

EVALUATION OF LESOTHO RURAL
HEALTH DEVELOPMENT PROJECT

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I. INTRODUCTION

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The members of the project evaluation team, Drs. Mervell W. Bracewell, John Karefa-Smart, and John E. Kennedy, were briefed by AID in Washington, D. C., on February 5, 1980. The team arrived in Maseru, Kingdom of Lesotho, on February 7. Their evaluation of the Lesotho Rural Health Development Project (LRHDP) ended February 28.

Purpose and Methodology

The team's assignment was to evaluate the first phase of the Lesotho Rural Health Development Project. During Phase I, project staff worked with the Ministry of Health (MOH) to improve its planning, administrative, and management capacities. The team's findings will be used to make "a collaborative decision (involving the evaluation team, the LRHDP team, USAID, and the MOH)"* on the future of the project before Phase I ends in September 1980.

Two alternatives were proposed: modify the project before beginning Phase II training and operation activities or "terminate the project in an orderly manner, if so recommended, in the remaining months of Phase I." One of the team's purposes was to recommend one of these alternatives after reviewing Phase I.

*

See Appendix C, "Statement of Work," p. C-4, LRHDP (632-0058).

Scope of Work

The team shared responsibility for the evaluation, although each member was assigned a specific function. Dr. John Karefa-Smart was the team leader and health planner; Dr. John Kennedy, health administrator; and Dr. Mervell Bracewell, nurse-clinician-educator and family nurse practitioner.

The scope of work included interviews, trips to rural clinics, reviews of data and available reports, and complete evaluations of training programs for nurse-clinicians, nurse-assistants, and village health workers. The team also made a complete assessment of the Ministry of Health and recommended ways to improve administrative, organizational, and logistical support.

Data Collection

The team visited training institutions, government departments, clinics, voluntary health agencies, and donors in Maseru and other districts. Each member held discussions with individuals concerned with his/her scope of work.

The project team and various MOH officials reviewed available reports and comprehensively documented all findings. The evaluation team found especially useful the Six-Month Status Report, submitted by LRHDP staff to the Ministry of Health on August 31, 1979; this report, a record of progress to date,

highlights the requirements for successfully achieving remaining program objectives.

Itinerary

The team made six trips to rural areas, two by air, to mountain districts, and four overland. The team visited a Flying Doctor Service clinic and a hospital-based clinic where village health workers are trained.

The team's itinerary was as follows:

<u>Date(s)</u>	<u>Appointment(s)</u>
February 8	Ministry of Health, Maseru
February 11, 18, 19, 21, 22	Visits and appointments, Maseru
February 12	Mafeteng Hospital Lesotho Dispensary Association Ts'akholo Training Site
February 13	Semonkong (air trip; with Flying Doctor Service)
February 14	Peka VHW Training Site Leribe Government Hospital Maputsoe Clinic Mapoteng Molvti Hospital
February 15	Thaba Tseka, Parau Hospital (air trip)
February 20	Moriija, Scott Hospital Roma, St. Joseph's Hospital
February 25	Work on Draft Report
February 28	Present and discuss Draft Report with AID/Lesotho, LRHDP staff, and MOH staff

II. BACKGROUND

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General Description of the Project

The Lesotho Rural Health Development Project is described fully in Project Paper 690-0058,* which was approved by USAID/Washington on September 29, 1977. This document includes a complete description of the population, topography, and climate of Lesotho, and the major disease problems of the health sector. (These subjects are not described in this report.)

This project, which aims to assist the Ministry of Health (MOH) of the Government of Lesotho (GOL) in providing basic integrated health services to the rural population, is divided into two phases. Phase I provides support to the MOH through advisory staff--a health planner, a management specialist, a physician-trainer, and a family nurse-clinician trainer. Phase I activities are designed to improve the efficiency of the MOH. Initiation of Phase II depends on the satisfactory completion and positive evaluation of Phase I. During the second phase, nurse-clinicians and village health workers will be trained to deliver rural health services throughout Lesotho.

Phase I will end in September 1980. If the government decides to initiate Phase II, activities will be conducted until August 1984.

*

Lesotho Rural Health Development Project Paper, January 1977.

Project Staff

Phase I began in March 1979 with the arrival in Lesotho of two members of the project team: Jeffrey A. Smith, the MHA-designated health administrator, and Dr. William Emmett, the management specialist. The other two team members, Dr. Lester Wright, the physician-trainer, and Pamela Prescott, the nurse-clinician trainer, arrived in August.

