

**PROJECT HOPE  
MATCHING GRANT EVALUATION  
SWAZILAND SITE VISIT REPORT**



*Dr. Carolyn Brye  
Dr. Martin Gorosh  
Pamela J. Putney*

May 1990

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### APPENDICES

*Acronyms*

*Swaziland Statistics*

*Documents Reviewed*

*Nursing Program Material*

*Traditional Healers Material*

## **I. ACKNOWLEDGEMENTS**

The team would like to express their appreciation to the Project HOPE team in Swaziland, Dr. Maggie Makhubu, Chief Nursing Officer, the faculties and students at the SIHS, Nazarene Nursing College, Good Shepherd Nursing School and SCOT, Mary Kroeger, Nurse Midwife/MSH PHC Project, Mr. Alan Foose, HPN/USAID and Mr. Jay Anderson, Assistant HPN/USAID, Mr. Chris Mkhonta, Principal Secretary, Mr. Ephraim Hlophe, Undersecretary, Tom Fenn, Pathfinder/FLAS Project, the Pharmacy Management Team at the MOH, the staff at THO, as well as the MSH PHC Project staff for their valuable contributions to this evaluation. The team would like to give special thanks to the local Project HOPE staff for their logistical support throughout our time in Swaziland.

## **II. EXECUTIVE SUMMARY**

The mid-term evaluation of Project HOPE matching grant activities in Swaziland notes the impressive progress that has been made in the nursing education project components at the Nazarene College of Nursing and at the Swaziland Institute of Health Sciences where new curricula have been developed and taught, counterpart faculty and the host institutions have been strengthened, and targeted numbers of graduates are being produced. At the Good Shepherd School the needs assessment for the additional training required by nursing assistants has been carried out and served the valuable purpose of clarifying and highlighting important and controversial issues regarding the training and utilization of nursing assistants in the health service delivery system of Swaziland.

Plans are being made to reinitiate the important materials management component. Much of the preliminary work in organizing an improved central drug supply operation has been consolidated. With the appointment of key new staff by the Ministry of Health, this component should now proceed with a reassessment of the current situation and a plan for the computerization of the inventory system.

The biomedical engineering program at the Swaziland College of Technology, after some delays in renovating facilities, receiving equipment, and recruiting students from other countries is prepared to start its Government Hospital and international training programs in July 1990.

Finally, the component developed to improve the practices of traditional healers, bringing them into closer collaboration with the primary health care system, has

made an impressive start and should be continued.

All of the Project HOPE matching grant program components are consistent with the policies and programs of the Ministry of Health and the USAID Mission.

The Project HOPE team, in Swaziland and at HOPE Headquarters should be commended for their dedication, commitment, and hard work in carrying out the Swaziland program.

### **III. BACKGROUND**

#### **A. EVALUATION TEAM AND METHODOLOGY**

After a three day briefing at Project HOPE Headquarters, the evaluation team, Dr. Carolyn Brye, Director of Nursing at Project HOPE and Swaziland Country Manager, Dr. Martin Gorosh, Professor of Clinical Public Health and Director of International Training Programs at the Center for Population and Family Health of Columbia University's School of Public Health, and Pamela J. Putney, a nurse-midwife/PHC expert and Senior Associate at Initiatives, Inc., travelled to Swaziland between April 27th and May 10th, 1990.

The extensive briefing documents prepared by headquarters and field staff provided a rich and valuable resource for the team. All project component sites and counterparts were visited, in addition to other collaborating institutions. Other contacts included USAID/Swaziland, the Ministry of Health, the MSH (Management Sciences for Health) Primary Health Care Project, and the Pathfinder Fund. Dr. Maggie Makhubu, Chief Nursing Officer, MOH, provided valuable background and insights into the nursing scene in Swaziland. Mr. Alan Foose, HPN/USAID Swaziland and Mr. Jay Anderson, Assistant HPN/USAID Swaziland, participated extensively in discussions with the evaluation team and in field visits to project sites.

#### **B. HISTORICAL OVERVIEW OF PROJECT HOPE INVOLVEMENT IN SWAZILAND**

In 1983, the Government of Swaziland adopted a National Health Policy which emphasized primary health care as a strategy for achieving "Health for All by the Year 2000." In collaboration with USAID/Swaziland, in 1984, the Ministry of

Health began a five year, multi-million dollar national primary health care project under the direction of MSH/Boston. A major constraint to the project's success was the fact that the majority of health professionals who staffed the health posts, health centers and hospitals (primarily nurses and nursing assistants) lacked the necessary skills to carry out their new responsibilities as providers of effective primary health care.

In response to this problem, in 1984, with assistance from USAID, the MOH established the Swazi Institute of Health Sciences and began revising the nursing curriculum at the Nazarene Nursing College, to improve the education and training of health professionals. At this time the MOH requested assistance from Project HOPE to develop and strengthen its educational programs.

Since 1984, Project HOPE's involvement in Swaziland has continued to grow. Currently, nursing programs with HOPE input are responsible for one half of the nursing training in the country. In addition to: textbook programs at the Nazarene Nursing College, the Swazi Institute of Health Sciences and the Good Shepherd Nursing School; a Pediatric Medical Technical Assistance Program at Raleigh Fitkin Memorial Hospital (1988); a Hepatitis B Vaccine Program for Health Workers (1989); and a Fracture Casting Materials Program at Mbabane Government and Raleigh Fitkin Memorial Hospitals, Project HOPE'S on-going programs have been as follows:

- 1984      ♦      General Nurse Education Program at Nazarene Nursing College
- ♦      Materials Management Program at MOH Central Stores (suspended since February 1986)
- 1986      ♦      Community Health Nursing Program at Swazi Institute of Health Sciences
- 1989      ♦      Biomedical Engineering Program at Swaziland College of Technology
- ♦      Nursing Assistant Midwifery Program at Good Shepherd Nursing School
- ♦      Traditional Healers Education Program at Traditional Healers Headquarters Siteki
- ♦      Prevention of HIV/AIDS Project

## **IV. PROJECT HOPE PROGRAMS IN SWAZILAND**

### **A. CROSS-CUTTING THEMES**

Three cross-cutting themes have been identified by the evaluation team; all of which have a direct impact on the nursing and nursing assistant programs in Swaziland. These issues also have the potential to affect the course of the other matching grant program components.

#### **1. Nursing/Tutor Shortage**

The first important theme is the critical shortage of faculty at all three nursing programs. Numerous factors contribute to this shortage, including: the Government of Swaziland practice of sending key counterparts for long periods of post-graduate training abroad (and the extent to which the recent Kellogg Foundation initiative has magnified this practice); and, the increasing migration of trained and experienced nurses to other countries in the regions where salary and benefits are often more than double the levels in Swaziland. These factors contribute to severe and often unpredictable shortages of key counterparts at critical moments in project life-cycles.

#### **2. Weak Links Between Education and Service Delivery**

The second theme concerns the weak link between education and training to service, i.e., newly educated workers or existing workers who are retrained to carry out new skills are often unable to practice in settings that are receptive to and supportive of their preparation. A broader, programmatic restatement of this theme concerns the relationship between project outputs to the needs of the Ministry of Health Primary Health Care initiative. Matching grant program components are unevenly and incompletely integrated into the health services delivery system of Swaziland.

### **3. Management and Evaluation**

The third theme is management and evaluation. Matching grant project components do not have the types of management systems to plan, schedule, coordinate, and monitor activities. Further, as the three nursing components and the traditional healers initiative move into their next phases, plans are needed for their systematic evaluation. Appropriate qualitative and quantitative evaluation tools must be developed and pretested to assure that outcome and impact evaluation proceeds smoothly and produces results that will be useful for program improvement.

These themes, singly or in combination, have produced an environment of uncertainty in the Nazarene, SIHS, and Good Shepherd educational and training programs. The traditional healers component, while demonstrating extensive coordination with other programs, requires new management and evaluation approaches. The materials management component, when reinitiated, must carefully develop systems that build on the considerable progress made in drug supply and logistics in the Primary Health Care Program. The BME component must plan astutely to avoid the sudden shortages of human resources that have affected the nursing components.

#### **B. THE PROGRAMS**

##### **1. Nazarene Nursing College**

###### *a. Background*

The Nazarene Nursing College is located at the Raleigh Fitkin Memorial Hospital, a 292 bed facility built by Nazarene Missionaries in the 1920's. Initially, the hospital was funded and administered solely by the missionaries, however, gradually the financial responsibility has shifted to the MOH. At the present time, 80% of the current budget is underwritten by the Swazi government.

Although the College has a separate budget, the administrative control remains with the hospital administration, with the nursing faculty being responsible to the Matron (who is under the direction of the Medical Superintendent). This administrative structure has led to conflicts between nursing education and the realities of managing busy hospital wards, where the occupancy rate averages 86% and an acute shortage of staff exists (currently 15-20 vacancies out of a

staff of 76). Nursing tutors are often relieved of their educational duties to act as staff nurses, leading to discontinuity in training and creating an atmosphere of uncertainty.

Prior to the creation of the SIHS in 1980, the College was the sole training program for nurses in the country. The basic diploma nursing curriculum requires three years to complete, with an option to continue in a post-graduate, one-year midwifery course. Students are admitted annually in June. Two classes have graduated under the new Project HOPE curriculum (total 27 students). Full tuition, room and board, books, uniforms and a E300 stipend (approximately \$120 dollars US) are provided by the Government through the Ministry of Education to all nursing students in Swaziland. At Nazarene, students are expected to carry a significant proportion of the workload on the hospital wards and despite efforts to reduce their ward responsibilities for educational time, they continue to constitute the main work force at the hospital.

The average number of full-time faculty available to cover the general nursing and midwifery program is ten, three of which are currently expatriate. The full number of faculty is fourteen to seventeen, however at any given time an average of five are absent due to educational leave abroad, home leave (expatriate staff) and retirements (mandatory at age fifty-five).

Project HOPE's involvement at the College began in 1984, with a request from the MOH to improve the basic nursing curriculum, with an emphasis on strategies for upgrading the community health and MCH content areas. In addition, the midwifery curriculum was revised with assistance from Project HOPE. In 1985 there were three full-time HOPE nurses assigned to the Nazarene program. By 1989 this number was reduced to one, as planned.

#### *b. Program Objectives*

The overall objective of the Project HOPE program at the Nazarene is to improve the quality of the basic nursing and midwifery education in order to prepare diploma level nurses to meet the primary health care needs of families in Swaziland, with a focus on MCH interventions where the majority of mortality and morbidity occurs.

*The major objectives are:*

1. Revise the basic nursing curriculum.

2. Revise the midwifery curriculum.
3. Provide assistance to the faculty in developing additional skills in curriculum development, planning, implementation and evaluation.
4. Incorporate current innovative teaching methodologies into the curricula to be used by the faculty to facilitate student learning.
5. Strengthen supervision and evaluation of the students in the clinical areas.
6. Strengthen the faculty's ability to write multiple choice questions and to set and grade student examinations.
7. Provide assistance to the College in developing improved administration and management skills.
8. Collaborate with the Swazi Institute of Health Sciences, the MOH and Nazarene College in developing in-service workshops and training programs for faculty and staff nurses.

*c. Inputs and Outputs*

**Objective # 1: Revision of Nursing Curriculum**

The basic curriculum has been revised and developed in stages, with each section under going evaluation and modification following implementation. The complete curriculum is fully utilized by the faculty and two groups of graduates have finished the new program, which emphasizes primary health care concepts.

*Some outstanding accomplishments within this objective are:*

1. The incorporation of physical, family and community assessment skills into the basic curriculum. The emphasis in training has shifted from "curative" to a more preventive and promotive primary health care approach to patient care in all settings (hospital, health center, health post and community).
2. The new curriculum demands more active involvement in the

learning process on the part of the students and encourages them to think more creatively and independently.

3. In 1986, WHO sponsored a Primary Health Care workshop for tutors from Lesotho, Botswana and Swaziland with the active participation of Project HOPE staff.

#### Objective # 2: Revise the Midwifery Curriculum

The midwifery curriculum has been completed, revised, printed and in use since 1988.

#### Objective # 3: Increase Faculty Skills in Curriculum Development, Planning, Implementation and Evaluation

A number of activities have been carried out in this area and faculty skills are continuing to be developed to meet this objective.

#### *Achievements in this area include:*

1. In 1985 a three day orientation program which included: teaching methods, curriculum, philosophy, Swazi customs and the use of audio-visual aids, was held for new tutors.
2. Between 1985 and 1986, individual faculty members assumed responsibility for regular in-service education programs which included sessions on: curriculum development, the nursing process, innovative teaching methodologies and the use of audio-visual materials.
3. HOPE staff have worked with the faculty on an on-going basis to develop faculty skills in developing course objectives and content, including evaluation techniques.
4. A student course evaluation tool was developed and used by the faculty in 1989.

#### Objective #4: Incorporation of Up-dated Teaching Methodologies into the Curricula by Faculty

Traditionally, classes have been conducted using the lecture format, with the students required to spend hours copying notes from transparencies. Teaching materials (including audio-visuals) were inadequate.

*Accomplishments towards this objective include:*

1. Teaching methodologies such as: role playing, team teaching, case presentation, student research for seminars and field trips, have been introduced to the students and faculty.
2. A system which requires the students to identify their learning needs for revision and encourages them to assist each other in learning has been instituted.
3. Project HOPE has made extensive contributions to the College's library and teaching materials collection (including audio-visuals) for use by the faculty and students.

#### Objective # 5: Strengthening of Supervision and Evaluation of Students in the Clinical Area

This objective has been difficult to achieve due to the shortage of nursing tutors available to supervise the students on the wards and in the clinics, in addition to resistance from the staff nurses to "new" concepts in the improved curriculum. This in part has been a result of a lack of adequate in-service to familiarize the staff nurses with the new curriculum, which would allow the older nurses to incorporate these "new concepts" into their experience.

*Accomplishments toward this objective include:*

1. In 1986 and 1988, second level students were given extra days on the ward, during which time faculty provided supervision.
2. A clinical evaluation tool was developed for use by students and faculty.
3. Faculty supervise students on field visits during their community health experience.

4. Nursing care plans are required of students in all clinical areas, with the exception of mental health.
5. A skills book, requiring supervisors' signatures, to assist in the evaluation of students' ability to carry-out procedures was developed.

**Objective # 6: Strengthen Faculty Skills in Writing Multiple Choice Questions and the Setting and Grading of Examinations**

The standard testing method throughout the Southern African region continues to be essay type examinations. Efforts have been made to collaborate with the Swaziland Nurse-Educators Committee, the Swazi Institute of Health Sciences and the Nursing Council on this issue.

*Achievements towards this objective include:*

1. In 1985, a half-day workshop was held to assist Nazarene tutors with test construction.
2. Over 200 questions were collected to form a "bank" for student examinations from the tutors at Nazarene and SIHS.
3. Swazi tutors have been involved in setting internal examinations, in addition to those for the Nursing Council, the University of Swaziland and the Nursing Examination Board of Botswana, Lesotho and Swaziland. In 1990 a Swazi tutor took over responsibility for setting the community health nursing exam from a HOPE tutor.
4. Swazi tutors use check lists to assess student performance during home visits.

**Objective # 7: Improve College Administration and Management Skills**

A number of management and administrative issues at the College have been addressed with assistance from Project HOPE. However, further skill development in this area among faculty and administration is warranted.

*Accomplishments in management and administration include:*

1. The revision of student rules and regulations.
2. The institution of a number of Ad Hoc Committees, including a Library Committee and In-Service Evaluation Committee.
3. The institution of weekly faculty meetings and a Swazi faculty coordinator.
4. Affiliate Status of Nursing Programs with the University of Swaziland was accomplished and students wrote the first examinations in May of 1989.
5. Additional secretarial help was acquired for the College through the Hospital Administration.

