervisors and Public Health Matrons in all aspects of her work.

### RESPONSIBILITIES:

With counterparts where appropriate, under the supervision of the Chief of Party and technical direction of the MCH Physician the incumbent is responsible for carrying out the following activities:

1. Assist in planning, implementation and evaluation of clinic-based training together with the team's MCH Physician and Nurse Midwife. Responsibility in the training and follow-up would be for simple clinic management interventions.
2. Follow-up of clinic staff in facilities where clinic based training has taken place emphasizing clinic management interventions to assure that all trainees are followed up at appropriate intervals post training.
3. Organize logistic components of clinic-related activities including drug management, referral and transportation for lab samples, communications, clinic supervision,
4. Follow up activities at the clinic level during clinic visitations and training including support of the referral system, drug management and clinic supervision activities.
5. Follow-up of the Communications Consultancy Report to implement, if appropriate, recommendations.
6. Within the bounds of the national health education strategy work through the RHMT's to collaborate with the national Health Education Unit to define the roles and functions of the returning Regional Health Educators who are expected to carry out training of clinic nurses in health education of clients and follow up recommendations resulting from the Health Education Survey.
7. Give assistance and guidance to the Health Education consultant in developing TB, hypertension, MCH, FP health education methods.

8. Work with the Health Planning Unit and the Project's Administrative Assistant to upgrade clinic nurses houses in line with the priorities of the RHMT's.
9. Using the Supervisory Checklist, monitor home visits made by rural clinics, establishment and maintenance of Community Health Committees and the frequency of clinic supervisory visits. Data obtained from the Checklist would be used as indicators for the monitoring the PHC Project as well as be used by the MOH.

#### TEAM FUNCTIONING:

The incumbent is expected to work together with the Project's MCH Physician and the Nurse Midwife as a member of an informal team focusing on clinic-based activities. Secondly, this person is expected to coordinate her activities with the Decentralization/Transportation Associate (Al Neill) at the RHMT level.

The incumbent is expected to attend weekly team meetings and hold individual regular meetings with the COP.

#### TRAVEL:

The incumbent is expected to work at a minimum 50% of his/her time in the field outside Mbabane.

#### MISCELLANEOUS

Each team member is expected to contribute to the team's monthly and quarterly reports and administrative activities as requested by the COP, and USAID.

#### SUPERVISION

Direct overall supervision in Swaziland is carried out by the COP with technical guidance and direction given by the MCH Physician. All team members will have performance review and planning as per MSH Guidelines each six months.

# SWAZILAND PRIMARY HEALTH CARE PROJECT

Clinic Management Associate

Abstract of Project output  
Indicators - March 6, 1990

## PROJECT OUTPUTS

1. Improved Service Delivery and Outreach Approaches Developed
  - 1.a. Number of outreach sites operational.
  - 1.b.1 Clinics doing regular home visits.
  - 1.d.1. Use of manuals developed/implemented by PHCF
    - Drug Formulary.
    - Clinic Reference Manual.
    - Clinic Orientation Manual.
  - 1.d.2 Drug Management System operational.
  - 1.e Functioning community health committees.
2. Improved skills and Motivation of Health Workers, Brought about by Improved Transport and Communications and Improved Supervision and Management support
  - 2.a.5. Clinic re-organized, including privacy curtains, filing systems, patient flow measures.
  - 2.b.9. Number of new health education materials developed.
  - 2.d. Conditions of service improved
    - 2.d.1 Nurses accommodation upgraded.
    - 2.d.4 Clinic Supervisory visits addressing conditions of service.
  - 2.f. Monthly Supervisory visits.
    - 2.f.1. Use of Supervisory Checklist.

12 March 1990

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CLINIC MANAGEMENT

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

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

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

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

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

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ACT NO.	CLINIC MANAGEMENT PROGRAMME	funds (E)	1989 QRT.2	1989 QRT.3	1989 QRT.4	1990 QRT.1	1990 QRT.2	1990 QRT.3	1990 QRT.4	1991 QRT.1	1991 QRT.2	UNPAID %	EXPLANATORY NOTES
1	20 Training regional trainers in clinic-based training including development of modules for clinic management.	3,000	xxxxxxx			12A, 2B	to be implemented as part of the clinic-based training to be done in all regions starting with Shiselweni						
2	21 Provide clinic-based training to clinic nurses in basic management skills including supervision, patient flow, drug mgmt., community profiles and outreach	2,000	xxxxxxx			12A	add'l funds available (see clinic-based training)						
3	22 Upgrade clinic nurses accommodations	44,000	xxxxxxx	xxxxxxx	xxxxxxx							120	
4	23 Finalize and evaluate nursing orientation manuals and procedures	500		xxxxxxx		xxx						12C, 10	
5	24 Implementation and evaluation of: - referral system pilot - drug management program - methods used for clinic supervision	16,000		xxxxxxx			xxxxxxx		xxxxxxx			12C, 10	
6	25 Generator maintenance and repair training	4,000			xxxxxxx							12D	
7	26 Complete TOT manuals for clinic management	500		xxxxxxx								10, 10	
8	27 Expand & eval clinic supervisory checklist	932	xxxxxxx	xxxxxxx								10, 10	
9	28 Trainers manual for drug management	2000			xxxxxxx							10	
10	29 Development of nursing incentives	1000				xxxxxxx						120	