Although the job descriptions for the four project technicians were written clearly, their titles caused confusion, and there is some question about their advisory roles. For example, early in the project, the physician-trainer was appointed the chief of project staff. To clarify the team's roles and to facilitate the appointment of nationals to corresponding positions in the Ministry before Phase II ends, the staff's job titles should be changed to the following:

- Technical Advisor, Chief of Project Staff
- Technical Advisor, Planning
- Technical Advisor, Administration
- Technical Advisor, Training

External Factors

There have been no major changes in the project setting or GOL priorities. Officials interviewed by the evaluation team confirmed the government's commitment to achieving the WHO goal,

"Health for all by the year 2000," which the Cabinet adopted formally on March 27, 1979. As stated in the Second Five-Year Plan,* Lesotho intends to reach the 96 percent of the population that resides in rural areas through the LRHDP. (This goal is also restated and emphasized in the draft version of the Third Five-Year Plan.**)

The team studied the possibility of using GOL resources to build a new modern hospital in Maseru. High-ranking government officials assured the evaluation team that the firm decision to construct the 400-bed hospital strengthens Lesotho's commitment to provide health services for the majority of the people. Those in favor of the hospital cite three reasons for building it:

1. It can serve as a referral hospital for patients from all part of Lesotho who need tertiary and specialized care. These persons must now be sent to facilities in the Republic of South Africa. Construction of the new hospital will lessen (eventually eliminate) Lesotho's dependence on other countries' services.
2. Specialists on the hospital's staff will become members of the proposed faculty of health sciences for the National University of Lesotho.
3. Valuable space now occupied by the Queen Elizabeth II Hospital will be released for other planning uses.

*

Second Five-Year Plan, 1975-1980.

**

Third Five-Year Plan (draft; for the 1980s).

It is not clear that the curriculum for all categories of health personnel will include preventive and curative studies. During Phase II, the project's training advisor and other short- and long-term consultants for the MOH and Ministry of Education should collaborate to avoid duplicating each other's training programs.*

*

Funds for the faculty of health sciences will be allocated to the Ministry of Education and will not compete with the MOH budget.

III. EXECUTIVE SUMMARY

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Dr. John Karefa-Smart, LRHDP health planner, Dr. John Kennedy, health administrator, and Dr. Mervell Bracewell, nurse-training specialist, went to Lesotho on February 8 to evaluate Phase I of the Rural Health Development Project.

Following a briefing by AID/Washington and AID/Lesotho, the team studied all available reports and interviewed government officials, health personnel in Ministry of Health agencies, and staff of hospitals and clinics run by the Private Health Association of Lesotho. The team also visited 10 hospitals and clinics; the three in the mountain districts were accessible only by plane.

Phase I activities required the technical assistance of four advisors (a team of project contractors from the University of Hawaii) whose assignment was to improve the capacity of the Ministry of Health to provide primary health care services throughout Lesotho.

Members of the project team served as staff of the Ministry of Health and worked closely with the Permanent Secretary and with the chief of the Planning Unit. They supported planning efforts and helped to organize several training workshops and seminars.

The evaluation team evaluated progress made during Phase I in three areas:

- the capacity of the Ministry of Health to plan;
- the capacity of the Ministry of Health to provide administrative and logistical support to rural health services facilities; and,

--the capacity of the Ministry of Health to train and field additional categories of health workers.

Descriptions of progress and problems in each of these areas are included in the evaluation report. Recommended solutions to the problems are also listed.

Substantial progress has been made in reorganizing the Ministry of Health to deliver health services more effectively in all parts of the country. The Ministry and the Private Health Association of Lesotho have begun to collaborate on their planning efforts. A system for producing, procuring, storing, and distributing pharmaceutical supplies has been designed. MEDEK modules have been adapted for training nurse-clinicians and village health workers. The Ministry is receiving assistance in long-range planning and in preparing legislative proposals.

Several issues and problems must be clarified. A system to maintain and repair facilities, equipment, and transport vehicles must be adopted. Radio communications must be improved. Adequate incentives to ensure effective staffing of health institutions at all levels must be provided, and mid-level administrative trainees must be recruited for the health system. The Ministry of Health must control more effectively all public and private health services in the country.

The evaluation team is convinced that the Government of Lesotho and the Government of the United States, both members of the World Health Organization, are committed to the WHO goal of

"Health for all by the year 2000." Both governments realize that to achieve this goal, health services designed to meet the country's specific health needs must be made available throughout rural Lesotho, where more than 95 percent of the population lives.

The general plan to provide health services through trained nurse-practitioners and village health workers (two new categories of health workers) is sound professionally, an appropriate approach which has achieved success throughout the world and which is gaining universal acceptance.