**Objective # 8: In-Service Programs for Faculty and Staff in Collaboration with SIHS and the MOH**

The Primary Health Care Project in 1985 identified the fact that for over 17 years, no staff nurses in the hospital, health center or health post levels had received in-service education. Although emphasis in strengthening this important area needs to be continued, Project HOPE has made efforts with the faculty at the Nazarene to achieve this objective.

*Accomplishments towards achieving this objective include:*

1. A Project HOPE Nurse-Educator participated in teaching physical assessment skills to nurse-practitioners.
2. A seminar in Human Sexuality was planned and implemented in collaboration with a HOPE Nurse-Educator.
3. Workshops on the Nursing Process, Management and HIV Infections were held by an In-Service Education Committee which was formed with the assistance of HOPE staff.

*d. Observations and Findings*

In general, the Project HOPE program at the Nazarene Nursing College is functioning successfully and appears to have made the important contribution of

sensitizing tutors and students to their community and meeting community needs. HOPE staff have worked hard with both students and tutors to develop their leadership and management skills. The majority of problems still facing the program (eg; critical staff shortages) are due to factors largely outside the control of the HOPE staff.

After reviewing relevant documents and conducting interviews with College students, tutors and Administration, the following are the major observations and findings of the team regarding the Nazarene program:

1. The library/learning resource center developed by Project HOPE appears to be making a valuable contribution to the students' educational development and is utilized extensively by both students and faculty. More copies of specific basic texts have been requested (eg; Helping Health Workers Learn).
2. The revised curricula in basic nursing and midwifery are functioning with the full support of the College and the MOH. All components have been strengthened, including community health and MCH. Students interviewed reported that they felt "confident" and "well prepared" to function as staff nurses. The majority of students expressed a desire to continue their education (eg; midwifery, orthopedics, health education).
3. Clinical experiences for students have been expanded and the community health component is considered by students and faculty to be a major strength of the curriculum.
4. The newly appointed Director of the College (late 1989) needs continued support, particularly in the areas of management and administration, in order to function effectively in her new role.
5. Two faculty positions will be vacant during the coming school year due to individuals being sent abroad for further education. The two positions are in the midwifery program and as a result, in all probability, there will be no midwifery class admitted for the coming year. This has serious implications for the MOH PHC Program in Swaziland due to the shortage of midwives country-wide. The situation will be exacerbated by the fact that the Nazarene Mission plans to phase out expatriate staff by 1992, leaving further gaps in faculty positions.

6. The Kellogg Foundation has a large responsibility in creating this current crisis by providing fellowships in excess to the number of faculty positions the country ~~is~~ able to replace in order to carry-out its education programs.
7. The critical shortage of staff nurses at the hospital results in:
  - a. Inadequate clinical supervision of students and graduates.
  - b. A high frustration level among recent graduates due to their inability to function in their role of providing high quality nursing care.
  - c. Decreased job satisfaction and low staff morale.
8. Relationships between education and service provision need to be strengthened. The current lack of a "working partnership" with a common goal results in often conflicting policies and differences in the provision of patient care, among other things. At the present time, no procedure manual is being used in the hospital setting, although a draft manual is in preparation (a clinic manual was developed and implemented by the PHC Project).
9. Evaluation of the program is in the initial stages and warrants further emphasis on the part of both Project HOPE and the faculty. The program would be strengthened by an evaluation of graduate performance (including supervisors) in the clinical setting. This evaluation should be carried out through a systematic collection of relevant qualitative and quantitative data through the use of appropriate and pre-tested tools. Swazi staff must participate in this process if the evaluation findings are to be fed back into the system for program improvement.
10. There continues to be a lack of basic administrative and problem solving skills on the part of the Hospital and College Administration and faculty.
11. Faculty continue to rely predominantly on traditional teaching methodologies (lecture format) in the nursing program.

12. Students and recent graduates of the program (10 from last year's class were hired by the hospital) expressed frustration at the lack of support for using their "new skills". "We are constantly required to make short-cuts in giving patient care," was a frequent complaint. Male students expressed the need for male tutors and role models.

*e. Conclusions and Recommendations*

1. Project HOPE should continue to work with the faculty, hospital and school administration at Nazarene to develop and implement increased management, administrative and evaluation skills and tools.
2. Technical assistance should be provided by Project HOPE to finish and implement a procedures manual which would be used in hospitals country-wide. Care should be taken in the development of the manual to complement and build-on the clinic manual already in use in the health centers/health posts.
3. The Kellogg Foundation should be contacted by the MOH, USAID/Swaziland and Project HOPE to discuss strategies for addressing the current faculty shortage crisis, precipitated by the number of concurrent fellowships the Foundation is providing for long-term overseas education in nursing.
4. Project HOPE should continue to provide the support of a nurse educator at the College over the next year, with the condition that the College and the MOH develop and implement effective plans to deal with the problem of tutor/staff shortages (both long-term and short-term). The current faculty shortage has created obstacles to entering into the planned "phaseover" period, which was to focus on program evaluation, fine-tuning and curriculum review.
5. Innovative strategies, including a variety of continuing education approaches, for bridging the gap between education and service provision (eg; one-on-one clinical preceptors, educators working regularly in the hospital/clinics/community as part of their job description) need to be developed and implemented at both Nazarene and SIHS to ensure that practicing nurses on the wards and in the clinics know what the nursing students are being taught. This will increase the effectiveness of the nurses in supervising students during their clinical assignments and enable these experienced nurses to

- work more effectively with graduates of the nursing school in their new professional positions.
- 6. Approaches for recognizing the contributions made by practicing nurses to nursing education should be developed and implemented as soon as possible (eg; adjunct faculty status, award dinners, special pins for supervisors).
- 7. Program evaluation, which systematically assesses the impact of the new curriculum on the provision of patient care should be carried out on an on-going basis. Findings should then be fed back to the tutors and administration for program modification and improvement.
- 8. The incorporation of innovative teaching methodologies into the teaching of the curriculum on a daily basis should be a future priority for Project HOPE staff.
- 9. Project HOPE should provide the Nazarene library with requested texts (eg; Helping Health Workers Learn), as well as additional relevant international PHC and development publications.

## 2. Swazi Institute of Health Sciences

### a. *Background*

The SIHS was created as an educational institution for nurses, dental hygienists and health inspectors, with the facility being constructed in 1980 with funds from USAID/Swaziland. Programs at the Institute in nursing include: a three year basic diploma program, and post basic programs in midwifery, community health nursing, community mental health and a nurse-practitioner program.

Administratively, the SIHS principal is directly responsible to the UnderSecretary in the MOH. Funds for the Institution's programs come directly from the Government, in addition to various donors (eg; Project HOPE, WHO).

Project HOPE's involvement with the Institute began in 1986, with the development of the one year post graduate Community Health Nursing Program. Students are chosen from their posts as staff nurses (generally clinic/health center based) in the field throughout the country and are expected to return to their former jobs upon graduation. The first curriculum was approved in 1987 and the third class is about to graduate. The SIHS has an extensive library, which has been expanded by Project HOPE, including teaching and audio-visual materials.

### b. *Program Objectives*

In the past, nurses in Swaziland were educated in a system which emphasized "curative", rather than preventive and promotive care. These nurses were sent to work in clinics, often in remote rural areas where they received little or no supervision, without adequate public health/primary health care training to carry-out their responsibilities to the community. The overall objective of the Project HOPE SIHS Program is to assist the faculty to develop and implement a post graduate community health nursing program to prepare public health nurses to effectively meet the primary health care needs of families in Swaziland.

*The major objectives are:*

1. Complete, evaluate and revise a one year post graduate community health nursing curriculum.
2. Strengthen the clinical component of the community health nursing

- curriculum in order to meet the overall course objectives.
- 3. Upgrade and evaluate community health components in other SIHS programs.
- 4. Collaborate with faculty and the MOH to develop in-service workshops in community health nursing for faculty and staff nurses in Swaziland.
- 5. Institutionalize the community health nursing course by June 1990.

*c. Inputs and Outputs*

**Objective #1: Complete, Evaluate and Revise a One Year Post Graduate Community Health Nursing Curriculum**

The one year curriculum was developed in 1987 and approved by the Swazi Nursing Council at that time. Evaluation of the curriculum has been on-going and appropriate revisions have been made, including the consolidation of the number of courses from twenty to sixteen. A fully revised curriculum was introduced to the third class in June of 1989.

*Some outstanding accomplishments within this objective are:*

1. A comprehensive assessment regarding the requirements for a community health nursing curriculum appropriate to the identified health needs of Swaziland was carried out prior to the development of the program.
2.  An orientation and delineation of administrative and technical policy issues which impact on the community health nursing program was conducted with faculty.
3. Excellent useful and innovative teaching materials for both students and faculty were developed and adapted for use in the program curriculum. (see Appendices for selected samples of materials developed)

## **Objective # 2: Strengthen Clinical Component of the Community Health Curriculum**

The clinical component has been given full course status as part of the curriculum. Emphasis has been on developing appropriate clinical experiences for the students to "test" and internalize their new skills in primary health care. Students interviewed stated that their clinical experience was an invaluable part of the program and requested that more time for clinical practice skill development in appropriate settings be given during the course.

## **Objective # 3: Upgrade and Evaluate Community Health Components in Other SIHS Programs**

Project HOPE Nurse Educators have worked extensively to improve the community health components in the: basic nursing, nurse practitioner, dental hygienist and health inspector programs at the Institute.

*Some outstanding achievements in this area include:*

1. A Community Health Team, with members from all the programs at SIHS and the Public Health Services, was organized to identify and address key community health concepts, resource persons and materials for the inclusion of a community health component in all Institute programs.
2. Key faculty were identified and collaborated with in all the programs to implement the community health component.

## **Objective # 4: The Development of In-Service Workshops in Community Health Nursing**

The HOPE Nurse Educator has worked with the SIHS faculty and the MOH in developing in-service programs, workshops and refresher courses in community health nursing for faculty and Swazi nurses.

*Accomplishments towards this objective include:*

1. HOPE Nurse Educator provided consultation for a primary health care workshop in a continuing education project.

2. Orientation sessions were conducted with faculty on the nursing process, nursing care plans, clinical assessment and the tutor's role in evaluating students' performance.
3. The Basic Nursing Program Coordinator received on-going assistance from the HOPE Nurse Educator in: objective writing, Nursing Theory, preparation of course Philosophy and continuous assessment.

Objective # 5: Institutionalize the Community Health Nursing Program by June 1990

Progress towards this objective has been on-going. Seven out of ten courses in Term I were taught by Swazi tutors with HOPE assistance. By Term II, Swazi tutors were teaching all courses, with input from the HOPE Educator. Plans for a total phase out of Project HOPE input need to be assessed, however, in light of the recent faculty shortage precipitated by a number of tutors being sent abroad for long-term education by the Kellogg Foundation.

*d. Observations and Findings*

1. The evaluation team heard frequent moving testimony from graduates, staff nurses and other health care professionals on the positive impact the HOPE Community Health Nursing Program has had on the provision of effective primary health care in Swaziland. Comments were made regarding the development of skills in: health education, community assessment, counselling, school health, epidemiology of disease and their prevention and clinic management. A 1988 graduate of the program stated that with the skills acquired during the program she: can organize her work now, carry-out community assessment and diagnosis to mobilize the community, collaborate with the rural health motivators and traditional healers, perform more effective outreach and share her new knowledge and skills with professional colleagues.

The third and most recent graduating class made the following statements about the program when asked to write an anonymous response to the following question:

*"Upon completion of the Community Health Nursing Program, when you return to your post, what will be the first new approach you will try to implement?"*

*"I will ask permission from my Supervisor to allow me to follow-up the cases who need help at their homestead. This will enable me to involve my staff, my community, and other sectors."*

*"I will encourage my health team to do home visits. I will emphasize the importance of health education. I will encourage our health team to collaborate with other sectors. I will encourage community participation."*

*"Share my new knowledge and its importance with the nurses at my clinic, especially on attitudes towards clients, the need to identify the problems together with the people in the community and in families. Stress the importance of primary prevention with regard to personal hygiene and environmental sanitation when conducting health education sessions."*

*"I will ask permission from the Sister in charge to tell my colleagues about what I have gained in this course so that I can work hand in hand with them in away that they can understand what I will be doing. After I have gained their confidence, I will be able to implement my new skills."*

*"Have a meeting with my colleagues and tell them what I have learned and that we have to do it. Draw up a schedule for our work. Set objectives for ourselves and work according to these objectives. At the end of each week we evaluate ourselves to assess our strengths and weaknesses. Where we failed, we find other means or solutions. Evaluation is very important in whatever you do."*

*"Write down my own work schedule. Have meetings with the staff. Discuss current problems in the clinics. Find solutions and involve everyone in the programme. Educate staff about the importance of home visiting and its effects. Do home visits with the staff. Discuss factors which might contribute to some of the problems. Collaborate with other sectors."*

*"Since many nurses do not know about the meaning of Primary Health Care, I intend to explain this during meetings with them. I will involve the parents and teachers when planning school health programmes. Have monthly meetings at the clinic to evaluate our work. Encourage home visiting."*

*"To let the other members of the staff know the importance of community health nursing. To encourage others to do home visits to the nearest homesteads and the whole catchment area to carry out family assessments. Do community diagnoses thoroughly. Try to identify community development projects especially for women and make appropriate referrals. Counsel clients appropriately and try to bridge the gap between community members and nurses concerning attitudes. Try to make the services more accessible to the community through health education."*

*"Improve nursing standards by applying the new skills learned in training. Share knowledge gained at the institute with co-workers. Collaborate with other ministries in implementing the primary health care program. Identify health problems of my catchment area and manage them well. Apply nursing process to individual patients and see that objectives are met. Make all services available to*

*the community regarding time, distance, and culture."*

*"Report to my supervisors about what I benefited from the course. Change my behavior, especially when giving health education. Home visits. Manage resources so as not to be wasteful." "Collaborate with other sectors in the community. Practice primary health care and involve patients and clients. Solve problems as a team through brainstorming and develop solutions. Do observations, especially when attending community meetings, in order to be able to assess the community."*

2. The curriculum has been completed, evaluated and revised as scheduled, with further adaptations and revisions to be on-going as necessary.
3. Due to the current faculty shortage, created by the Kellogg Foundation's plan to send a number of tutors overseas for long-term training, the faculty are operating on a crisis mode. The Community Health Program may have to be suspended next year due to the faculty shortage. Three positions will be vacant, including the key position of Principal because the current Principal has been appointed acting CNO.
4. Some evaluation of the curriculum has been carried out, however a systematic evaluation of graduate performance in the field through the use of appropriate pre-tested tools needs to be conducted.
5. Adequate planning, problem solving and administrative skills among the faculty and administration do not currently exist. This merits further program inputs and emphasis.
6. The need to increase the time spent on clinical experience was a universal observation/request among the program graduates and students. This should be implemented as soon as possible.

#### **e. Conclusions and Recommendations**

1. Project HOPE should continue to provide a full-time Nurse Educator at the Institute over the next year in order for the program to continue.
2. Written agreements with the MOH and SIHS should be required to insure the rapid development of permanent solutions to the chronic

and serious faculty shortage. Innovative approaches such as: using administrative staff as part-time faculty, evening and weekend classes, re-hiring retired faculty and recruitment of outstanding recent Community Health Program graduates for faculty positions.

3. The development of increased management and administrative skills for faculty and administration at SIHS should be a priority for continued HOPE Program inputs.
4. In addition to increasing the time allocation for the clinical experience component in the program, the course should be expanded to include: occupational health, and working with the large refugee population in Swaziland. Student complaints about too much time spent in the Public Health Unit and needless repetition of basic practical skills (eg; giving injections) should be addressed.
5. A systematic evaluation of Program graduates' performance in the field should be conducted as soon as possible with full participation of the faculty in order to institutionalize/transfer evaluation skills

### 3. Good Shepherd Hospital Nursing Assistant Program

#### a. Background

The Good Shepherd Hospital is a 115 bed facility (with average of 150 deliveries per month), located in the Lubombo Region, bordering Mozambique. Its Governing Board consists of representatives of the local community, the Catholic Church, the MOH, and Good Shepherd administrative staff. The hospital is supported financially by the MOH and fees for service, in addition to other donations by church groups.