# APPENDIX B

## Outreach Sites

# SWAZILAND PRIMARY HEALTH CARE PROJECT

CLINIC MANAGEMENT ASSOCIATE

## OUTREACH SITES

### SHISELWENI REGION (11)

#### HLATIKHULU FHU

S/N Alexia Masuku

1. Quomintaba
2. Tjedze - I (Mkitsini)
3. Tjedze - II
4. Mlindazwe
5. Zindwendweni
6. Ngololweni
7. Kholwane

#### NHLANGANO FHU

S/N Muriel Tshabalala

8. Mfenyane
9. Vulamehlo
10. Othandweni
11. Dudusini

LUBOMBO REGION (30)

SITEKI FHU (7)

Sr. Elizabeth Nyoni

1. Ndumo
2. Mafubule
3. Hlane
4. Nisbulubhuku
5. Sulutane
6. Mbulweni
7. Mhlangabata

ST. PAUL'S (9)

Matron Zwane

1. St. Paul's (Classroom)
2. Nqunini "
3. Ndlalane "
4. Matsisa "
5. Enthandweni "
6. Esiweni "
7. Sitsatsaweni Church
8. Kashoba "
9. Ngcina "

SITHOBELA HEALTH CENTRE (9)

S/N Elizabeth Langwenya

1. Nkonjwa (rooms)
2. Gucuka (class)
3. Maloma (room)
4. Kukhanyeni
5. Makwekweti (school)
6. Mbosi (tree; started structure)
7. Mahhoshe (tree)
8. Mphaphati
9. Dume

ST PHILIPS (3)

Sr. Raphael Sharkey

1. Ndobandoba
2. Maloma
3. Ngudzeni

NDZEVANE REFUGEE (2)

Sr. Paulina Mdziniso

1. Mbuthu
2. Dlakadia

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HHOHO REGION (22)

SOUTH (14)

Sr. Harriet Kunene

1. Jubukweni
2. Lundzi
3. Makhwane
4. Mantabeni I
5. Mantabeni II
6. Mlindazwe
7. Siphocosini
8. Luhlendlweni
9. Bhikini
10. Melete
11. Maphalaleni
12. Steendorp
13. Kalamgabhi
14. Dlangeni

NORTH (8)

- |    |           |   |             |
|----|-----------|---|-------------|
| 1. | Mbeka     | - | Near School |
| 2. | Zandondo  | - | School      |
| 3. | Nkomazi   | - | (Gushede)   |
| 4. | Nkambeni  | - | School      |
| 5. | Ngomane   | - | School      |
| 6. | Mavula    | - | School      |
| 7. | Ludlawini |   |             |
| 8. | Mzimmene  |   |             |

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MANZINI REGION (21)

MANZINI

Sr. Prisca Khumalo

1. Mkhulamini
2. Ntabamhloshana
3. Mampembeni
4. Lesibovu
5. Mpuluzi
6. Bulunga I
7. Bulunga II
8. Mbekelweni
9. Lozitha
10. Thulwane

MANKAYANE

Sr. Dora Simelane

1. Siyendle
2. Ehahwini
3. Luzelwini
4. Mlindzini
5. Dilini
6. Mafutseni
7. Ticantfwini
8. Dzanyana
9. Gugwini
10. Lunyaweni
11. Mtini

(First 7 are pilot sites)

Total PHC Project - Assisted Sites 84

10 July '90

marg/outsits

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62'

# APPENDIX C

Lundzi Outreach Site-Speech  
and  
Newspaper Article

SPEECH - DEDICATION - LUNDZI OUTREACH SITE

Dr. Marilyn Edmondson

10th August, 1990

To: Your Royal Highness, Prince Mthembu,  
Indvuna Magagula,  
Headmaster Zwane,  
Regional Health Administrator, Miss Mbuli,  
Sr. Harriet Kunene, Acting Matron,  
Esteemed Members of the Lundzi Community  
Honoured Guests

As a representative of the Swaziland Primary Health Care Project and its Funding Organization, the United States Agency for International Development (USAID), I wish to commend the community on the completion of this outreach site

The Swaziland Primary Health Care Project, in cooperation with the government of the Kingdom of Swaziland, through the Ministry of Health, is committed to strengthening the delivery of Primary Health Care in Rural Areas. One of the strategies to accomplish this goal, is the provision of accessible, preventive health services by assisting communities to construct outreach sites. In support of this essential component of Primary Health Care, the Primary Health Care Project provides basic furniture and limited materials for upgrading or completing structures. To date, 75 sites throughout the country are receiving support at a total cost of approximately E50,000. The construction of outreach sites is a self-help, community-initiated activity with guidance being given by nursing personnel in the regions.

The 1983, National Health Policy of Swaziland states that improving health status of people requires a partnership between government and community. The community is not only the recipient of health care, but shares in the responsibility for developing health services. Community Participation is therefore an essential element in achieving the social goal of "Health for All by the year 2000". The Lundzi community serves as a model of what a highly motivated community can achieve with limited financial support from government and international donors. My task is to present to the community, the furniture for the outreach site and share in the celebration of this important occasion. The sum of E750 was also contributed.

To assist with bulding materials USAID/Swaziland and Primary Health Care Project encourage your strong, well functioning health committee to continue its active role in assisting His Majesty's Government, through the Ministry of Health, to provide basic health care to all.