Despite initial delays, project staff enthusiastically assumed their tasks of advising and assisting the Ministry of Health in improving its capacity to plan for and administer a primary health care system consistent with Lesotho's declared health goal. Significant progress was made following the creation of a planning unit within the Ministry. The unit is understaffed now, but the Ministry intends to hire soon additional planning specialists.

The private health sector, which provides a significant proportion of the health services in rural areas, is willing to cooperate with the government to achieve its goal, and it has already participated in preliminary seminar workshops on major problems and on the proposed solutions which the Ministry is implementing now.

The MEDEX curriculum modules, a unique contribution facilitating the goals of the project team, have been accepted and are being adapted to meet the specific needs of Lesotho's training programs.

Several major problems have not been resolved. The management support systems of the Ministry are weak; the government is unable to retain trained personnel because general service conditions (salaries, postings, lack of inducements, etc.) are less attractive than those of the private sector; and the delayed approval and implementation of the organization plan are hindering efforts to administer all rural health services through one authorized official or group. The GOL is aware of these problems and is making an effort to resolve them.

The evaluation team discussed its findings with AID/Lesotho, Ministry of Health officials, and project staff. Citing accomplishments in Phase I, the team concluded that the government should initiate as planned Phase II training and development activities.

IV. OBSERVATIONS, FINDINGS, AND RECOMMENDATIONS

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The goal of the Ministry of Health is to improve the health status of citizens of the Kingdom of Lesotho, 96 percent of whom live in rural areas. To achieve this goal, the government proposed in its Second Five-Year Development Plan (1975-1980) two major objectives:

--improving and expanding health services outside the capital and in the few urban communities;
and,

--emphasizing and improving preventive and promotive health care.

The Lesotho Rural Health Development Project (LRHDP) was designed to promote achievement of these objectives by helping the Ministry plan and administer "an appropriate, improved, and integrated health service delivery system." It provides technical assistance in two phases.

This chapter is the evaluation of progress made during Phase I in improving the Ministry's capacity to plan, to provide administrative and logistical support to rural health services facilities, and to train and field other categories of health workers.

Planning Capacity of the Ministry of Health

A. The Planning Unit

Established in 1974 as part of the Central Planning Office, the Health Planning Unit is now under MOH authority. It

occupies a separate building which also accommodates LRHD Project technicians who advise the unit. Modestly staffed, it is headed by a principal planning officer whose various Ministry duties are not restricted to planning.

Original plans called for one statistician and three planning officers; two staff have left for higher paying positions and a third is pursuing graduate training in the United Kingdom.* The highest priority should be given to filling these vacancies and to making staff salaries competitive with salaries for personnel in other government departments. Statisticians for the unit should be recruited directly, not from the Central Office of Statistics. Activities to strengthen the unit should be completed. The unit should function as an advisory group for the Permanent Secretary and be relieved of distracting, time-consuming administrative tasks not related to planning.

The unit's significant accomplishments include:

- Drafting and promoting the national primary health care program (PHC).
- Contributing the health chapter for the Third Five-Year Plan.
- Promoting several donor-funded programs (e.g., the expanded immunization program, the rural sanitation project, and the nutritional surveillance program).

* See Appendix D.

- Promoting the improvement and renovation of rural clinics (with the assistance of the Ministry of Rural Development).

1. MOH Response to Six-Month Status Report Recommendations (SRR)

The Six-Month Status Report recommended that a Director of Rural Health Services be appointed and that MOH operations be reorganized. A new "Plan of Organization" was recommended during the management seminar workshop held at the Mazenod Conference Center in November 1979.* Under this plan, the new director will be responsible for health services at all levels down to the village health worker. (S)he will report directly to the Permanent Secretary.

The Ministry amended the proposed plan to provide for two deputy directors, one responsible for hospital services, the other for rural health services. The line of direct reporting responsibility was retained. The Cabinet approved the plan at the end of the evaluation team's visit.

Participants at the management seminar workshop and two consultant-specialists supported the proposal to design a system of health service areas (SRR2). Lesotho has now been divided into 17 such areas, each served by a hospital. Ten of the area administrators who have been appointed are at their posts. This

* See Appendix E.

initial step toward decentralization will reduce the number of officials that the Permanent Secretary and his staff must supervise and provide time for preparing and implementing policy.

The MOH is discussing now the recommendation (SRR3) that a National Health Council be appointed to advise it on all aspects of the national health care system. The Ministry expects to appoint a council before the second management seminar workshop, scheduled for November 1980. If appointed in time, the council will cosponsor the seminar.