The Good Shepherd Nursing School, which has had a nursing assistant program since 1973, is an affiliate of the hospital. Initially, the program was one year, however, in 1975, the Swazi Nursing Council recommended that the program be extended to eighteen months and be modified to include increased emphasis on preventive and promotive care. In 1979, on the recommendation of the MOH, the program was expanded to twenty-four months, at which time the curriculum was again revised and standardized. Since 1989, 316 nursing assistants have graduated from the Good Shepherd Program. Currently there are three full-time and seven part-time faculty at the School.

Nursing assistants in Swaziland work in a variety of health care delivery settings, including hospitals, Public Health Units (clinics), health centers and health posts. In the rural areas, due to a shortage of registered nurses, they are often left with the sole responsibility of staffing the health centers and health posts.

The recommendation to expand the program to include midwifery training and community health skills was first proposed in 1978 by tutors and students. In 1985, a study tour of enrolled nurse midwifery programs in Kenya, Zaire and Zambia was conducted by the Principal Tutors of the Good Shepherd School and the SIHS. Following the tour, recommendations were made to the MOH to initiate a similar program in Swaziland.

Project HOPE received a request from the MOH to assist in the development and implementation of the new program and in June of 1989 a Project HOPE Nurse-Midwife Educator arrived in Swaziland to begin the initiation of the program. The projected time-frame for Project HOPE's involvement in the program was three years.

### *b. Program Objectives*

The overall objective of the program is to incorporate key primary health care and midwifery skills into the Good Shepherd Nursing Assistant Program.

*The major objectives are:*

1. Assess factors influencing the program, in addition to its requirements and needs and secure approval for the program.
2. To develop the curriculum and create an Advisory Committee to provide guidance.
3. Strengthen the midwifery and community health components of the existing nursing assistant curriculum.
4. Evaluate the curriculum.
5. Institutionalize the program by 1992.

### *c. Inputs and Outputs*

#### **Objective # 1: Assess Factors Influencing Program, Determine Requirements and Secure Program Approval**

Project HOPE's Nursing Educator conducted a needs assessment and curriculum design following HOPE's agreement to work with the Nurses Assistant program to improve the ability of nursing assistants to carry-out primary health care, community health and selected maternity care interventions. Over the past six months, the Educator's inputs have greatly facilitated efforts by the MOH and other key players (including the evaluation team) to focus on the critical issues facing the program, as well as understand a complex set of often conflicting strategies.

Part of the motivation for upgrading the capabilities of Nursing Assistants is based on the assertion that they are often faced with emergency obstetrical cases in situations where they must function without supervision. The Project HOPE assessment cast doubt on this assertion, as nearly 70% of nursing assistants are assigned to hospitals and public health clinics; settings in which they would rarely

be called upon to do unassisted deliveries. The actual percentage may be less than 70%, as nursing assistants may be assigned temporarily to sites where they may be called upon to deal with emergency situations. It is possible that the intention for the proposed upgrading was to confer additional status, rank and pay for this category of health worker.

The one year curriculum developed for the program, as well as the increased rank proposed for its graduates, created numerous points of contention and resistance involving the Swaziland Nurses Association, the Swaziland Nurse Educators' Committee, the Nursing Council, and the Ministry of Labor. From the Government's point of view, the new level of Nursing Assistant to be produced by the new training program did not exist and would have to be subject to all procedures associated with the creation of a new category of posting. The Nursing Educators' Association raised numerous questions related to credentials and qualifications for entry into the proposed new position.

An ad hoc committee of nurse educators, administrators, health service delivery providers and nursing assistants met in March of 1990 at the request of the MOH to further explore the issues and develop recommendations concerning the proposed nursing assistant program. This committee put forth a compromise it hoped would meet most objections. However, the compromise appears to further confuse the issues and create more problems than it solves in that it calls for: a two year program toward a diploma in midwifery, including completion of the first year of the basic nursing program at SIHS; in addition to the option of a one year "maternity nursing program" at the Good Shepherd School. The Nursing Council plans to issue its decision regarding the program in the near future.

Major accomplishments towards meeting this objective include:

1. A training needs assessment questionnaire was designed and implemented in collaboration with the Principal Tutor of Good Shepherd. Twenty-six rural health facilities were visited in the four regions, with one hundred and thirty Nursing Assistants interviewed.
2. Appropriate teaching materials, reference and text books to be used in the program were identified and approved for purchase with support from Project HOPE.
3. Meetings were held with various "key players" in getting approval for the program, including the Nursing Association and Nursing

Council.

**Objective #2: Develop the Curriculum and Create and Advisory Board for Guidance**

Attempts to create an Advisory Board failed due to the work demands of its members. However, a draft curriculum has been completed and submitted to the Nursing Committees for approval (pending).

\*Objectives # 3, 4 & 5 are pending the resolution of constraints identified in Objectives # 1 & 2.

**d. Observations and Findings**

1. After extensive discussion and deliberation, the evaluation team seriously questions the rationale for deciding to add a full year of midwifery preparation to Nursing Assistant training, as proposed by the Nursing Council. The team also questions the validity of a one year midwifery program which does not include extensive community health and primary health care components. Further, the team has reservations regarding the ability and desirability of Nursing Assistants completing one year of a basic nursing program. In effect, those who would go on to successfully complete the midwifery year will no longer be "Nursing Assistants," as they will have qualifications similar to nurse-midwives in Swaziland. This has merit as a career ladder, however, it goes well beyond the original intention of upgrading Nursing Assistant skills.
2. In anticipation of smooth sailing for the proposed Nursing Assistant training program, Good Shepherd cancelled its November 1989 intake of trainees, and unless a decision is forthcoming in the near future, the School faces a similar cancellation of the November 1990 intake.

**e. Conclusions and Recommendations**

1. The team recommends that Project HOPE explore the above issues

with the MOH. Until these critical issues are resolved, the midwifery component of the program should be suspended. The MOH needs to decide and put in writing: what needs are to be met by Nursing Assistants in Swaziland; what roles are they to play in the health service delivery system; what combination of long-term training and continuing education should be considered; and what new levels of status, rank and pay should be set for Nursing Assistants. When these issues are resolved and put in writing, reinitiation of the midwifery portion of the project may be considered.

2. In order to maintain continuity, the HOPE Nurse Educator should continue at Good Shepherd on a part-time basis to assist the faculty in improving the existing Nursing Assistant Program, with special emphasis on including community health, primary health care and limited birthing skills into the current curriculum. The Nurse Educator would spend the remainder of her time in supporting other HOPE nursing activities at the Nazarene College.

#### **4. Materials Management**

##### *a. Background*

Project HOPE support in pharmaceutical management began in February, 1985 and continued through February, 1986 during which time a Project HOPE Pharmacist Educator was placed at the Central Medical Stores in Matsapha. This was one year short of the projected two years of technical assistance to be provided. The goal of the program was to develop a materials management system that would provide effective inventory control; improve security and efficiency of operation; reduce procurement costs; and establish a management training program that would provide qualified personnel to make the system work. This is outlined in detail in Dr. David Kuhl's program plan of April, 1985 which was approved and signed by the Permanent Secretary of the Ministry of Health on July 1, 1985.

##### *Accomplishments included:*

1. Successful move to a new Central Medical Stores

- 2. Design and maintenance of a new manual inventory control system in anticipation of computerization
3. Improved security procedures
4. Reinitiation of the Drug Supply Action Group and National Formulary Committee
5. Expired items inventoried and removed
6. Provision of monthly reports to MOH Statistics Unit on drug expenditures
7. Reassessment of essential drugs list for clinic nurses completed

Numerous obstacles to progress, primarily of a personnel nature in the Central Medical Stores and MOH, led to considerable frustration on the part of the Project HOPE Pharmacist Educator, who elected in February 1986 not to renew his contract for a second year. During the first year, these issues were brought to the attention of the MOH by Project HOPE and USAID, but were not addressed.

*The issues included:*

1. The lack of a Chief Pharmacist since 1982 to provide effective leadership and decision-making authority
2. Insubordination on the part of the accountant and storekeepers at CMS towards their Pharmacist supervisor
3. Failure of all CMS personnel to comply with security procedures
4. Lack of telex capability for making orders

Following discussions with the MOH and USAID, Project HOPE support for pharmaceutical management was put on hold at this point, though numerous options were explored. The MOH appointed a Commission of Enquiry at the time of Minister of Health Chief Shongwe, but there was no known action taken. In the meantime, Project HOPE included pharmaceutical management in the preparation of the Matching Grant for 1987-92 during mid-1986.

Project HOPE has maintained regular contact with the MOH concerning the status of this sector and has worked together with USAID towards the resolution of the issues. In September, 1987, Project HOPE sent an external consultant, Milton Skolaut, former Chief Pharmacist at Duke University, for a two week site visit to assess the environment for HOPE's re-entry into pharmaceutical management.

*His recommendations included:*

1. The position of Chief Pharmacist, MOH, must be filled. At the time, the general impression was that there were no suitable or experienced candidates in the country.
2. That Project HOPE re-establish the program at the Central Medical Stores once this had been accomplished.
3. That the CMS was ready for and would benefit from computerization of the inventory system.
4. That a telex system needed to be installed to eliminate partial deliveries.

The report was presented to and discussed with the MOH and USAID. Numerous follow-up discussions concerning reinitiation were held with the MOH by both Project HOPE and USAID separately and together. In March, 1988, the Program Director conducted an evaluation of nursing prescribing practices in collaboration with the MOH and the PHC Project Clinic Management Advisor to assist in the development of a training program for clinic nurses. In March, 1989, Project HOPE submitted a Memorandum of Understanding to the MOH outlining the proposed steps to take for reinitiation. These steps (outlined in Attachment 2 of the Project HOPE written response to Mid-Term Evaluation Questions) called for the MOH to:

1. Appoint a Swaziland pharmacist to the position of Chief Pharmacist within the Ministry with the authority to carry out the implementation of a Nationwide Centralized Pharmaceutical and Materials Management System throughout Swaziland.
2. Assure the continuing appointment of a Pharmacist at the Central Medical Stores.

3. Identify the key counterparts with whom Project HOPE personnel will work in order to facilitate and assist with the establishment of a Nationwide Centralized Pharmaceutical and Materials Management System.
4. Secure the approval of all Swaziland officials necessary to fully support and implement a Nationwide Centralized Pharmaceutical and Materials Management System.

At the May, 1989 WHO Assembly Meeting in Geneva, the MOH and Project HOPE further discussed collaboration in the pharmaceutical sector.

#### *b. Observations and Findings*

The key finding of the evaluation team is that the conditions set forth in March 1989 have been essentially fulfilled and that a "positive environment" for reinitiation of this component has been created. The team recommends that reinitiation of the project be undertaken at once.

In February, 1990, the MOH appointed Mrs. Thulie Sibiya, Senior Pharmacist at CMS since 1987, as Chief Pharmacist in the MOH. She will move to Mbabane into new offices adjacent to the Public Health Unit and will be replaced at CMS by Ms. Emmina Madonsela, Pharmacist at Hlatikulu Government Hospital. The vacant post at the Government Hospital will be filled by a newly recruited Zambian Pharmacist who was being oriented at CMS during the period of the evaluation team's visit.

Recommendations made earlier have been implemented regarding manual inventory and purchasing systems.

Priorities have been established as follows: computerization of inventory, purchasing, distribution, and related systems at central stores and regional supply sites; development of approaches to quality control; staff training; and, revision of the Pharmacy Act of 1929.

#### *c. Conclusions and Recommendations*

The evaluation team visited the new central stores facility, observed its operations, and had lengthy discussion with the Chief Pharmacist. Based on these observations and discussions, and the high priority attached to this activity by

both USAID/Swaziland and the Ministry of Health the team recommends the following:

1. Project HOPE proceed immediately to reactivate the materials management component of the matching grant project. Project HOPE and the MOH should jointly develop a revised program plan to serve as a guide for the provision of the agreed upon assistance to be provided.
2. A critical first step in the reinitiation process is to conduct a re-assessment of the current materials management situation. The team suggests consideration of a new consultant to provide a "fresh look" at issues and problems. Moreover, to assure prompt action, the team urges Project HOPE to try to obtain consultant services from within the region. Further, the team recommends that Project HOPE, pending the outcome of the assessment, reconsider the original design which called for a long-term resident expatriate advisor. An effective alternative, given the different skills required to meet the materials management priorities, would be to utilize a planned and coordinated sequence of short-term specialist consultants (again, focussing on regionally available experts).
3. The team strongly recommends close collaboration and coordination with the MSH Primary Health Care Project in the development of the central materials management operation. The Primary Health Care Project has made important contributions to drug supply and management at the clinic level in all regions of the country and it is imperative that any new central systems are consistent with systems already in place in the field and draw on the extensive and successful experience of the Primary Health Care Project.
4. When the materials management component makes plans for the training priority, the team recommends close collaboration with MSH. MSH is highly regarded for its work in Drug Supply Management and Training. Their courses offered in Boston should be considered for key personnel. Alternatively, a cost-effective possibility would be to engage MSH to develop a customized in-country training program that would involve the entire Swaziland materials management team, including Chief and Assistant Chief Pharmacists and Central and Regional staff. Training of this type, in the pharmaceutical area (as well as in other sectors) is likely to be "certificate" training. It is important to obtain concurrence from Government education and

training authorities for recognition of certificate training for career development purposes.

5. The proposed assessment called for above should address several issues related to the quality control component of the materials management program. The most important issue is the question of the need for an independent quality control laboratory in Swaziland. With less than 150 items on the current list of drugs, the cost-effectiveness of a laboratory in Swaziland must be compared with the use of regional laboratories established by the World Health Organization or private sector laboratories offering quality control services.

## 5. Traditional Healer Training

### a. Background

Support for traditional healer training began in April 1989 in response to a request from the Traditional Healers Organization (THO) in November, 1988. Subsequently, Project HOPE and THO, in collaboration with the MOH, NGOs, and the community, conducted seven training workshops between April to December, 1989 for more than 600 traditional healer participants.

The majority of Swazis utilize the services of the estimated 8000 traditional healers for the prevention and treatment of illnesses and for consultation concerning domestic and personal issues. Healers are readily accessible and available to both rural and urban populations. There is approximately 1 traditional healer for every 100 Swazis compared to a physician/population ratio of 1:10,000. The healer is able to explain an illness, event, or other issue in a manner that is culturally relevant to the Swazi traditional belief system. The population using traditional health care crosses all socioeconomic lines in the country. In addition to having credibility with the Swazi, through which positive health interventions could potentially be channeled, traditional healers also engage in numerous harmful practices which contribute to infant and child morbidity and mortality.

Though the MOH lacks a formal policy concerning collaboration with the traditional healers, they were supportive of these training sessions and peripheral workers participated fully in spite of numerous other demands on their time. The last formal training for the healers had been during 1984 under the CCCD project and the Health Education Unit, MOH with respect to control of diarrheal diseases.

The traditional healer is included as a key figure in USAID/Swaziland's health program strategy statement for 1990 to 1995.

Numerous organizations participated in conduct of this project, including: Ministry of Health, Coordinating Assembly of NGOs, Health Education Unit, Raleigh Fitkin Memorial Hospital, Control of Diarrheal Diseases Program, Nazarene Nursing College, EPI, Emkhuzweni Health Center, Health Inspectorate, Good Shepherd Hospital, AIDS Control Program, Family Life Association of Swaziland, Public Health Units, Ministry of Agriculture, Regional Health Management Teams, Ministry of Justice, Speech and Hearing Services, Judicial Commissioner, Central Medical Stores, Members of Parliament, Manzini Town Council, Tinkhundla.