My God bless your efforts and give you strength to continue the upgrading of your community.

Siswati Interpreter  
Mr. W.M. Jele

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The Times of Swaziland

Thursday, August 16, 1990

## Communities must also take part in health projects

BY MHLENGI  
MBATHA

PRIMARY health care educator and USAID deputy director in Swaziland, Dr Marilyn Edmondson has told the Lundzi community they are not only recipients of health, but are also expected to share in the responsibility for its improvement.

Speaking when she presented furniture to the Lundzi Clinic recently, Dr Edmondson told the community it is for this reason that community participation in the improvement of health services is deemed an important element in attaining the social goal of "Health For All By The Year 2000."

"The Lundzi community serves as a model of what a highly motivated community can attain with meagre financial support from the government and donors," Dr Edmondson said.

The Lundzi community built the clinic themselves. The furniture was donated by the Primary Health Care Project in collaboration with its funding organisation, the United States Agency for International Development (USAID).

Dr Edmondson said the 1983 National Health Policy of

Swaziland stipulates that the improvement of the health status of the nation calls for a partnership between government and communities, a step the Lundzi community has taken by building itself a health outreach structure.

"The Swaziland Primary Health Care Project, in cooperation with the government of Swaziland through the Health Ministry, is committed to enhancing the discharging of primary health care in rural areas.

"A stratagem in achieving this goal is the provision of accessibility and preventive health services by assisting communities to construct outreach sites. To support this component of importance to the Primary Health Care (PHC), the PHC project makes provisions of basic furniture and limited materials for upgrading or completing structures.

"To date, there are 75 sites throughout the country receiving support at a total cost of approximately E50 000. The construction of outreach sites is a self-help, community initiated programme and under strict guidance of nursing personnel in the region."

# APPENDIX D

## Survey Questionnaire

SWAZILAND PRIMARY HEALTH CARE PROJEC

CLINIC NAME: \_\_\_\_\_

1. Outreach Site

Number \_\_\_\_\_  
Name: \_\_\_\_\_

Structures built \_\_\_\_\_

Furniture \_\_\_\_\_

2. Home Visits

Frequency (How often) by:

Nurse: \_\_\_\_\_

Nursing Assistant: \_\_\_\_\_

Is there a clinic record of home visits?

[YES] ----- [NO] -----

If the clinic has not made home visits, state the reason(s) WHY  
(Example: No transportation, clinic too busy, etc.)

3. Manuals

Are there copies of:

	<u>Yes</u>	<u>No</u>	<u>How Many?</u>
a. Drug Formulary Manual			
b. Clinic Reference Manual			
c. Clinic Orientation Manual			

Frequency of use of each Manual:

	<u>Frequently</u>	<u>Infrequently</u>
a. Drug Formulary Manual		
b. Clinic Reference Manual		
c. Clinic Orientation Manual		

4. List the Clinic Nurses accommodations (name of site) in most need of repair.

Make a list of the basic repairs that would upgrade the accommodations

5. Supervisor's Checklist

Copy of checklist in clinic? [YES] ----- [NO] -----

How often did the supervisor visit you clinic in 1989? .....,  
Number of visits in 1990 .....

Appendix

SWAZILAND PRIMARY HEALTH CARE PROJECT

Home Visits - Lubombo Region

M. Edmondson

March 19, 1990

Clinics Making Home Visits (Clinic Staff)

Clinic	Frequency (weekly)			Clinic Record	
	Once	Twice	(Three times)	Yes	No
1. Lomahasha		x			x
2. Mpaka Railway	x			x	
3. Ndzevane	x			x	
4. Siteki Nazarene	x			x	
5. Siteki PHU	x			x	
6. Siphofaneni	x			x	
7. St. Philips	x			x	
8. Tambuti		x			x
9. Simunye			x	x	
10. Mpolonjeni			Not stated	Not stated	
11. Tambankulu					
12. Bholi					
13. Ubombo Ranches					

Clinics Not Making Home Visits

1. Tikhuba
2. Tshaneni Health Centre
3. Mhlume
4. Mpaka Refugee
5. Manyeveni
6. Shewula
7. Sigcaweni
8. Sithobela Health Centre

The above nine clinics stated reasons for not making home visits as either too busy or shortage of staff.

9. Ebenezer
10. Gilgal
11. Good Shepherd Hospital
12. Ikhwezi Joy
13. Langa Bricks
14. Lubuli
15. Sinceni
16. Vuvulane

\* Follow-up:

Additions: Making visits - Bholi and Ubombo Ranches, thus 45% (13 of 29) of clinics in the Lubombo Region report making home visits.

The eight clinics numbered 9-16 did not give reasons for not making home visits.

Summary:

Thirteen of twenty - nine clinics are making home visits for a total of 45%. The other sixteen clinics (55%) do not make visits. eight of the clinics in the latter groups cited shortage of staff or too busy as reasons for not making visits. The other eight clinics did not give reasons.