2. MOH Response to Implementation Plans

In response to the need for collected, analyzed planning data (SRR4), the new planning unit will include a statistics section and a planning section. Staff of the statistics section will work closely with the Central Statistics Office to provide the planning section with the data and analyses it needs for sound planning.

The Six-Month Status Report recommended that the MOH work closely with the private sector (in particular with the PHAL) to collect information (SRR5). The establishment of functional relationships at all levels, from the village health worker to the Permanent Secretary, was proposed. The Planning Unit is preparing a manual describing these relationships.

To further strengthen its planning capabilities, the MOH has agreed to commit staff time for a major review of the Ministry's organizational activities (SRR6). Time will become available as

decentralization proceeds. In accordance with the new organizational plan, the Deputy Director of Rural Health Services will assume soon his duties.

One important step the MOH took to facilitate implementation of the status report recommendations was to convene the seminar workshop on management. Held in November at the Mazenod Conference Center, the workshop addressed general management and eight management support systems. Specific planning proposals were prepared. (Follow-up actions on these proposals are reviewed in this report.)

The MOH should take advantage of the government's commitment to "Health for all by the year 2000" by preparing concrete, realistic proposals on budget increases needed to recruit required administrative and professional staff; to purchase supplies, equipment, and vehicles (especially 4-wheel drives to reach mountain clinics); and to provide financial incentives to recruit and retain personnel willing to serve rural areas. The government should contribute the additional office space (and office supplies and furniture) needed to accommodate the Director of Rural Health Services.

Recommended training in health service administration (requiring approximately seven person-years at the diploma level and four person-years at the graduate level) should be supported with funds allocated for participant training. The MOH must give assurances that the trained national(s) will be retained in the Ministry.

B. Development of Health Service Areas

MOH officials reassured the team of Lesotho's commitment to a "national, three-tiered primary health system to provide preventive, promotive, and curative services to all the people of Lesotho, the majority of whom live in the rural areas."

The system will require dividing the country into health service areas (HSAs), each of which will have as its focal point an existing hospital serving between 50,000 and 100,000 persons. Health services will be provided in villages by village health workers (VHWS) who will be supervised by nurse-clinicians. Referrals will be made to health clinics and hospitals when necessary.

The first 10 health service area administrators have been trained, appointed, and posted. Their functions will be emphasized as the MOH decentralizes its district functions. The administrators will report directly to the area medical director. In each service area, a head nurse-clinician will supervise other nurse-clinicians, whose main responsibility will be to train and supervise village health workers.

The highest priority should be given to completing the official job description manual. This manual should describe the functional relationships of all workers in the primary health system (i.e., village health workers, nurse-clinicians, supervising nurse-clinicians, health service directors, district

health officers, and the Director of Rural Health Services). It should be based on the findings and recommendations of the Mazenod seminar participants.

C. PHAL and MOH Relationships

The Private Health Association of Lesotho (PHAL) was founded in 1974. A voluntary association of four Christian churches, it aims to improve, expand, and coordinate health services in Lesotho and to provide a single means for integrating its own services with those of the Ministry of Health. The association is administered by a nine-member board of trustees and a full-time executive secretary.

PHAL physicians and nurses constitute approximately 25 percent of all physicians and nurses working in Lesotho. Eight of the 17 hospitals in Lesotho are PHAL-managed; they handle approximately one-third of all admissions. PHAL hospitals and clinics treat approximately 50 percent of all outpatients.

The PHAL and the MOH recently collaborated to develop a national primary health care program. They have also jointly trained nurses. The Lesotho Dispensary Association (LDA), a manufacturing facility at Mafeteng and a PHAL operation, has been integrated into the MOH National Drug Stockpile Organization (NDSO). Central medical stores have been absorbed into the organizations' structures.

The PHAL/MOH relationship is not problem-free. The PHAL has complained about a lack of adequate consultation on several major

matters, including the MOH's decision not to accept enrolled nurses in the training program for nurse-clinicians and logistical problems in training nurse-clinicians and returning them to duty posts. The association is also concerned about the Ministry's uncertainty about providing continued support for nurse-assistant training.

The MOH should reconsider its decision not to allow enrolled nurses to train as nurse-clinicians. The Nursing Council recommended that enrolled nurses be given an opportunity to acquire the skills they need to register as nurse-midwives; this status would qualify them for nurse-clinician training. This is a reasonable recommendation which should be accepted.

The MOH should allocate specific responsibilities to the PHC Action Committee. The committee should be required to meet regularly and to submit its findings and recommendations to the Ministry.

The MOH should also review the nurse-assistant training program with the PHAL and make a firm decision on its future in the primary health care program.