Project HOPE and THO collaborated in contacting the appropriate institution or organization for planning the specific activity under the workshop agenda. Opening speeches were presented on behalf of the Minister of Health by the TB Control Officer, on behalf of the Minister of Agriculture by the Principal Secretary, and by the Minister of Justice. The protocol used was for THO to make the initial contact to the MOH Regional Health Management Teams (RHMT, the decentralized decision-making body at the regional level for health) requesting their participation followed by support to facilitators from Project HOPE in terms of preparation of presentations, logistics, and educational materials and equipment. Working through the RHMTs proved to be an effective approach, though regions were at different stages of development in the decentralization process. THO spent considerable time with the process of notification of local leadership and sending out messengers to notify the appropriate traditional healers.

### *b. Program Objectives*

THO requested training of traditional healers in the following areas and Project HOPE had the following objectives, which are consistent with MOH policy, for providing this support:

#### **PRIMARY HEALTH CARE**

##### *Objectives*

1. To educate healers on the components of the MOH strategy
2. To examine ways in which the healers can be supportive of the MOH strategy

#### **DIARRHEAL DISEASES, CONSTRUCTION, REFUSE PITS**

##### *Objectives*

1. Practice prevention in terms of latrine construction, refuse pits and hand washing
2. Administration of ORT (SSS, home fluids, continued feeding)
3. Referral of severe cases
4. Reduction of harmful traditional practices

#### **RESPIRATORY INFECTIONS**

##### *Objectives*

1. Check immunization cards/refer
2. Home management of mild cases

3. Referral of significant ARI

## **IMMUNIZATIONS**

### *Objectives*

1. Check immunization cards/refer
2. Know the immunizable diseases

## **NUTRITION**

### *Objectives*

1. Check growth charts
2. Be able to identify a good, very good and dangerous growth curve/refer
3. Promote breastfeeding and sound infant feeding practices

## **STD/AIDS**

### *Objectives*

1. Identify STDs and refer
2. Understand HIV transmission
3. Understand prevention of HIV transmission
4. Know how to use a condom

## **MODERN MEDICINE**

### *Objectives*

1. Understand how modern drugs are made
2. Discourage use of modern drugs by traditional healers

## **MODERN CLINIC**

### *Objectives*

1. To know the services that are available at the various levels of health facilities
2. Promote referral of patients to the clinic/hospital

In addition, THO made regular presentations to participants with the following implicit objectives:

## **THO**

### *Objectives*

1. To explain the organizational structure
2. To promote membership and registration
3. To recruit Traditional Healer Promoters of THO
4. To introduce THO Field Officers

## TRADITIONAL CLINIC STRUCTURES

### *Objectives*

1. To promote the upgrade of traditional clinic structures, including water storage and latrines
2. To standardize patient charges
3. To identify "specialists" for referral among healers

It should be noted that family planning was not included in the training program because of planned training from the Family Life Association of Swaziland for traditional healers.

### *c. Inputs and Outputs*

Training materials included extracts from the Rural Health Motivator Training Manual (developed with support from UNICEF), Health Education Unit posters, individual presentations developed by facilitators, extracts from the MOH nutrition manual and other MOH publications, films, and materials provided by Project HOPE. These included slide sets from Teaching Aids At Low Cost, slide projector, and the growth chart flannelgraph, which had been purchased for Project HOPE's nursing educational programs. In addition, Project HOPE negotiated with counterpart institutions for traditional healers to tour their health institutions.

Each participant was provided with a folder containing largely pictorial information on nutrition, immunizations, SSS preparation, latrine construction, and a sample of referral cards developed by THO. Though some of the script was in English, it was THO's impression that somebody in the individual's homestead would be able to read it to the participant, which made it feasible to use existing materials.

*Training methods used included:* verbal presentations, folders, posters, slides, flannelgraphs and practical demonstrations.

During each 5 day session, traditional healers divided into discussion groups concerning questions put to them by modern health worker facilitators and THO. Out of these groups, workshop recommendations were formulated and included in the report. Role plays were conducted ~~at~~ the end of most workshops for participants to demonstrate what they had learned.

Time, financial, and personnel constraints precluded the conduct of an appropriate baseline survey of traditional healers with respect to the areas in which THO requested training. In addition, in the beginning Project HOPE did not yet have a trusting and working relationship established with THO on which to base such a request. A follow-up evaluation of traditional healers who participated in the training workshops is planned during the next phase of Project HOPE support for this sector.

*Lessons learned from the initial phase include:*

1. While THO does not have membership of all traditional healers in the country, it represents a viable organization with which to collaborate in order to reach this sector.
2. Traditional healers are accepting of preventive measures towards diarrheal disease control and the use of SSS.
3. Traditional healers are reluctant to accept ORS packets at this point because of uncertainty concerning contents and the lack of a reliable supply line.
4. Traditional healers are aware of Child Health Cards and will check them for nutritional and immunization status.
5. While they are willing to refer patients to modern clinics, they also expect modern clinics to refer patients to them.
6. THO promotes non-integration of traditional and modern health systems, though there are those who want integration.
7. THO has a potential supervisory mechanism through its Field Officers.
8. The majority of healers are not familiar with condoms, but are accepting and they could serve as a distribution point to reach the community in HIV/AIDS control.

9. Most do not understand the asymptomatic HIV carrier state.
10. Many feel because they have been treating infectious diseases that may occur in the patient with AIDS, that they have therefore been treating AIDS.
11. They are interested in alteration of traditional health care practices that may transmit HIV.

The proposed next phase would concentrate on training of THO Field Officers in supervision of traditional healers with respect to the training objectives of the first phase. The Field Officers are secondary school leavers, who are not themselves healers, but are daughters or other relatives of healers. THO would also use them to link traditional healers in the field with the organizational headquarters. THO has adequate conference and accommodation space at their headquarters for conducting regular training sessions for its membership. Project HOPE support would include technical assistance, training costs, and the provision of educational materials and equipment to THO.

#### *d. Observations and Findings*

The Traditional Healers component of the matching grant represents an important, innovative, and exciting strategy to target difficult to reach and high risk populations through an extensive network of trusted, accessible, and frequently used "private sector" practitioners. An estimated eighty percent of the population of Swaziland routinely seek the services offered by traditional healers. To date, this component has provided training to some six hundred healers on AIDS and key child survival interventions including the use of ORT, immunization, referral, and basic sanitation and hygiene. The component proposes to expand to include other elements of Primary Health Care and Child Survival and to reach out to greater numbers of healers.

The evaluation team met with the President of the Traditional Healers Association, and one of the key trainers in the 1989 workshops. The evaluation of the workshops and the changes in traditional healer attitudes and practices following the workshops, while positive and enthusiastic, has been entirely anecdotal, e.g., upon completion of training, traditional healers referred so many clients to the hospitals that the hospitals were overloaded and had to request a cut back in referrals. However, data on numbers of referrals, conditions, and outcomes were not available.

The evaluation team concurs with the importance of the traditional healers component in the expansion of primary health care service delivery in Swaziland. The Project HOPE program has had a major impact on the Ministry of Health policy regarding traditional healers. The shift in policy represents recognition of the position of healers in society in general and their importance in the health sector in particular.

While the focus of future work with traditional healers is to equip them with the knowledge and skills needed to incorporate contemporary primary health care interventions in their practice, it also affords an excellent opportunity for a better understanding of traditional practices and may offer insights into useful approaches to influencing those practices known to be harmful (e.g., withholding of fluids during periods of diarrhea, use of incense and intensive heat in enclosed spaces and in close proximity to sensitive body parts leading to severe burns and harmful smoke inhalation).

#### *e. Conclusions and Recommendations*

1. The evaluation team strongly supports a continued and expanded involvement in training and collaboration with traditional healers through the THO (Traditional Healers Organization). Two critical areas of project management, however, must be carefully adapted to meet the unusual requirements of "doing business" with institutions such as the THO. These are project administration and evaluation.
2. With regard to administration, the challenge to Project HOPE is the development of innovative and adequate management systems to ensure that project activities are planned and implemented "properly." There is a strong oral tradition and intuitive approach in the THO's conduct of its affairs. Project HOPE, in its continued collaboration with this organization, must assume the burden of converting these modes of operation into the formats, reports, activity schedules that are assumed when dealing with mainstream organizations.
3. Similarly, the burden will be on Project HOPE to assume the responsibility for developing and carrying out adequate evaluation of the process and impact of this component. Systematic observations, using pretested checklists, should be developed to record post-training practices to determine the impact of training on practice. Where

possible, comparative analyses should be carried out (e.g., pre and post training practices and trained vs. untrained healers).

## 6. Biomedical Engineering

### a. Background

In December, 1987, Project HOPE began discussions with the Swaziland College of Technology (SCOT) after learning that a regional Medical Equipment Repair Technician Course had been discontinued and the Swazis were interested in restarting it. The course was run from 1978 to 1985 with students from 10 English-speaking Sub-Saharan African countries. Funding and technical assistance was provided by the Commonwealth Regional Health Secretariat. Unsatisfactory reports on graduates' performance from participating countries to the Commonwealth Regional Health Secretariat led to an evaluation in March, 1985. This evaluation led to course discontinuation.

*The major deficiencies outlined in the report included:*

1. Lack of development of Swazi Educators to assume responsibility for the course.
2. Lack of sufficient medical equipment for the students to use for practical exercises.
3. Absence of a relationship between the training course and a repair/maintenance workshop in a health facility.
4. Curriculum deficiencies.
5. Inadequate external technical assistance.

Following discussions between Project HOPE and the MOH, the MOH in subsequent Commonwealth Ministers of Health Meetings, lobbied for the return of the program to Swaziland. Project HOPE's BME Coordinator at International Headquarters conducted a site visit in January, 1989 in collaboration with the Commonwealth Consultant sent to assess MOH and SCOT plans for improving on the course. Following this Commonwealth assessment and the development of an agreement between the MOH and Project HOPE, the Commonwealth Ministers of Health and the Commonwealth Regional Health Secretariat Advisory Group to

the course approved of restarting the program in Swaziland. In June, 1989, Bhekie Ntshangase returned from the US after USAID-supported long-term training as the MOH Biomedical Engineer. He has since played the leading role in development of the course and serves as Project HOPE's primary counterpart in planning assistance.

#### *b. Program Objectives*

The broad goals of the program are to assist in setting up a training course for individuals from the eleven countries involved who will return to their own countries to provide repair and maintenance of equipment in health facilities, and to assist in the development of a model functional BME repair and maintenance facility at the Mbabane Government Hospital. The hospital facility will serve as a practical training site for the students enrolled in the regional training program.

*Specific objectives include:*

1. Formal program for biomedical engineering technician training established by July 1990.
2. Two potential students are recruited from each of the eleven countries involved in the program at SCOT.
3. Set up a model maintenance and repair laboratory in the Mbabane Government Hospital.
4. Formal teaching at SCOT is institutionalized within SCOT by 1992.
5. The maintenance and repair laboratory and program at Mbabane Government Hospital is institutionalized within the MOH after October 1991.

#### *c. Inputs and Outputs*

Project HOPE assigned Dr. Richard Campbell of Ohio State University to Swaziland in October, 1989 as the long-term Coordinator for the Medical Equipment Repair Technician Course at SCOT. This was in anticipation of the Commonwealth Ministers' requested date of January, 1990 for course start-up. Since his arrival, together with MOH and SCOT counterparts, the course syllabus

was developed; procurement of educational materials and equipment was initiated; course and laboratory space at SCOT was arranged; contacts have been made with participating countries; the MOH spent \$ 20,000 on the renovation of space at Mbabane Government Hospital for a National Repair/Maintenance Workshop to be linked to the course; Project HOPE has provided 4 months of short-term technical assistance towards the establishment of this shop; the MOH Biomedical Engineer conducted site-visits to Botswana and Lesotho to arrange additional clinical teaching sites. In December it was learned from the Commonwealth that processing of applications for scholarships would take several months and, therefore, the first class has been delayed to June, 1990. Applications from participating countries are being received at SCOT and those that meet the entry requirements are being forwarded to the Commonwealth for processing.

#### *d. Observations and Findings*

Following the development of the training curriculum; completion of renovations to laboratory, teaching, and dormitory space; receipt of shipments of equipment for use in training; and, recruiting and processing applicants for training from the eleven participating Commonwealth Association countries, the BME component at SCOT (Swaziland College of Technology) is prepared to commence its training in July, 1990. At the present time, six students have been accepted and have continued their enrollment and it is expected that the minimum number of ten students will be achieved prior to the start of the program. Despite extensive recruitment efforts, communications problems in the region, especially with Tanzania, contributed to the low level of currently enrolled students. The BME component at the MOH hospital in Mbabane is fully staffed and prepared to proceed with the training that will make the unit operational for hospital equipment maintenance and for SCOT student practical experience.

#### *e. Conclusions and Recommendations*

Counterpart faculty are assigned and in place, and when appropriate, should be provided with additional BME training. While no specific time table has been established for training abroad for key faculty, the experience of the matching grant nursing programs must be considered. Careful planning is essential to coordinate faculty coverage of teaching responsibilities with needed faculty development to avoid shortage induced crises and to promote program sustainability.

Although the program originally was designed to accommodate Commonwealth Association countries, the team sees no reason to limit recruitment of students to these eleven countries. Enrolling students from other English-speaking nations would serve to expand the pool of applicants and contribute to the long-term sustainability of the program. SCOT should use the communications channels of international agencies to promote the BME program and to solicit sponsorship for additional participants. USAID/Swaziland has offered to use its communications channels to assist SCOT to follow-up on pending applications for the program scheduled to start in July.

The modern equipment and the maintenance skills being taught in the program suggest a unique opportunity to develop a self-financing initiative. SCOT, in collaboration with Project HOPE should consider an approach that would assess the workload requirement of the trained biomedical engineering staff to determine their potential availability to service modern equipment in use in the private and consumer sectors. The assessment should also consider needs in the modern Swaziland economy for equipment maintenance. A first priority would be to serve the health and health related private sector with possible later expansion to non health sectors.

### C. FUTURE DIRECTIONS

Future directions concern the remaining two years of the current matching grant and the period in the future beyond the completion of the grant. For the final two years of the current grant, Project HOPE will be completing some activities according to plan, initiating some new and expanded activities, and setting the stage for future activities.

The Nursing Education programs at Nazarene and SIHS are to enter a period of evaluation and fine tuning of curriculum. The Nursing Assistant program at Good Shepherd is to enter a period of strengthening the existing program and reassessing the need for major changes. In all nursing education programs it will be important for Project Hope to try to meet demands for filling in faculty gaps to avoid losing the momentum of progress made to date. At the same time Project HOPE must firmly convey the message that filling gaps cannot go on indefinitely and that improved planning systems are needed. The BME program is on track and set to start its training activities in July 1990. The Materials Management component will be reinitiated shortly and the Traditional Healers activity is scheduled to continue in an expanded manner. As these components are implemented over the remaining years of the matching grant it is increasingly important to build into them management systems and tools and evaluation designs and methods to improve their effectiveness and sustainability.

Along with the continuation of these activities over the next two years, Project HOPE should consider steps to assist in the resolution of some of the major issues noted in this report: the nursing shortage, the relationship between education and service, the appropriateness of the Kellogg initiative, the impact of the affiliation initiative, and coordination and integration of Project HOPE activities with the larger health system.

The following activities will be likely areas for continued programming following the completion of the matching grant: Biomedical Engineering, Materials Management, Traditional Healers, Continuing Education and In-service Training Programs in Nursing, Assistance to Good Shepherd in Nursing Assistant training, and consideration of assistance in the development of baccalaureate nursing programs. The initiation of any baccalaureate nursing program in Swaziland should have as its focus the preparation of nursing leaders with advanced skills in primary health care service delivery and health care management. In addition, care needs to be taken to design a program which meets the health care needs of Swaziland and the Region, rather than imposing a standard "Western" nursing model.