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# APPENDIX E

## Clinics Making Home Visits

Appendix

Individual Clinics Making Home Visits (Total - 42)

and Number of Visits Made

January - October 1990

Hhohho

South - 6 of 8 = 75%

1. Salvation Army	65
2. Motshane	32
3. Lobamba	30
4. Sigangeni	10
5. St. Mary's	5
6. Nkaba	4

North - 4 of \*7 = 57% (data Incomplete)

1. Herefords	43
2. Ndzingeni	33
3. Mshingishingini	17
4. Horo	9

Manzini

Manzini Sub-region - 4 of 19 = 21%

1. St. Florence	37
2. Mafutseni	19
3. Bhekinkosi	18
4. Engculwini	7

Mankayane Sub-region - 8 of 11 73%

1. Gebeni	41
2. Sigcineni	33
3. Musi	20
4. Ncabaneni	20
5. Mahlangatsha	12
6. Cana	11
7. Luyengo	10
8. Mangcongco	2

Lubombo - 10 of 29 = 34%

1. St Philips	84
2. Simunye	48
3. Siteki Nazarene	34
4. Tambuti	26
5. Ngomane	16
6. Sigcaweni	9
7. Ikwezi	5
8. Shewula	4
9. Sinceni	2
10. Bholi	2

(Home visits reported by Refugee clinics where not included)

Shiselweni - 10 of 16 = 63%

1. Mashobeni	66
2. J.C.I	64
3. Our Lady of Sorrows	40
4. Lavumisa	20
5. Zombodze	15
6. Nkwene	6
7. Phunga	6
8. Mahlandle	4
9. Ntshanini	4
10. Dwaleni	2

\* Only 7 of the clinics in Hhohho North reported.

# APPENDIX F

## Active Community Health Committees

Active Clinic Health Committees

Hhohho

South - 9 of 9 = 100%

1. Sigangeni
2. Nkaba
3. Lobamba
4. Motshane
5. Ekuphileni
6. Florence (on HIS - Listed Manzini)
7. St. Mary's
8. Malandzela
9. Salvation Army

North - 7 of 9 = 78%

1. Bulandzeni
2. Herefords
3. Mangweni
4. Ntonjeni
5. Horo
6. Endzingeni
7. Balegane

Manzini

Manzini Sub-Region - 4 of 19 (Gov't, Mission, NGO's) = 21%

1. Bhekinkosi (Nazarene)
2. Mliba (Nazarene)
3. Sigcineni (Gov't)
4. Sigombeni (Red Cross)

Mankayane Sub-Region - 6 of 11 (Gov't, Mission = 55%)

1. Mahlangatsha
2. Gebeni
3. Ncabaneni
4. Musi
5. Mangcongco
6. Cana

Lubombo - 13 of 29 (Gov't, Mission, Industry) = 45%

- |                                  |              |
|----------------------------------|--------------|
| 1. Sithobeia Rural Health Centre | 11. Yuvulane |
| 2. St. Philips                   | 12. Lomasha  |
| 3. Sinceni                       | 13. Gilgal   |
| 4. Ikwezi                        |              |
| 5. Lubuli                        |              |
| 6. Mpolonjeni                    |              |
| 7. Siphofaneni                   |              |
| 8. Shewula Nazarene              |              |
| 9. Bholi                         |              |
| 10. Tabankulu                    |              |

Shiselweni - 8 of 16 = 50%

1. Gege
2. Zombodze
3. Ntshanini
4. Dwaleni
5. Matsanjani
6. J.C.I.
7. Nkwani
8. Phunga

Total Number of Clinics - 93  
Total Number with Active  
Community Health Committees - 47

Percent of Clinics  
With Active  
Committees - 51%

Summary - Active Health Committees by Region

Region

1. Hhohho

South - 9 of 9 = 100%  
North - 7 of 9 = 78%

2. Manzini

Manzini - 4 of 19 = 21%  
Mankayane - 6 of 11 = 55%

3. Lubombo

Lubombo - 13 of 29 = 45%

4. Shiselweni

Shiselweni - 8 of 16 = 50%

# APPENDIX G

## Clinic Based Training Follow-up Form

# SWAZILAND PRIMARY HEALTH CARE PROJECT

CLINIC FOLLOW-UP VISIT

- CLINIC MANAGEMENT  
ASSOCIATE

Region \_\_\_\_\_

Clinic \_\_\_\_\_

Date visited \_\_\_\_\_

Visited by \_\_\_\_\_

Clinic staff/dates \_\_\_\_\_

Attended Training \_\_\_\_\_

Post-test \_\_\_\_\_

## Follow-Up Activities

### 1. Clinic Organization

- a. Filing system
- b. Patient flow
- c. Consulting room set-up
- d. Position of refrigerator  
for vaccines
  - (1) Vaccines correctly planed
  - (2) Gas supply (cylinders)
- e. Privacy curtains

### 2. Immunization/Growth Monitoring

- a. Activities placed for avoid  
Congestion-separate sick  
from well children
- b. Immunization schedule
- c. Use of disposable/reusable syringes  
disposal methods
- d. Use of salter scale
- e. Road to health card

3. Oral Rehydration Therapy (ORT)
  - a. Corner functioning/frequency of use
  - b. Equipment maintained - table, two benches, ORT Chart, plastic cups, spoons, buckets, measuring cups.
  