## D. CROSS-CUTTING RECOMMENDATIONS

In addition to the conclusions and recommendations made for each of the matching grant components, a number of cross-cutting recommendations have been developed during the evaluation team's analysis and assessment. These recommendations are grouped under the headings of: Contextual Recommendations, Matching Grant Component Improvement Recommendations, and Management Recommendations.

### 1. Contextual Recommendations

#### a. *Project HOPE and the Nursing Tutor Shortage*

Project HOPE should work with the MOH, other Government Ministries, professional associations, and international agencies to assist in the development of improved systems for long term planning related to human resources development and allocation. For the health sector worker shortages related to the practice of sending professionals abroad for extended periods, alternative approaches need to be explored such as evening and weekend courses taught by "administrators," use of retired professionals as working emeritus faculty, use of recent Community Health Nursing graduates as faculty tutors, distance learning, intensive programs, use of short certificate courses instead of longer degree programs, and developing some kind of university or consortium mechanism for in country education.

Project HOPE should work with GOS officials to reexamine the recognition of short certificate courses for career development purposes. At numerous times during site visits, the suggestion that certificate courses would be appropriate was met with the observation that they were not recognized for professional advancement.

Project HOPE should assist the MOH and the individual training institutions to develop schedules to assure minimal conflict between program needs and training opportunities. Monitoring systems are needed to assure adherence to these schedules.

Project HOPE should collaborate in a reexamination of current salary and benefit packages in an effort to reduce the large numbers of trained nurses leaving Swaziland for more attractive opportunities in neighboring countries. The good

derived from Project HOPE nursing education effort is diminished by the exodus of graduates.

*b. Project HOPE and Coordination with Other Programs*

Project HOPE should improve coordination with other actors, e.g., The Primary Health Care project (in relation nursing curricula and to the materials management component) and high level contacts with the Kellogg Foundation (in relation to the critical issues facing all of the nursing components).

*c. Project HOPE and the Need for Better Links Between Education and Service Delivery*

Project HOPE should initiate an effort to forge stronger links between its educational programs and the service delivery system in Swaziland. In the nursing components, efforts need to be made to bring the nurses who were not trained in the new curriculum "on board" through innovative approaches to continuing education and recognition of the contributions of these health workers to the education of new nurses. Also in the nursing components, curricula should be refined to reflect the progress made in the Primary Health Care program. Nurses should be prepared to work with the management information systems and drug supply systems developed for the Primary Health Care initiative. In the nursing assistant program, curriculum should be adjusted to reflect the changing roles of nursing assistants in the field.

Just as hospital, clinic, and field workers need to be informed and involved in the new approaches to nursing education, nurse educators must also get to the field and supervise their students on-site if these educators are to provide a relevant educational experience for nursing students. The separation of Nurse/Tutors and Nurses in Practice has strong historical roots and Project HOPE should seek to devise approaches to bring the two groups closer together.

Project HOPE should stimulate efforts to inform hospital administrators and physicians about the changes in nursing education. The evaluation team observed that new graduates were perceived as spending less time in patient care and more time on administrative matters. On probing, administrative matters turned out to be important applications of the new training program, such as accurate charting of patient care and extensive pre-discharge counseling.

## **2. Matching Grant Component Improvement Recommendations**

### *a. Project HOPE and Matching Grant Component Management*

Project HOPE should continue to assist in the development of approaches to improve management and use of simple management tools at matching grant project component levels. Management of the nursing programs would benefit greatly from use of tools such as simple formats for assigning faculty to courses, activity schedules that would flag important milestones and allow for appropriate lead time, and faculty training schedules that would facilitate dealing with projected shortages.

### *b. Project HOPE and Matching Grant Component Evaluation*

Project HOPE should assure that evaluation design and evaluation methodology ~~expertise is available to produce rigorous findings that will be useful for program documentation and program improvement.~~ This is particularly important for the nursing components which are scheduled to begin "phaseover" activities in which evaluation is featured prominently. Evaluation approaches to date (the follow-up survey of graduates at Nazarene and the measures used to assess progress in all nursing programs) have been weak and largely lacking in useful quantitative and qualitative dimensions. Evaluation expertise from HOPE Center or from consultants should be sought.

### *c. Project HOPE and the Employment of Swazi Professional Staff*

Project HOPE should consider increasing the participation of Swazi nationals in Project HOPE staff positions. Opportunities currently exist in the materials management, community health nursing, and the traditional healers programs. This would be an appropriate course of action during the closing phases of the matching grant to enhance the prospects for sustainability.

### 3. Management Recommendations

#### a. *Project HOPE and Management and Development Training and Orientation for Staff*

Project HOPE should consider additional preparation or qualifications for matching grant staff. While project staff are technically qualified to carry out their roles, the evaluation team noted gaps in preparation with respect to management and development skills. Given the important contextual issues noted throughout this report, the team recommends that technical staff be prepared through intensive short courses and workshops to meet the managerial, development, and Public Health issues that must be dealt with if progress and eventually success is to be achieved in technical areas. Project HOPE should also expand the hiring qualifications for technical staff to include management and development experience and training in Public Health.

#### b. *Project HOPE and Centralization vs. Decentralization and Delegation*

Project HOPE should reexamine the extent to which decision-making is centralized and consider greater decentralization and delegation of authority to the field and to Country Managers when in the field. In numerous instances, the evaluation team observed the need for project staff to refer to HOPE center for decisions. The team also observed that this produced the image that project staff were functioning as "middle men" and were not empowered to act authoritatively and decisively.

#### c. *Project Hope and Workloads for Program Directors, Country Managers, and Technical Directors*

Project HOPE should undertake a reassessment of the current and likely future workloads of staff to assure that responsibilities can be carried out effectively. Of particular note are the workloads of two professional staff members involved in the Swaziland project. The Director of Nursing/Country Manager has a workload of 18 to 20 nursing projects in her role as Director of Nursing and an additional (sometimes overlapping) responsibility for four countries as country manager. Beyond this, she is often called upon to take the lead in preparing new proposals for funding. The Program Director, has also experienced increased

responsibilities and expanded roles. Since his arrival in Swaziland he has undertaken new activities such as the BME, traditional healers, and HIV/AIDS projects in Swaziland and the Safe Motherhood, Child Survival, and HIV/AIDS initiatives in Malawi. These examples ~~are~~ not unusual in projects of this nature and in organizations such as Project HOPE; however, they need to be monitored carefully and periodically reviewed to assure staff effectiveness and to avoid staff "burnout."

*d. Project HOPE and Professional Staff Issues*

During the course of the site visit to Swaziland a number of issues were raised by the professional staff members assigned to the matching grant project. These issues are reported here as they were repeatedly raised by staff and Project HOPE is urged to consider approaches to improve the conditions which cause staff members concern. Orientation to Swaziland and to the matching grant project was uneven. Staff also noted the lack of a formal policy regarding such matters as sabbatical leaves for training, and procedures for continuing education and attendance at professional meetings. Staff were concerned about uneven practices such as free shipment of journal subscriptions for the Program Director but not for other professional staff members. Finally, the issue of overzealous time accounting was raised. Professional staff invariably work more than eight hours per day, five days per week and resent being asked to account for all time and being charged for leave when they had clearly put in excess time in carrying out their responsibilities.

*e. Project HOPE and Local Staff Issues*

Project HOPE should consider requests made by local staff during the evaluation team's visit. These included increasing staff benefits to the same level as USAID local staff. Currently, matching grant local staff receive a thirteenth month salary as their only benefit. They would request consideration of health and educational benefits as well, in recognition of the uncertainty of a long term future with Project HOPE. Local staff also noted the recent pay raise given to all Ministry workers and requested consideration of a similar increase. The final item raised with respect to compensation packages was the question of loans and salary advances from Project HOPE.

Local staff also raised issues of additional training to improve job performance and to equip them for future advancement. Specific training was requested in

computer applications (word processing and use of spread sheets) and vehicle and equipment maintenance.

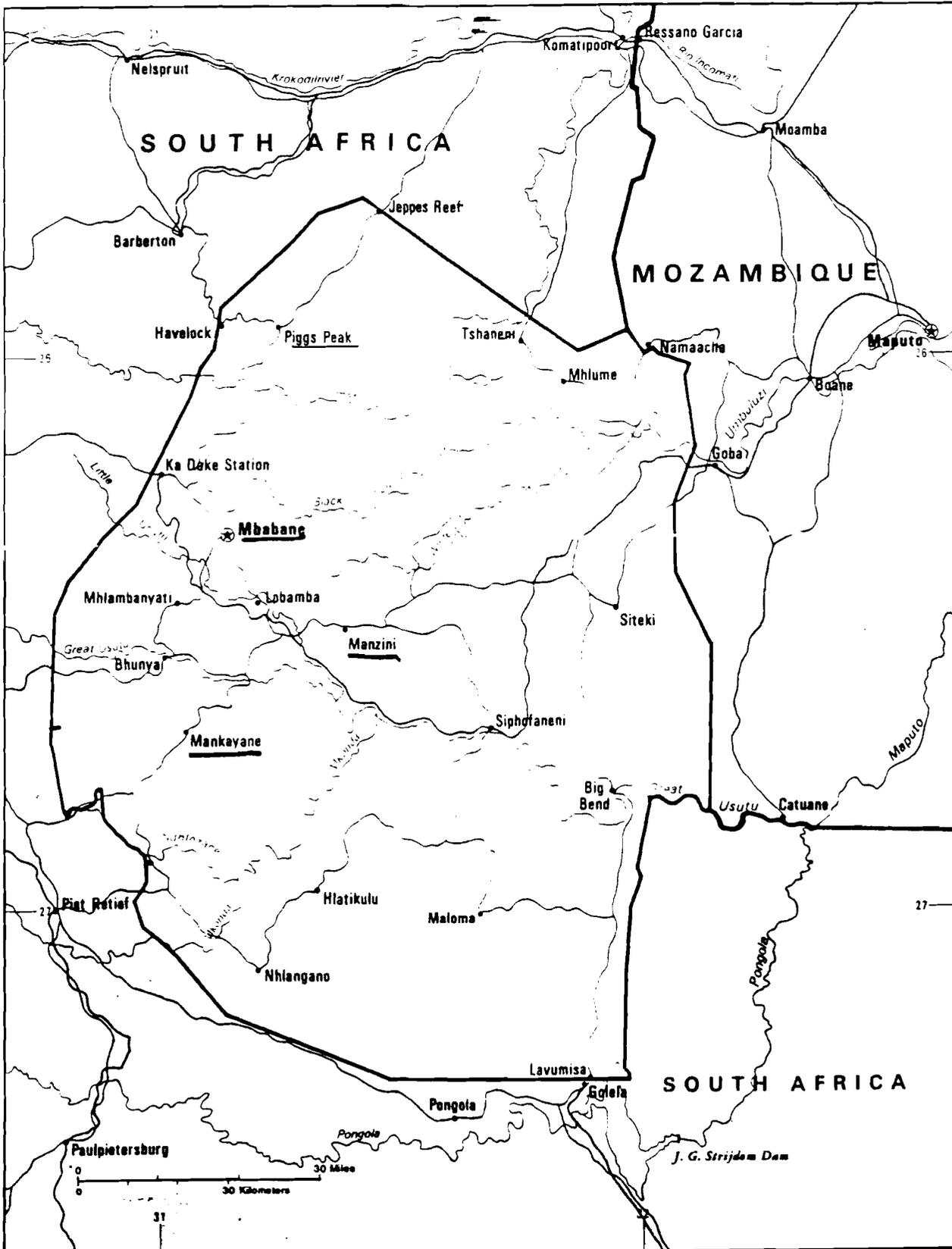
Local staff have the impression that they were hired to work on the matching grant and expressed a desire to be remunerated for work they considered to be outside the scope of the grant, e.g., HIV/AIDS and various Malawi initiatives. Project HOPE should clarify the scope of work and assignments to local staff.

## APPENDICES

## ACRONYMS

|               |  |
|---------------|--|
| <b>BME</b>    | <b>Biomedical Engineering</b>                                  |
| <b>CCCD</b>   | <b>Center for Disease Control Communicable Disease Project</b> |
| <b>CNO</b>    | <b>Chief Nursing Officer</b>                                   |
| <b>FLAS</b>   | <b>Family Life Association of Swaziland</b>                    |
| <b>HIV</b>    | <b>Aquired Immunity Dificiency Virus</b>                       |
| <b>HPN</b>    | <b>Health, Population and Nutrition</b>                        |
| <b>MCH</b>    | <b>Maternal and Child Health</b>                               |
| <b>MOH</b>    | <b>Mlnistry of Health/Swaziland</b>                            |
| <b>MSH</b>    | <b>Management Sciences for Health</b>                          |
| <b>NGO</b>    | <b>Non-Governmental Organization</b>                           |
| <b>ORT</b>    | <b>Oral Rehydration Therapy</b>                                |
| <b>PHC</b>    | <b>Primary Health Care</b>                                     |
| <b>RHMT</b>   | <b>Regional Health Management Team</b>                         |
| <b>SCOT</b>   | <b>Swazi College of Technology</b>                             |
| <b>SIHS</b>   | <b>Swazi Institute of Health Sciences</b>                      |
| <b>STD</b>    | <b>Sexually Transmitted Disease</b>                            |
| <b>THO</b>    | <b>Traditional Healers Organization</b>                        |
| <b>UNICEF</b> | <b>United Nations Children's Fund</b>                          |
| <b>USAID</b>  | <b>United States Agency for International Development</b>      |
| <b>WHO</b>    | <b>World Health Organization</b>                               |

# Swaziland



502744 9-77 (541832)  
 Lambert Conformal Projection  
 Standard parallels 6° and 30°  
 Scale 1:1,150,000

— Railroad  
 — Road

54

SWAZILAND STATISTICS

FERTILITY & POPULATION

|  |               | REFERENCE |
|--|---------------|-----------|
| POPULATION   | 712,131       | 1         |
| LIFE EXPECTANCY AT BIRTH                               | 47years       | 2         |
| CRUDE BIRTH RATE                                       | 49/1,000      | 2         |
| CRUDE DEATH RATE                                       | 16/1,000      | 2         |
| GROWTH RATE  | 3.3%;3.2%     | 2 , 1     |
| DOUBLING TIME  | 21 years      | 2         |
| % POPULATION UNDER AGE 15                              | 46%;47%       | 2 , 1     |
| LOW BIRTH WEIGHT                                       | 8.4%          | 6         |
| INFANT MORTALITY RATE                                  | 134;110       | 2 ; 3     |
| PERINATAL MORTALITY RATE                               | 39.7/1,000    | 6         |
| MATERNAL MORTALITY RATE                                | 128.5/100,000 | 6         |
| TOTAL FERTILITY RATE                                   | 6.87;6.5;5    | 4 , 2 , 5 |
| LITERACY   | 64%           | 1         |
| MALE: FEMALE RATIO                                     | 47%;53%       | 5         |
| % CHILD BEARING AGE WOMEN<br>NOT USING FAMILY PLANNING | 93.4%         | 5         |

1. 1986 CENSUS, SWAZILAND GOVERNMENT
2. 1983 WORLD POPULATION DATA SHEET, POPULATION REFERENCE BUREAU
3. 1987 UNICEF PLAN OF OPERATIONS AND PROJECT PLANS OF ACDM.  
FOR 1988 - 1992.
4. AMOAH, ET.AL. LAW, POPULATION AND DEVELOPMENT IN SWAZILAND, 1982.
5. FINAL REPORT, FAMILY HEALTH SURVEY, 1989
6. REPORT, NATIONAL MATERNAL AND PERINATAL MORTALITY MEETING OF SWAZILAND, 1987.

NURSES IN SWAZILAND.

SOURCE: Sr. J. Zwane, Registrar  
Swaziland Nursing Council  
22 April, 1990

State Registered Nurses (R.N.) 1085  
Singly and doubly qualified  
- single qualified grad. of GNP Program  
- double qualified grad. of GNP and one  
- post-basic programs; principally  
midwifery

State Enrolled Nurses 105  
Singly and doubly qualified  
- single qualified grad. of the old 2 year diploma program  
- double qualified grad. plus midwifery  
(no longer a viable option - when these retire --- that's it)

Nursing Assistants (N.A.) 354

Doctors Approximately 80

## LIST OF CONTACTS

### USAID/SWAZILAND

*Roger Carlson, Mission Director*  
*Mary Huntington, Deputy Director*  
*Alan Foose, HPNO*  
*Jay Anderson, Assistant HPNO*  
*Jim Bendnar, Evaluation Officer*

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*Mrs. Lucille Anerson, Nurse-Educator*  
*Mrs. Roberta Caffrey, Nurse-Educator*  
*Dr. Richard Campbell, BME Coordinator*  
*Dr. Arline Duvall, Nurse-Educator/Nursing Coordinator*  
*Miss Agatha Lowe, HIV/AIDS Project Coordinator*  
*Mr. Paul Attwood, Short-term BME Educator*  
*Mumsie Mabuza, Secretary, Main Office*  
*Busie Dlamini, Secretary, GSH*  
*Patrick Vilakati, Driver*  
*Mduduzi Shongwe, Administrative Assistant*

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*Mr. Chris Mkhonta, Principal Secretary*  
*Mr. Ephraim Hlophe, Undersecretary*  
*Dr. Maggie Makhubu, Chief Nursing Officer*  
*Dr. John Mbambo, Director of Health Services*  
*Mrs. Nester Shongwe, Acting CNO*  
*Mrs. Louise Dlamini, Deputy CNO*  
*Director of Finances*  
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*Assistant Chief Pharmacist*

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*Mrs. Frieda Hlatshwayo, Principal, NNC*  
*Mrs. Lois Dlamini, Acting Vice-Principal, NNC*  
*Mr. Bert Friesen, Hospital Administrator*  
*Dr. Bob Merkie, Senior Medical Officer*  
*Matron Mary Meighan, NNC, Advisor to Principal*

*Ms. Winnie Mhlengethwa, NNC Tutor*  
*Ms. Marjorie Mavuso, NNC Tutor*  
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*Ms. Catherine J. Sihlongoryane, NNC Tutor*  
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*Faith Llahmini, NNC Graduate*  
*Emman Dlamini, NNC Graduate*  
*Bheka Simelane, NNC Graduate*  
*Current Students at NNC*  
*Dr. Zama Gama, Former Community Physician for RFMH*

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*Ms. Isabel Zwane, Acting Vice-Principal*  
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*Ms. Thabi Mlongo, Tutor*  
*Ms. Siphwe Chowa, Tutor*  
*Ms. Faith Motsa, Tutor*  
*Ms. Phyllis P. Mamba, Tutor*  
*Ms. Thoko Myein, Tutor*

### *Graduating Class in Community Health*

*Ms. Mana Nyoni, Mliba Nazarene Unit*  
*Ms. Kharysile Nkabindze, Siteki PHU*  
*Ms. Assunta Simelone, Shiselweni School Health*  
*Ms. Busisiwe Ngwenya, Mankayane Public Health*  
*Ms. Faith Simelane, Mafutsei Nazarene Clinic*  
*Ms. Lilly Simelane, Sinleni Clinic*  
*Ms. Salatia Naziniandze, King Sabuza II Clinic*  
*Ms. Mary Magagula, Piggs Peak PHU*  
*Ms. Thandie Maphalala, Hlatikulu PHU*  
*Ms. Thoki Dlamini, Shewula Clinic*

### *1988 Graduate in Community Health*

*Ms. Miriam V. Mabilhia, Mbabane PHU*

## **GOOD SHEPHERD HOSPITAL NURSING ASSISTANT PROGRAM**

*Dr. Phillips, Administrator and Senior Medical Officer*  
*Matron Anna Zwane, Matron*  
*Sr. Justin Mkhabela, Principal*  
*Sr. Angeline Thwala, Tutor*

## **MANAGEMENT SCIENCES FOR HEALTH/PHC PROJECT**

*Dr. Dan Kraushaar, Chief of Party*  
*Al Neill, Management Specialist*  
*Mary Kroeger, Nurse-Midwife*  
*Dr. Marilyn Edmondson, Management/Training Specialist*

## **FLAS PROJECT**

*Tom Fenn, Pathfinder*

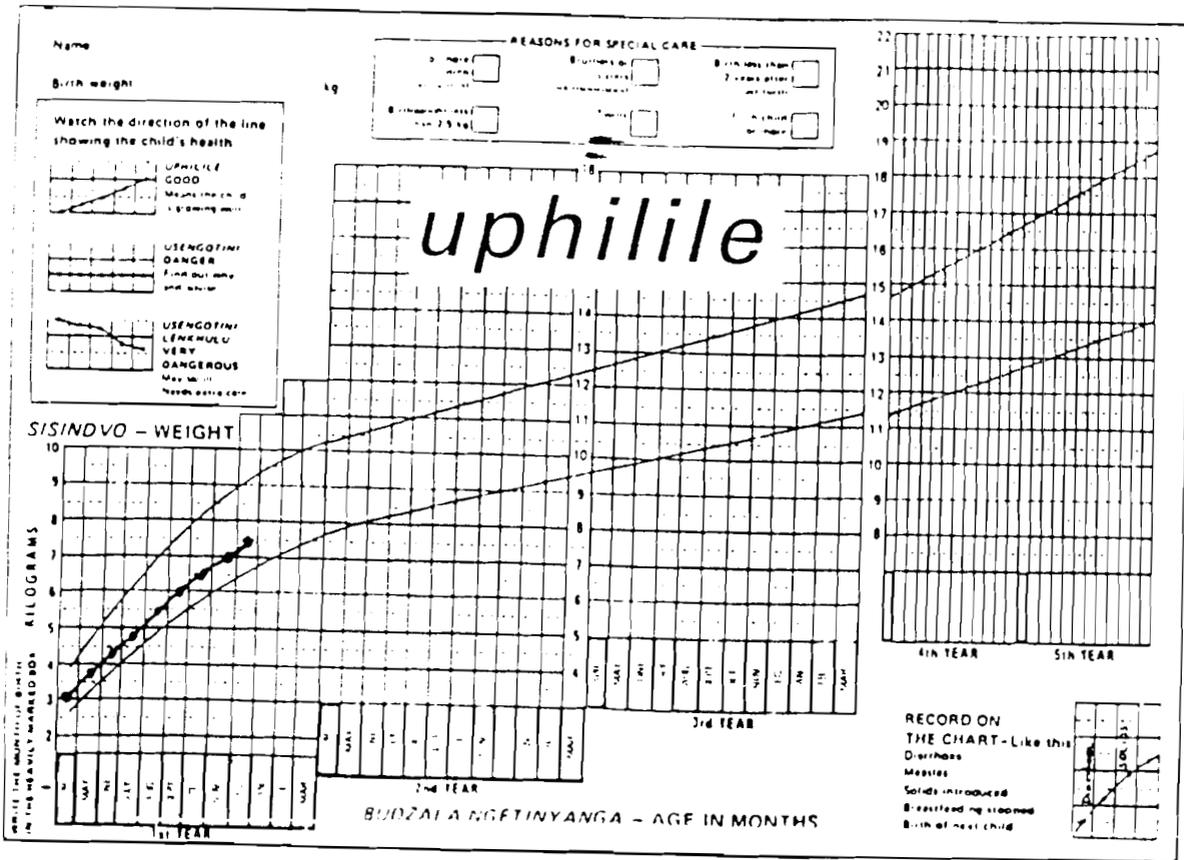
## **SCOT BIOMEDICAL ENGINEERING PROGRAM**

*Mr. Leonard Lukhele, Principal*  
*Mr. Alvis Ndlangamandla, Tutor*  
*Mr. Bhekie Ntshangase, BME MOH*

## **THO**

*Dr. D. Nhluvana Museko, Director*  
*Three Active Traditional Healer THO Members*

**TRADITIONAL HEALERS  
TRAINING MATERIAL**

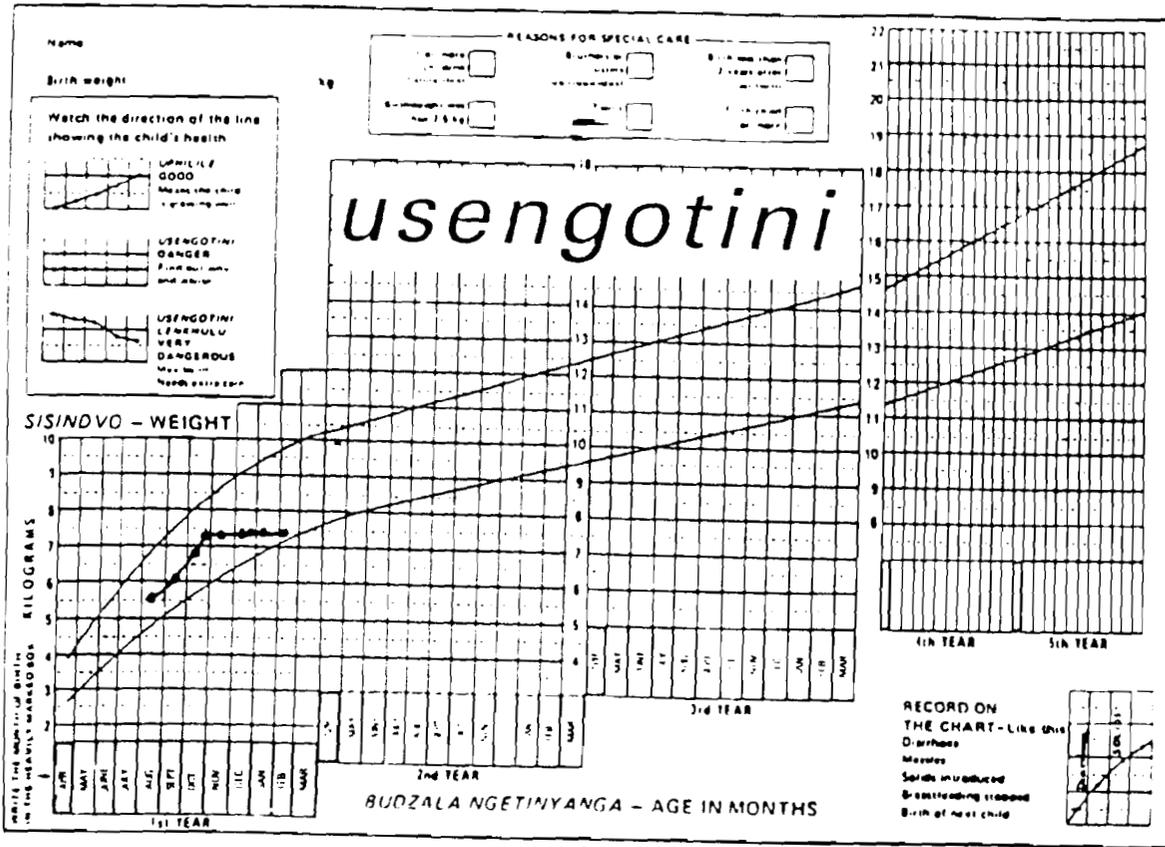


*The growth chart*

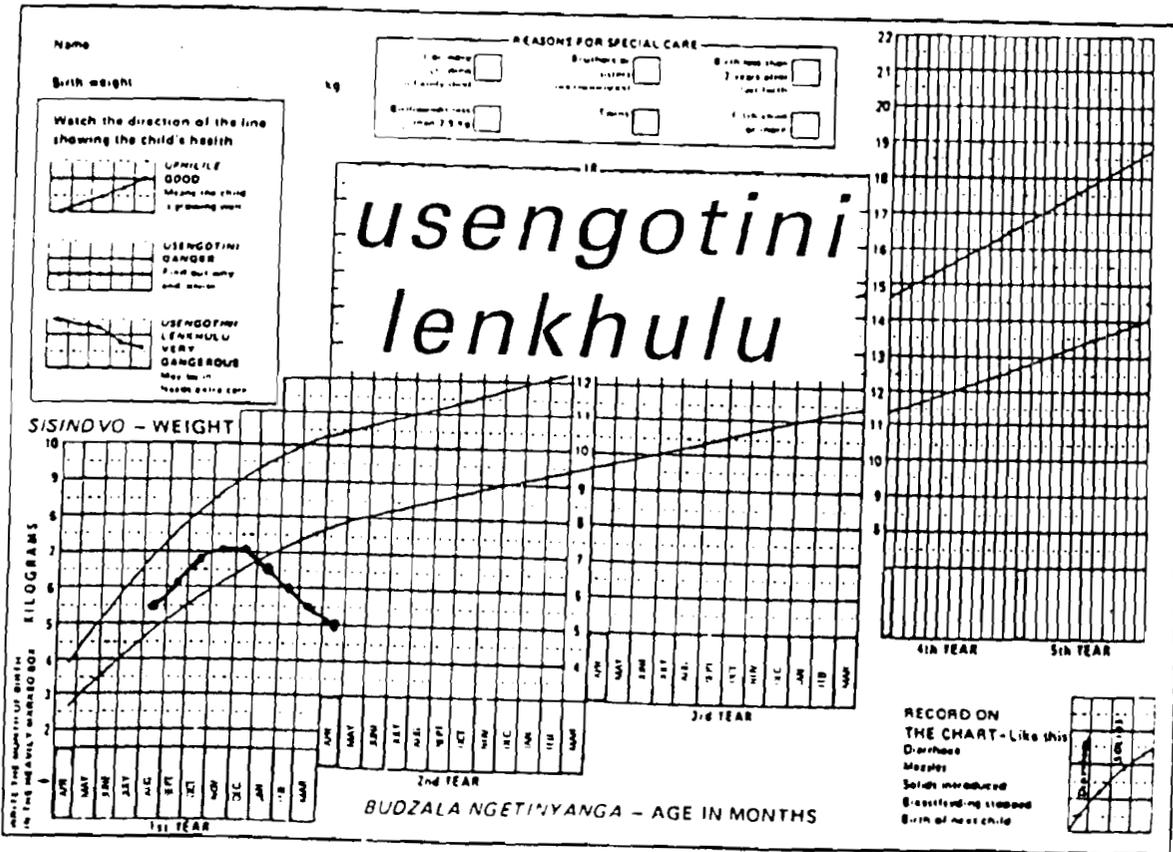


*Measuring growth is one way of  
Measuring health and the adequacy  
Of food that a child eats.*

*A child who grows well is probably  
Healthy and adequately nourished*



The growth chart



The growth chart

# PREVENTING MALNUTRITION

## 1. **Breastfeed your baby.**

BREASTMILK IS THE BEST FOOD FOR A BABY. BOTTLE FED BABIES GET MALNOURISHED BECAUSE THERE IS NOT ENOUGH MILK POWDER IN THEIR FOOD.



## 2. **Feed your child enough good food.**

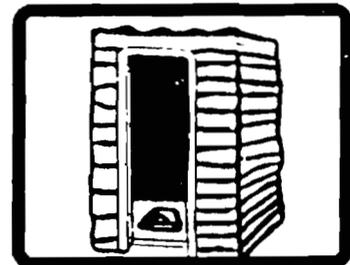
THIS MEANS FEED THEM FOODS FROM THE 3 FOOD GROUPS. CHILDREN NEED TO EAT MORE FOOD THAN JUST MEALIE MEAL. THEY MUST EAT FOODS LIKE MILK, EGGS, FRUITS AND VEGETABLES IN ORDER TO GROW WELL.



## 3. **Prevent diarrhoea.**

CHILDREN OFTEN BECOME MALNOURISHED WHEN THEY GET DIARRHOEA BECAUSE THEY LOSE A LOT OF FLUIDS FROM THEIR BODIES.