4. Manuals
  - a. Drug Formulary
  - b. Clinical Reference
  - c. Clinic Orientation
  
5. Drug Management System
  
6. Community level activities
  - a. Supervision of RHMs
  - b. Home visits
  - c. Community health education
  - d. Community health committee
  
7. Supervisory Visits
  - a. Supervisory Checklist used on visits
  - b. Visits addressing conditions of service
  
8. Nurses' accommodation
  
9. Other

Comments/Actions

# APPENDIX H

Trainees  
Clinic Based Follow-up

# SWAZILAND PRIMARY HEALTH CARE PROJECT

## LUBOMBO REGION - CLINICS/TRAINEES FOLLOW-UP CLINIC MANAGEMENT ASSOCIATE

1. Siteki PHU  
Hazel Sembe  
Laurene Mlambo  
Dumisile Mavuso (relief nurse  
Tikhuba)  
Trainers  
S/N Nomsa Magagula  
S/N Thandie Ndabandaba
2. Tikhuba  
Elsie Nlabatsi - Nursing Assistant  
(S/N relief from Siteki PHU)
3. Lubuli  
Anna Dlamini  
Elizabeth Simelane
4. Gilgal  
Venancia Dlamini  
Lillian Shongwe
5. Lomahasha  
Nelisiwe Mamba  
Dudu Masilela  
Ruth Nyoni
6. St Philips  
Priscilla Gina  
Sr. Raphael Sharkey  
Janet Yeboah
7. Sithobela Health Centre  
Beauty Dlamini  
Mildred Dlamini  
Fortunate Magagula  
Netty Fakudze  
Khetsiwe Thwala  
Trainer - Thembe Dlamini  
(transferred Sinceni Clinic)

8. Siteki Nazarene

Sibongile Mdlalose  
June Stewart

9. Sinceni

Sindile Gamedze

Trainer - Thembe Dlamini  
(now Staff Nurse at clinic)

10. Vuvulane

Tobhie Mndzebele  
Phephile Nsibandze

11. Mpolonjeni

Otilia Mlotsa  
Dinah Gele

12. Siphofaneni

Veronica Vilakati  
Elizabeth Nxumalo  
Dudu Ndzimandze

13. Good Shepherd

Trainers

Sibongile Vilakati  
Maureen Mayenge  
Rose Matsenjwa (PHU)

Sr. Eunice Hlalaza  
S/N Flavia Katuramu

14. Bholi

Trainer

Happiness Maziya  
Mildred Zwane

Patricia Gina

15. Shewela Nazarene

Beauty Magagula  
Ruth Nsibandze

16. Ndzevane Refugee

Elizabeth Matsebula  
Pedro Fumo  
Lydia Gumedze  
Pauline Mdziniso

17. Ikhwezi Joy  
Gertrude Gamedze  
(S/N - working alone)
18. Manyeveni (Malindza/Mpaka Nazarene)  
Busisiwe Dlamini  
Irma Lukhele
19. Mpaka Railway  
Minah Mathabela  
Albertina Matsenjwa
20. Simunye  
Khosi Mhlonga  
Sizakele Magaguia
21. Simunye/Ngomane (separate clinic - administered by Simunye)  
Emma Nhlapho
22. Tambankulu  
Angeline Simelane  
Sr. Julia Ndlangamandla
23. Ebenezer  
Phyllis Mamba/Nursing Assistant
24. Sigcaweni  
Sellina Magagula  
Gugu Maarja
25. Ubombo Ranches  
Elizabeth Lukhele S/N  
Maggie Dlamini S/N
26. Mpaka (Malindza) Refugee  
Christine Mutube S/N  
Jenny March S/N

No Trainees

1. Mpaka Collieries (Emaswati Coal)
2. Mhlume
3. Tshaneni
4. Big Bend Sugar
5. Sitsatsaweni

Did Not Complete Training

1. S. Simelane (H.I. Bholi)
2. N. Mtsetfwa (Malaria Ass't - St. Philips)
3. James Dlamini (H.I. Malaria - Ubombo Ranches)

10 July '90

MARG/LUBREG

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Clinic Management Associate

Clinic Visits - January - December 1990

January 15

Orientation field visits - Dr. V. Joret, PHC MCH Physician.

Lubombo Region

Lubuli Clinic - Clinic based training site Good Shepherd School of Nursing - Planning for Training of Trainers.

January 18

Orientation Fields Visits - Dr V. Joret and Mrs Joyce Mtimavalye, UNFPA.

Shiselweni

Hlatikhulu PHU  
Nhlangano HC  
Zombodze - Clinic-based Training Site

January 25 -26

Hhohho South - Sister Hope Msibi, Clinic Supervisor

Nkaba  
Motshane  
Lobamba  
St. Mary's  
Salvation Army

March 27 and 29

Shiselweni - Dr. T. Braeken, PH Medical Officer

Nhlangano	Gege
Zombodze	Matsanjani
Mahlandle	Lavumisa
J.C.I.	Hluti

August 7 Sister E. Nyoni

Joyce Mtimavalye UNFPA Project

Lubombo

Simunye  
Tshaneni  
Mhlume  
Shewula Nazarene  
Lomahasha  
Tabankulu  
Vuvulane

August 8 K. Nkabindze, Community Health Nurse Siteki PHU, J.  
Mtimavalye

Lubombo

Ubombo Ranches  
Big Bend Sugar Estate  
Bholi  
Ndzevane Refugee  
Lubuli  
Sithobela  
Siphofaneni  
Gilgal

September 5 - Dr. V. Joret

Hhohho North

Emkhuzweni HC - Reconnaissance visit - Hhohho Region clinic based training site.