1. Wash your hands with soap and water.
2. Boil or disinfect your water.
3. Keep food in clean containers.
4. Do not feed your child food that is old or that has gone bad.
5. Space your children. This gives you more time for breastfeeding.
6. Use a toilet. Teach your children how to use a toilet.



# MALNUTRITION

MALNUTRITION MEANS STARVING FOR FOOD. IT HAPPENS WHEN:

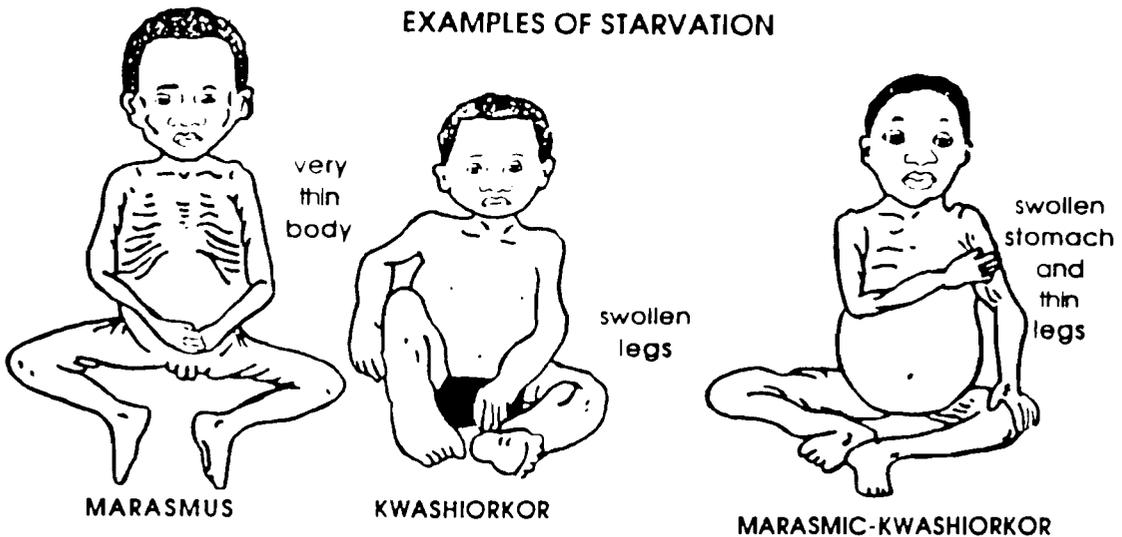
1. A child does not eat enough food  
OR
2. He does not eat enough of the right kinds of food.



## DANGER

MALNUTRITION IS VERY DANGEROUS. IT CAN CAUSE SICKNESS AND DEATH.

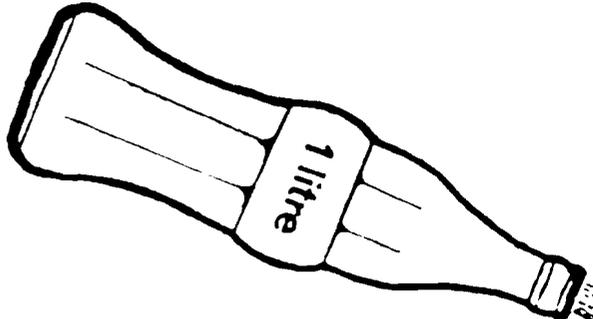
### EXAMPLES OF STARVATION





**EMANTI —**

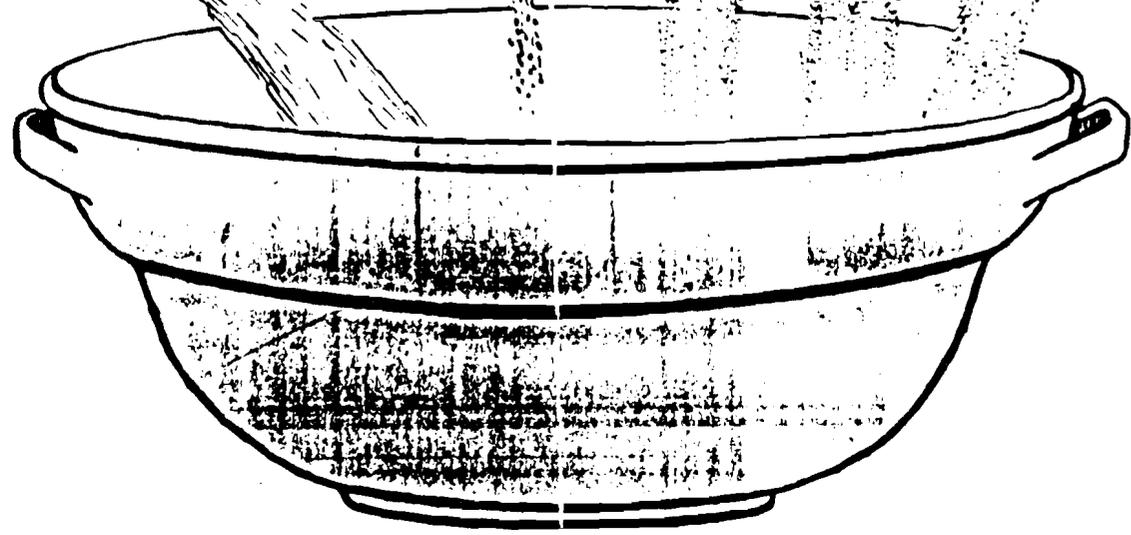
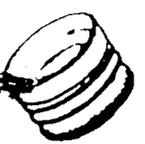
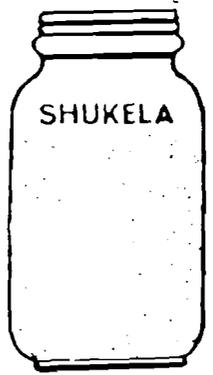
**libhodlela lelitha**



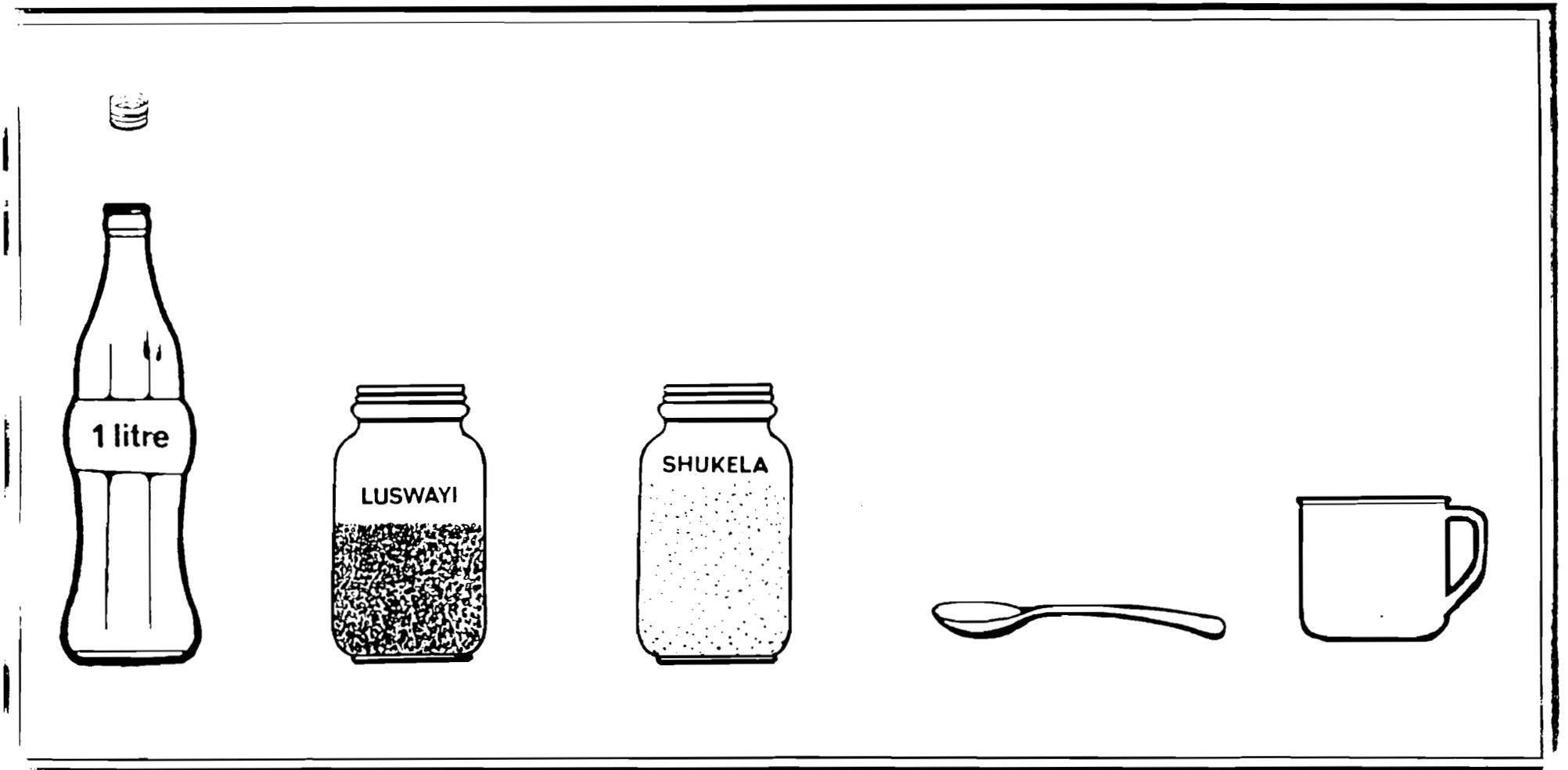
**Hhafu wesivimbo  
selibhodlela  
lelitha**



**Ungampongisi**



# SIKHWAMA SEKULWA NEKUHLUTEKA KWEMANTI EMTIMBENI



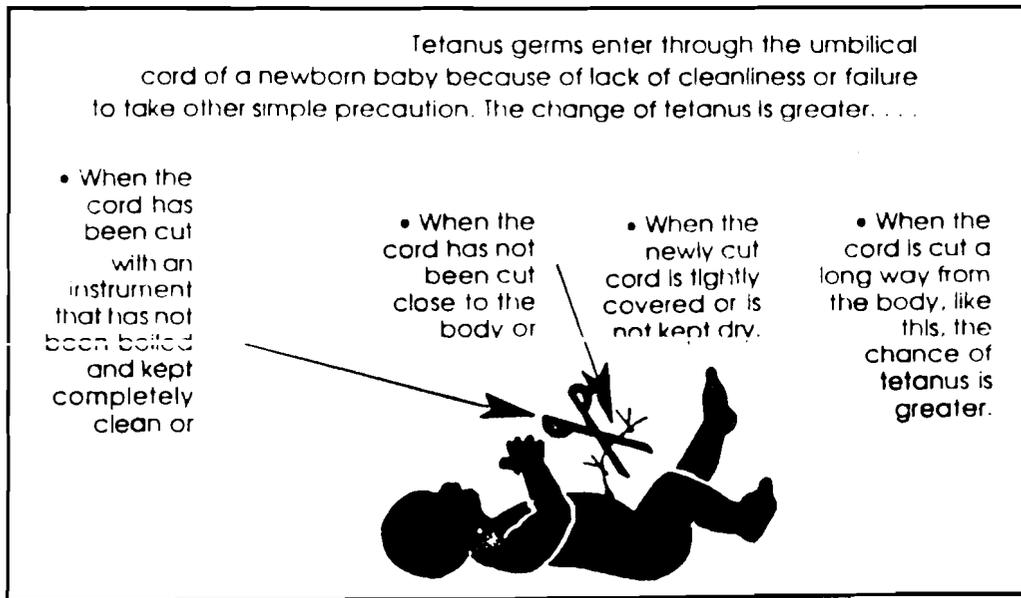
# TETANUS



## DANGER

Many babies die of Tetanus when they are born at home and germs get into the cord from a dirty razor blade.

### CAUSES OF TETANUS IN THE NEWBORN CHILD:



### CAUSE

1. Cut by dirty knife or razor.
2. Puncture by dirty needle.
3. Stab wound.
4. Animal bite.

### SIGNS

### BABIES

1. Cry a lot.
2. Cannot suck.
3. Stiff body.
4. Difficulty breathing.
5. Chills and fever.

# MARASIMUS

## Prevention:

1. Breastfeed your baby.
2. Begin to feed your baby mashed foods at 3 months.
3. Feed your child enough food from the 3 Food Groups.
4. Take your child to the clinic to see if he is growing well.
5. PREVENT DIARRHOEA.

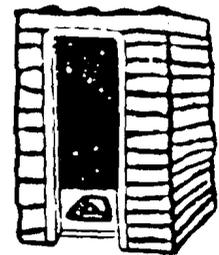


- (a) Wash your hands with soap and water.
- (b) Boil or disinfect your water.
- (c) Use a toilet. Teach your child how to use a toilet.
- (d) Space your children. This gives you more time to breastfeed.
- (e) Keep food in clean containers.
- (f) Do not feed your child food that is old or that smells bad.

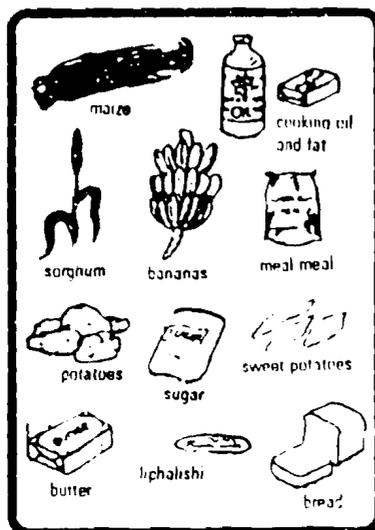


## Treatment

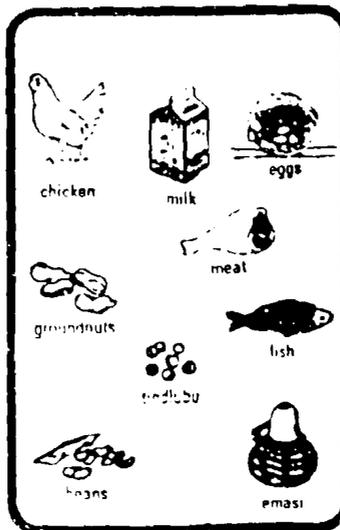
Feed your child enough good food from the 3 FOOD GROUPS



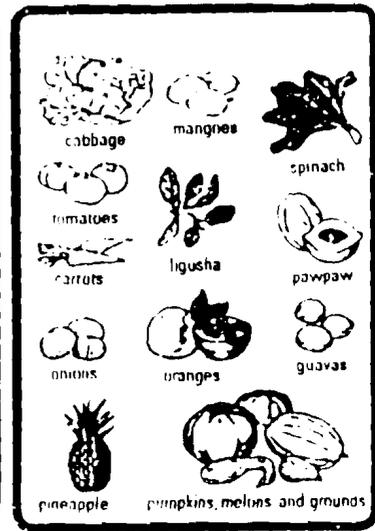
### ENERGY FOODS



### BODY BUILDING FOODS



### PROTECTIVE FOODS

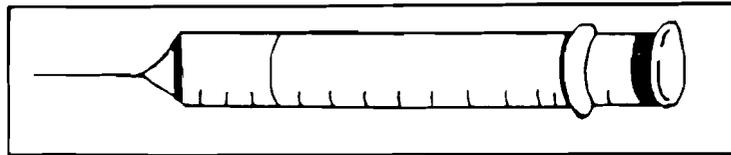
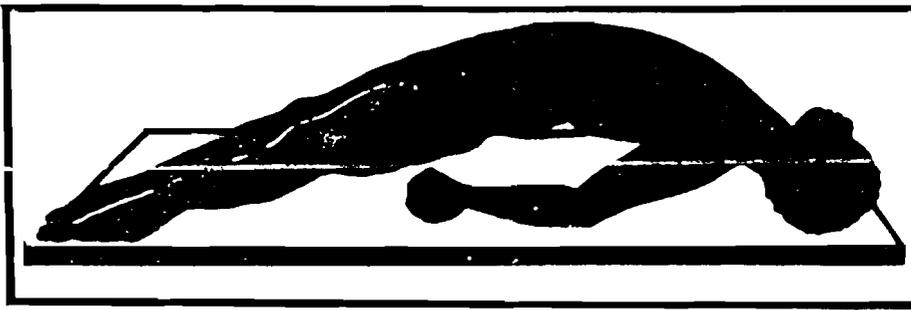


# TETANUS

## SIGNS

### In Others

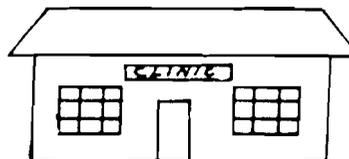
1. Pain in a wound.
2. Pain in neck, back and legs.
3. Stiff jaw.
4. Cannot swallow easily.
5. Whole body gets stiff.
6. Body muscles tighten.