September 19-21 Sister Dora Simelane Mrs Joyce Mtimavalye, UNFPA Project

Manzini Region - Mankayane

Mahlangatsha Luyengo  
Bethlehem Ncabaneni  
Musi Gebeni - Proposed site for Manzini clinic based training  
Cana Sigcineni  
Dwalile Mankayane PHU  
Usutu Pulp-Mill HC Mankayane Hospital - OPD, ORT and Maternity Unit

APRIL - JUNE 1990

QUARTERLY REPORT NO. 17.

9 April Accompanied by Sr. Elizabeth Nyoni, Siteki PHU

Tikhuba  
Ebenezer  
Good Shepherd  
Siteki PHU

14 and 15 May Accompanied by S/N Nomsa Magagula, Trainer, Siteki PHU.

Mpolonjeni  
Siteki Nazarene  
Good Shepherd (visited 14 & 15)  
Tikhuba  
Ebenezer

12 - 15 June Accompanied by S/N Elizabeth Langwenya, Sithobela Health Centre.

Bholi  
St. Philips  
Ikhwezi Joy  
Siphofaneni  
Sithobela Health Centre  
Sinceni  
Gilgal

19 - 21 June Accompanied by Mr. A. Nyoni, PHC Project.

Tabankulu  
Shewula Nazarene  
Lomasha  
Ubombo Ranches  
Mpaka Railway  
Malindza (Mpaka) Refugee  
Simunye/Ngomane  
Vuvulane  
Ndzevane Refugee  
Sigcaweni  
Manyeveni

2 clinics, Tikhuba and Ebenezer - visited twice  
Good Shepherd - visited three  
times

Visited, but no trainees

Mpaka Collieries (Emaswati Coal)  
Tshaneni  
Mhlume  
Big Bend Sugar

11 July '90  
17rptref

# APPENDIX I

## Nurses Accommodations Upgraded

UPGRADING NURSES' ACCOMMODATIONS - PHC PROJECT

\*Shiselweni (11)

Lubombo (11)

1. Ka-Phunga
2. Nkwene
3. Lavumisa
4. Hluti
5. Matsamoni
6. Mhlosheni
7. Nhlelweni
8. Mashobeni
9. Mahlandla
10. Zombodze

1. Tikhuba
2. Vuvulane
3. Ebenezer 3 completed
4. Siteki Nazarene
5. Sigcaweni
6. Shewula
7. Manyeveni
8. Siteki, PHU
9. Sinceni
10. Bholi
11. Lubuli

Rhobhe (14)  
South (8)

1. Sigangeni
2. Nkaba
3. Lobamba
4. Malandela (Under Manzini)
5. Motshane

Manzini (16)  
King Sobhuza II PHU (4)  
3 completed

- |                                 |                    |
|---------------------------------|--------------------|
| Mission (2)                     | Ngoalweni          |
| Mliba                           | Ngouluni           |
| Mafutseni                       |                    |
| <u>Mankayane Sub-Region</u> (4) |                    |
| **1. Dwalile                    | 5. Musi            |
| 2. Mahlangatsha                 | 6. Luyengo         |
| 3. Mangcongco                   | 7. Gebeni          |
| 4. Sigcineni                    | 8. Ncabaneni       |
|                                 | <u>8 completed</u> |

North (9)

- |                    |                    |
|--------------------|--------------------|
| 1. Mangweni        | 7. Mshingishingini |
| 2. Hore            | 8. Endzingeni      |
| 3. Entfonjeni      | 9. Balegane        |
| 4. Herefords       |                    |
| 5. Bulandzeni      | <u>1 completed</u> |
| 6. House No. 12151 |                    |

\*\* Nurse & Nursing Assistant expected to share very small house. Health inspector's house currently being used by nurse, but must vacate soon.

Total accommodations to be upgraded - 52 - 30 completed

\* Shiselweni - Work coordinated in the region with PWD

Gege - New house but - Problem with water - Collecting water from river - No water tank. (4 staff houses).

Jericho - New house - Electricity connected to one house not the other.

Mashobeni } Nurses houses not connected to generator. Electricity  
Ka-Phunga } Board application submitted by Kara Hanson (Reported  
Hluti } 9th March 1990). Education to share costs - schools  
Gege } near could share same line.

# APPENDIX J

## Supervisory Visits

Appendix

Individual Clinic Supervisory Visits

January - October 1990

<u>Region</u>	<u>Clinic (16)</u>	<u>No. of Visits</u>
Hhohho	Lobamba	29 (Visited Monthly)
	Sigangeni	27 (Visited Monthly)
	Bulandzeni	15
	Nkaba	15
	Ndzingeni	15
	Horo	11
	Herefords	11
	Mangweni	9
	Motshane	8
	Mshingishingini	7
	Salvation Army	6
	Ekupheleni	5
	Ndvwangeni	5
	Malandzela	4
	Mbabane Family Life	3
	St. Mary's	2

\*\* 172

\* Individual data sheets not available for all Clinics in Hhohho Region.

\*\* Summary Report list - 176 visits.