## Prevention

1. IMMUNIZE THE PREGNANT MOTHER.
2. IMMUNIZE THE CHILD.
3. When the baby is born;
  - a) Boil razor or knife before using.
  - b) Keep the cord dry and clean.
4. Clean wounds well with soap and water.

**Treatment** You can die in a few days. GO TO THE CLINIC IMMEDIATELY.



# MARASMUS

Marasmus occurs when a child does not eat enough food.



## DANGER

Many children get sick and die because they are malnourished.

### When a child suffers from Malnutrition:

1. He is more likely to get diarrhoea and die.
2. He is more likely to get measles or T.B.
3. He is more likely to get sick and stay sick for a long time.

## SIGNS



1. Thin arms and legs.
2. Thin face with sunken eyes.
3. Very dry and wrinkled skin.
4. Weakness.
5. Child fails to grow.
6. Sadness and lack of energy.
7. Always hungry.

**SIHS NURSING PROGRAM MATERIAL**



B. ROLE OF FAMILY MEMBERS:

Who are the decision makers in the household? \_\_\_\_\_  
\_\_\_\_\_

Who makes decisions:

About money? \_\_\_\_\_

About food? \_\_\_\_\_

About family planning? \_\_\_\_\_

About deliveries? \_\_\_\_\_

About immunizations and health care? \_\_\_\_\_  
\_\_\_\_\_

What are the assigned household tasks of the various family members?  
\_\_\_\_\_  
\_\_\_\_\_

C. FAMILY DYNAMICS:(Interactions)

Relationship of family members \_\_\_\_\_  
\_\_\_\_\_

What does the nurse perceive as the strengths within the family?\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What does the nurse perceive as the weaknesses within the family?\_\_  
\_\_\_\_\_  
\_\_\_\_\_

D. SOCIAL ACTIVITIES:

Leisure Activities-what are the usual activities?

Of adults? \_\_\_\_\_

Of children? \_\_\_\_\_

Of family? \_\_\_\_\_

Political activities? \_\_\_\_\_

Community activities? (list) \_\_\_\_\_

Religious activities, Clubs, Sports, Others? \_\_\_\_\_  
\_\_\_\_\_

E. CUSTOMS, PRACTICES, BELIEFS, TABOOS (include childbearing, breast feeding, nutrition, disease prevention, care of ill, and family planning)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

F. FAMILY AND HEALTH CARE SERVICES

Utilization of Health Facilities:

Distance between the home and health services (in km or travel time)

Health Centre \_\_\_\_\_ Clinic \_\_\_\_\_  
 Hospital \_\_\_\_\_ Physician's Office \_\_\_\_\_

Use of preventive services(list) \_\_\_\_\_

Use of curative services(list) \_\_\_\_\_

Use of mother and child services-including family planning (list) \_\_\_\_\_

Deliveries at health facility \_\_\_\_\_

G. FAMILY ILLNESSES AND DEATHS

When there is illness in the family not requiring a treatment, from whom do you seek help?

Family member \_\_\_\_\_ Neighbor/friend \_\_\_\_\_ Other \_\_\_\_\_  
 Own knowledge \_\_\_\_\_ Family never ill \_\_\_\_\_

How often on an average do you/family members consult a traditional healer?

Every two weeks \_\_\_\_\_ Monthly \_\_\_\_\_ Every 3 months \_\_\_\_\_  
 Every 6 months \_\_\_\_\_ Yearly \_\_\_\_\_ Only when ill \_\_\_\_\_  
 Never \_\_\_\_\_ Other \_\_\_\_\_

Communicable Diseases Contracted by family during the past year (count from date of interview)

| Disease         | adult | child | Disease      | adult | child |
|-----------------|-------|-------|--------------|-------|-------|
| Measles         |       |       | Chicken pox  |       |       |
| Mumps           |       |       | Pertussis    |       |       |
| Meningitis      |       |       | Tuberculosis |       |       |
| Hepatitis       |       |       | Influenza    |       |       |
| Gastroenteritis |       |       | Malaria      |       |       |
| Others:(list)   |       |       | no disease   |       |       |
|                 |       |       |              |       |       |
|                 |       |       |              |       |       |

Deaths: Have there been any deaths in the family during the past year? yes \_\_\_\_\_ no \_\_\_\_\_  
 if yes, (list by name, sex, age/birth date, date of death and cause)

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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H. FAMILY NUTRITION:

DAILY INTAKE OF 3 FOOD GROUPS

Body building \_\_\_\_\_  
Body regulatory \_\_\_\_\_  
Energy \_\_\_\_\_

Meal pattern (number of meals per day, who eats when etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Food bought by \_\_\_\_\_  
Food bought from \_\_\_\_\_

Meals prepared by \_\_\_\_\_

Children's feedings supervised by \_\_\_\_\_  
\_\_\_\_\_

I. ECONOMIC INDICATORS

INCOME:

Occupations of working members \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Family income regular \_\_\_\_\_ irregular \_\_\_\_\_  
Source: Salary \_\_\_\_\_ Pension \_\_\_\_\_ Cattle \_\_\_\_\_ Chickens \_\_\_\_\_  
Goats \_\_\_\_\_ Other animals \_\_\_\_\_  
Subsistence: Land for food \_\_\_\_\_ Vegetable garden \_\_\_\_\_  
Water for garden \_\_\_\_\_ Time for Garden \_\_\_\_\_  
Expenses: Greater than income \_\_\_\_\_ Less than income \_\_\_\_\_  
Equal to income \_\_\_\_\_ Don't Know \_\_\_\_\_

COMMUNICATIONS:

Television \_\_\_\_\_ Radio \_\_\_\_\_ Newspaper \_\_\_\_\_ Telephone \_\_\_\_\_  
Chief's Meeting \_\_\_\_\_

TRANSPORTATION:

Own car: Pleasure only \_\_\_\_\_ Business only \_\_\_\_\_ Business & pleasure \_\_\_\_\_  
No car \_\_\_\_\_

Public or collective transport:

Bus: regularly \_\_\_\_\_ irregularly \_\_\_\_\_  
Taxi: regularly \_\_\_\_\_ irregularly \_\_\_\_\_  
Bicycle \_\_\_\_\_ Hitch-hike \_\_\_\_\_  
No transportation \_\_\_\_\_ Other \_\_\_\_\_

J. ENVIRONMENT:

TENURE: Own home \_\_\_\_\_ Rent \_\_\_\_\_ Supplied by employer \_\_\_\_\_  
Other \_\_\_\_\_

DWELLING: Homestead \_\_\_\_\_ House \_\_\_\_\_ Flat \_\_\_\_\_  
Room \_\_\_\_\_ Other \_\_\_\_\_

Roof: Grass \_\_\_\_\_ Corrugated iron \_\_\_\_\_ Asbestos \_\_\_\_\_  
Concrete \_\_\_\_\_ Tile \_\_\_\_\_

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Outer walls: Brick/cement\_\_\_\_\_ Corrugated iron\_\_\_\_\_ Wood\_\_\_\_\_ Plastic & card board\_\_\_\_\_ Stick & mud\_\_\_\_\_ Stick\_\_\_\_\_

Floor: Cement\_\_\_ Tile\_\_\_ Wood\_\_\_\_\_ Packed mud\_\_\_\_\_ Smoothed cow dung\_\_\_\_\_ Other\_\_\_\_\_

Number of rooms: Kitchen\_\_\_\_\_ Sleeping rooms\_\_\_\_\_ Toilet\_\_\_\_\_ BATHROOM\_\_\_\_\_

## LIGHT:

Electricity\_\_\_\_\_ Paraffin lamp\_\_\_ Candles\_\_\_\_\_ Other\_\_\_\_\_

## COOKING:

Equipment: Stove\_\_\_\_\_ Cooker\_\_\_\_\_ Coal pot\_\_\_\_\_ Fireplace\_\_\_\_\_ Open fire\_\_\_\_\_ Other\_\_\_\_\_

Fuel: Electricity\_\_\_ Paraffin\_\_\_\_\_ Coal\_\_\_\_\_ Gas\_\_\_\_\_ Wood\_\_\_\_\_ Combination\_\_\_\_\_ Handigas\_\_\_\_\_ Other\_\_\_\_\_

## WATER SUPPLY:

Source of supply: River\_\_\_ Tap in yard\_\_\_ Tap in house\_\_\_ Protected spring\_\_\_\_\_ Unprotected spring\_\_\_\_\_ Communal stand pipe\_\_\_ Tank\_\_\_\_\_ Well\_\_\_ Other\_\_\_

## Availability:

Available all seasons\_\_\_ Distance from dwelling\_\_\_\_\_

## Treatment before drinking:

Boil\_\_\_ Tablets\_\_\_ Filtered\_\_\_ Chlorinated(JIK)\_\_\_ Settling\_\_\_ None\_\_\_ Other\_\_\_\_\_

Storage container: washed before use\_\_\_ not washed before use\_\_\_

Storage cover: Fully\_\_\_ Incomplete\_\_\_ No cover\_\_\_

Bathing/Washing: at home\_\_\_ Stream/river\_\_\_ Communal stand pipe\_\_\_ Other\_\_\_\_\_

## SEWAGE DISPOSAL:

## Type and location of toilet:

Location: Inside\_\_\_ Outside\_\_\_ (distance from dwelling)\_\_\_\_\_ None\_\_\_\_\_

Type: Pit latrine\_\_\_ Bush\_\_\_ Communal toilet\_\_\_ Water flush\_\_\_ Other\_\_\_

Use of latrine: Pathway to latrine apparent\_\_\_ Pathway to latrine not apparent\_\_\_

Location of sewage disposal in relation to water supply: Uphill\_\_\_ Downhill\_\_\_ Adjacent\_\_\_

## Type of drainage for water used:

Natural\_\_\_ Earth\_\_\_ Pipe\_\_\_ concrete\_\_\_ none\_\_\_

Condition of drainage system: Surrounding area dry\_\_\_ Stagnant ponds of water\_\_\_ Moisture in drainage area\_\_\_

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REV.  
SEP. 89  
AMD

REPORTABLE YES - NO -

DISEASE

CAUSATIVE AGENT

RESERVOIR

PORTAL OF EXIT

MODE OF TRANSMISSION

PORTAL OF ENTRY

SUSCEPTIBILITY 1. HUMAN FACTO  
2. ENVIRONMENT  
FACTORS

PREVENTION PROGRAM

PRIMARY PREVENTION

- 1. HUMAN CONDITION
- 2. ENVIRONMENT CONDITION

CONTROL PROGRAM

SECONDARY PREVENTION

- 1. EARLY DETECTION
- 2. TREATMENT
- 3. CARRIERS
- 4. INVESTIGATE SOURCE

Arlene M. Duvall, Project HOPE Nurse-Educator

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**DOCUMENTS REVIEWED**

## CURRICULA

1. Basic Nursing Midwifery
2. Community Health Nursing 1987
3. (a) 1st Group: Student Evals of Curriculum  
(b) Student Evals - completed 1989  
GNP  
Midwifery
4. Status of faculty at NNC  
(a) 1988 - Projected to 1998  
(b) 1989 - 1991
5. Program Plan - Nursing Assistant
6. Nursing Assistant - Training Needs Assessment  
Assessment Tool  
Report of Assessment
7. Progress Reports - Nursing Assistant Program
8. Tributes and Notes of Appreciation - Good Shepherd Nursing School

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## BIOMEDICAL ENGINEERING

1. Program Plan  
Reports by HOPE
2. Supportive Documents

## ADMINISTRATION

1. Project HOPE Agreement with the Kingdom of Swaziland
2. CV's of Project HOPE Staff
3. CV's of Local Hires
4. Program Director's Quarterly Reports
5. Gift-In-Kind Program  
Supportive Documents
6. Teaching Materials/Equipment  
Shipment Lists 1987-April, 1990
7. Program, Reports, AID, Project Implementation Reports 1987-1989
8. Memos, letters to the Ministry of Health
9. Report on Potential Project HOPE Expansion in Swaziland 3/88

NURSING EDUCATION

1. Affiliation Process NNC 1988-1990
  - (a) Minutes from Meeting at UNISWA 03/08/88
  - (b) Copy Revised Nurse Practice Act
  - (c) Draft copies of Governing Board  
Job Descriptions
  - (d) Organizational charts
2. Nursing Needs in Swaziland  
"Potential Proposals"
3. Report of Overall Nursing Programs in Swaziland  
Report Period 01/06/89 - 31/05/90  
(Response to Sections IV and VII)
4. Nurse Educator  
Job Description
5. Human Sexuality Seminar 1988
6. Minutes - Swaziland Nurse Educators' Meetings (Roberta's copies)
7. CHN
8. Nursing Team Meetings
9. Program Participation
10. Transportation
11. SIHS - Community Health Nursing  
Applications for Program Approval 1985, 1986, 1988
12. Quarterly Program Report - CHN
13. Tributes and Notes of Appreciation - SIHS
14. Affiliation
15. (a) University based Nursing Education Affiliation Folder No. 1  
(b) University based Nursing Education Affiliation Folder No. 2  
(c) Project HOPE NNC/Affil: AMD (d) Affiliation Process
16. Nazarene Nursing College
  - (a) History of Nursing
  - (b) History of Manzini Nazarene Mission
17. (a) Copies of NNC Program Plan Applications  
(b) Current Agreement between Kingdom of Swaziland and People-to-People  
Health Foundation  
(c) Original - 20/8/84  
Revised and Extended 6/88  
Proposed, Revised and Extended 4/90

18. (a) Copies of NNC Quarterly Reports & Final Reports
  - (b) Final Report - F. Richardson 7/24/89
  - (c) Final Report - A. Lowe 31/8/89
  - (d) Final Report - V. Abler
19. Nazarene Nursing College
  - (a) Student Rules & Regulations
  - (b) Nursing Hostel Regulations
  - (c) Student Skills Book
20. Minutes of Meetings - NNC  
Level III
21. (a) Evaluation Tools - NNC during period 1985-1990
  - (b) Course Evaluation - One Tutor - 1990
22. Course Syllabi - Level III
  - (a) Peds II, Third Level
  - (b) Nursing Leadership & Management
23. Minutes - NNC faculty meetings (Roberta's copies)
24. Tributes & Notes of Appreciation - NNC
25. Curriculum - General Nurse Program 1985
26. Home Visits Record Book - 1986-1990
27. Pre & Pro I-III - NNC
28. Nursing Science & Arts I - NNC
29. Basic Program:  
Community Health Regional Examinations & First Exam Under Affiliation

#### PHARMACEUTICAL MANAGEMENT

1. Supportive Documents
2. (a) Old Program Plan (1985-87)
  - (b) Reports

#### TRADITIONAL HEALER

1. Agreement between Project HOPE & THO concerning Traditional Primary Health Care in Africa
  2. Preliminary Draft Report
  3. Training Materials, Minutes of Planning Meetings, Training Workshop Agenda
  4. Workshop Reports.
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