Individual Clinic Supervisory Visits

<u>Region</u>	<u>Sub-region (16)</u>	<u>No. of Visits</u>
<u>Manzini</u>	Engculwini	21 (Visited Monthly)
	Bhekinkosi	16
	Mafutseni	14
	Mliba	13
	Malkerns Family Life	10
	Family Life Association	10
	Ekudzeni	7
	Swazican	6
	St. Juliana's	5
	St. Florence	4
	Kwaluseni	4
	Emoyeni	3
	Kabudla	3
	Sicelwini	2
	Swaziland Railway	2
	St. Theresa's	1
	Nonhlanhla	1
Esigombeni	1	
	<b>Sub-total</b>	123 Manzini 124 Mankayane * 247

Summary Report Lists 263

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Individual Clinic Supervisory Visits

<u>Manzini</u> <u>Mankayane</u>	<u>Sub-region (10)</u>	<u>No. of Visits</u>
	Luyengo	30 (Visited Monthly)
	Musi	26 (Visited Monthly)
	Gebeni	16
	Ncabaneni	13
	Mangcongco	9
	Cana	8
	Sigcineni	8
	Mahlangatsha	6
	Dwalile	5
	Bethlehem	3
		+ 124

Individual Clinic Supervisory Visits

For 10 month Period

<u>Region</u>	<u>Clinic (CR)</u>	<u>No. of Visits</u>
Lubombo	Malindza Manyeveni	16
	Sinceni	9
	Gilgal	9
	Ubombo Ranches	7
	Lomahasha	7
	Siteki Nazarene	6
	Bholi	6
	Mpolonjeni	6
	Vuvulane	6
	Lubuli	5
	Ikwezi	4
	Simunye	4
	Shewula	4
	Tikhuba	3
	Malindza Refugee	3
	Ndzevane Refugee	1
	Siphofaneni	1
	Tambutu	1
	Ngomane	1
	0	*99
	St. Philips	
	Ebenezer	
	Sithathaweni	* Summary Sheet 104
	Mpaka Colliers	
	Tambankulu	
	Mill Clinic	
	Mhlume	
	Mananga College	
	Dr. Martin's	
	Flame	

Individual Clinic Supervisory Visits

January - October 1990

<u>Region</u>	<u>Clinic (It)</u>	<u>No. of Visits</u>
<u>Shiselweni</u>	Hluti	11
	Zombodze	1
	Mashobeni	0
	Matsanjani	7
	Lavumisa	7
	Mhlosheni	5
	Bethany	4
	Our Lady of Sorrows	4
	Nkwene	4
	Gege	4
	Ntshanini	3
	Phunga	3
	Mahlandle	3
	J.C.I.	2
	Dwaleni	1
	Nhletsheni	1

\*77

\* Summary Sheet = \*80

# APPENDIX K

## Supervisory Checklist

SWAZILAND

SUPERVISORS CHECKLIST FOR CLINICS

REGION ..... CLINIC: ..... CLINIC CODE: ..... NO.: .....

NURSE-IN-CHARGE: ..... SUPERVISOR: ..... RATING SCALE

1. Excellent all items present
2. Satisfactory - absence of item
3. Needs Improvement - More than 1 area unsatisfactory - Needs Improvement
4. N/A Not Applicable

AREAS	DATE		DATE		DATE	
	RATING	REMARKS/ACTION	RATING	REMARKS/ACTION	RATING	REMARKS/ACTION
1. PATIENT CARE MANAGEMENT ===== Maternal Health/Family Planning (MH/FP) -----						
1.1 Complete Medical and obstetric and/or FP history and physical examination						
1.2 Risk identification and referral						
1.3 Tetanus Toxoid status						
1.4 Sexually transmitted Disease (STD) screening/protocol						
1.5 Neonatal immunization						
1.6 Relevant FP interview examination, counselling						
1.7 Annual PAP SMEAR						
1.8 Required data correctly entered on antenatal, delivery and FP Cards/registers						
2. Child Welfare ===== Immunization -----						
2.1 Adequate supply of vaccines/dilutents						
2.2 Current immunization schedule						
2.3 Sterile syringe/needle for each injection						
2.4 Proper injection technique						

AT

AREAS	RATING	DATE	RATING	DATE	RATING	DATE
		REMARKS/ACTION		REMARKS/ACTION		REMARKS/ACTION
2.5 Operation/maintenance of Cold Chain 2.5.1 Temperature 2.5.2 Vaccine Placement/rotation 2.6 Prompt diagnosis, tracing and reporting of communicable disease outbreaks. Growth Monitoring/Nutrition ----- 2.7 Proper weighing equipment, procedure and plotting. 2.8 Interpreting growth chart to Caregivers 2.9 Diagnosis and nutrition counselling for growth faltering 2.10 Breast feeding promotion 2.11 Storage/distribution of World Food Supply Childhood Diseases ----- 2.12 Dehydration assessment and Oral Rehydration Therapy (ORT) for children with diarrhea						

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BEST AVAILABLE COPY

AREAS	RATING	DATE REMARKS/ACTION	RATING	DATE REMARKS/ACTION	RATING	DATE REMARKS/ACTION
2.13 ORT Corner functional 2.14 Home use of ORS/SSS demonstrated to Caregiver 2.15 Diagnosis of Acute Respiratory Infections (ARI) on basis of breathing rate 2.16 Current Management protocol to treat/refer coughing children						
3. HEALTH EDUCATION/COUNSELLING =====						
3.1 Health messages and counselling intergrated in all health activities						
3.2 Individual and group health education and counselling sessions provided						
3.3 Written educational plan reflects priority topics and target groups						
3.4 Appropriate teaching strategies involve clients (songs, drama, return demonstrations)						
4. RECORDING AND REPORTING =====						
4.1 Ledgers/registers maintained						
4.2 Patient Cards contain required data						
4.2.1 Risk factors and action taken recorded in red						
4.3 Health Information System (HIS) tally sheets completed accurately and submitted on time.						
4.4 Data feedback used to improve services						
4.5 Graphs posted and up to date						
4.6 Filing System organized						

AREAS	RATING	DATE REMARKS/ACTION	RATING	DATE REMARKS/ACTION	RATING	DATE REMARKS/ACTION
5. INVENTORY/DRUG MANAGEMENT =====						
5.1 Equipment, supplies and drugs adequate to support priority services						
5.2 Timely ordering and procurement						
5.3 Inventory list available/current						
5.4 Preventive maintenance/repair of equipment						
5.5 Authorized Minimum/Maximum Stock of essential drugs						
5.6 Ordering, Storing, Dispensing and controlling drugs by established procedures						
5.7 Prescribing by national protocols						
5.8 Safety precautions - Drugs						
5.8.1 Shelved and labelled						
5.8.2 Unit doses						
5.8.3 Proper disposal of syringes needles						
5.9 Appropriate instructions/advise patients						
5.10 Follow-up on patient compliance with prescribed medication						
6. INTER-INTRA PROFESSIONAL/COMMUNITY ACTIVITIES =====						
6.1 Supervision and support of Rural Health Motivators (RHMs)						

AREAS	RATING	DATE REMARKS/ACTION	RATING	DATE REMARKS/ACTION	RATING	DATE REMARKS/ACTION
6.2 Home visits where feasible						
6.3 Functioning of community health committee						
6.4 Cooperation with Traditional Health Workers, community leaders, women's group						
6.5 Monitoring of Outreach Site activity, as applicable						
6.6 Collaboration with national programs and other sectors to address community needs						

Summary of Findings / Action Taken:

Suggestions for Improvement:

Clinic / Staff Strengths:

Other:

June 1989 - 1st Edition

Revisions: Oct-Dec 1989

October 1990 - Clinic Supervisors and  
Clinic Management Associate  
Swaziland PHC Project

Date(s) of Discussions with Staff:

# APPENDIX L

## Debriefing Agenda and Participant List

SWAZILAND PRIMARY HEALTH CARE PROJECT

NATIONAL MEETING OF PUBLIC HEALTH MATRON & SUPERVISOR HANDOVER  
ACTIVITIES OF DR MARILYN EDMONDSON CLINIC MANAGEMENT ASSOCIATE -  
PRIMARY HEALTH CARE PROJECT

DATE: Monday 3rd December, 1990  
TIME: 9:30am - 12:30pm  
VENUE: Mbabane Public Health Conference Room

AGENDA

- 9:30am                      Devotion - Sr Mabilisa
- 9:40am                      Opening Remarks - Dr. John Ngubeni, Medical Officer  
for Public Health.
- 9:50am                      Overview of major clinic management associate  
handover activities - M. Edmondson.
- 10:00-10:40am              Status Reports (tea break - 10:15)
1. Outreach sites - Sr. M. Jele
  2. Nurses accommodations - M. Edmondson and Robert  
Shongwe, Planning Unit.
  3. Supervisory checklist revision - Ad hoc  
Committee Report - Sr. H. Msibi.
  4. Follow - up of clinic based training - M.  
Edmondson and Sr. Kunene.



SWAZILAND PRIMARY HEALTH CARE PROJECT

PUBLIC HEALTH MATRONS AND SUPERVISORS MEETING - HANDOVER ACTIVITIES

Dr. M. Edmondson  
Clinic Management Associate

Name	Designation	Workplace
*****		
L. J. Ngubeni	MO. PH	Mbabane. PHU
M.V. Mabilisa	Sister	Mbabane. PHU
D.N. Simelane	N/Sister	Mankayane. PHU
M.H. Dube	Matron. SRPH	Shiselweni
Elizabeth Magagula	S/N	Public Health Hlati
Murrier Tshabalala	S/N	Nhlangano P.H. Subcentre
R.N. Mkhonta	S/N	Mbabane. PHU
G.S. Magagula	N/Sister	F. Peak. PHU
Mary Magagula	N/Sister	Hhohho North Clinics
J. Vilakati	N/Sister	Hhohho North Clinics
Thokosile Mncina	S/N	Peak PHU
Thandie Mndzebele	S/N	Mbabane. PHU
H. Msibi	S/N	Mbabane. Gov't Hospital
L.D. Dlamini	S/N	Mbabane. PHU
H. Kunene	N/Sister	Mbabane. PHU
Marilyn Edmondson	Clinic Management Associate	PHC Project
Mavis Nxumalo	S/N	Mbabane. PHU
E.T. Mndzebele	Matron. MRFH	King Sobhuza II

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Prisca S. Khumalo	Sister	King Sobhuza II
Mary L. Magwaza	Sister	King Sobhuza II
Anna Mdluli	Sister	K.F.P Hospital
Matilda Jele	S/N	Mbabane, PHU
Thandie Nxumalo	Matron LRPB	Siteki, PHU
Elizabeth Nyoni	Sister	Siteki, PHU
Mary Kroeger	M.H.F.P Midwife	PHC Project