D. Epidemiological Determinants of Health Planning

Effective planning requires the consideration and recommendation of specific solutions to specific problems. An effective health plan must address specific health problems about which epidemiological information is available.

The collection and interpretation of epidemiological data on the most common diseases in Lesotho should be the function of the Planning Unit of the Ministry of Health. Steps have been taken to improve the Ministry's capability to obtain such data.

For example:

- The collection and reporting of data on diseases encountered, treated, or referred are included in the training curriculum for village health workers, nurse-assistants, and nurse-clinicians.
- Suitable reporting forms have been designed and are now used by village clinics, health centers, and dispensaries and hospitals, as well as in the nutrition surveillance program and the expanded immunization program.
- A statistics sub-unit has been added to the new staffing plan for the Planning Unit. This sub-unit will assemble, analyze, and interpret planning data collected at all levels of the three-tiered PHC system.
- Problems with data collection were an important item on the agenda of the Mazenod seminar workshop.
- The national information gathering system was tested successfully in 1978. Epidemiological data was collected during the trial run.

The statistics sub-unit should be moved to the same building as the Planning Unit. As recommended at the workshop, a minimum staff of eight statistical clerks should be employed. Adequate equipment (electric calculators, typewriters, drafting equipment, stationery, etc.) should be supplied.

The project technical advisor for planning should discuss with the Ministry appropriate training for staff of the statistics sub-unit. A long-term consultant on sector statistics should be hired to upgrade the section's capabilities.

All government and PHAL health facilities should use standard reporting forms. All data should be reported regularly to a common information gathering center. All planning proposals should be supported by relevant data.

E. Participant Selection, Training, and Placement

Candidates who may be trained to participate in the LRHD Project include MOH personnel, especially Planning Unit staff, and personnel in the three-tiered primary health care system. (Problems in selecting and placing both groups were discussed fully at the sub-workshop on personnel.)

Among other recent positive responses to seminar participants' recommendations, the MOH has:

--appointed a senior personnel officer recruited from the Cabinet;

--accepted a recommendation from a task force on personnel management that the MOH be authorized to select and recruit staff below the level of Permanent Secretary (this must be approved by the Minister of Public Services);

--provided incentives (e.g., increased leave time for rural nurses) to encourage personnel to serve in rural areas; and,

--increased physicians' salaries to discourage their frequent resignations for financial reasons.

The PHC Action Committee should assist the MOH in preparing for approval revised position descriptions; providing incentives for rural service; posting regulations, including compulsory rotation in rural areas; etc.

The MOH should appoint the proposed joint public-private sector salary task force before April 1980. The task force should be required to report its findings to the Permanent Secretary by September.

The remaining steps for implementing the new organization plan (see "Implementation Plan," pp. C17-18) should be completed at least three months before Phase I ends.

More than 25 percent of the funds for Phase I were allocated to participant training. As described in the project paper, by the end of Phase I (1980), nine Lesotho nationals will have received a total of 405 study-months (33 years, 9 months) of training. (The contract provides for only 19 study-years of long-term and 24 months of short-term training in the U. S. and Third World countries.) The training should be in progress or have been completed when Phase I ends.

Two workshops on participant training were held last year. A management seminar workshop, attended by 118 persons, over 100 of whom were nationals, was held at the Mazenod Conference Center,

November 26-30, 1979. This seminar was project-funded. A curriculum adaptation workshop, attended by 40 persons, was held in January 1980. A regional management workshop has been scheduled for June 1980, and a tutor preparation workshop for July. During Phase II, two other management workshop seminars will be held, one in November 1980 and one in November 1981.

One MOH official who received a year of management and planning training in the U. S. before the project began officially is now the principal planning officer. Another official who studied development management in Botswana is in the United Kingdom participating in a training program in public health administration. This training is not project-funded.

Eleven nationals have been trained at the Regional Institute of Development Management in Botswana. Ten have returned to Lesotho and are working as health service area administrators. One is receiving additional training abroad.

The expectations for participant training, especially long-term study overseas, are unrealistic. There are not enough candidates for such training in government agencies, nor are there enough recent graduates to fill the program. Even if enough candidates were available, there is no guarantee they would be attracted to MOH posts or be willing to accept the service conditions. The private sector offers more lucrative opportunities.

If the GOL does not improve service conditions, including basic salaries, and provide incentives to encourage service in remote mountain areas and in rural clinics, few well designed projects will succeed. This problem is not unique to the Ministry of Health, but steps should be taken immediately to correct it.

The Government of Lesotho should give high priority to a national review of the many studies on the problems of recruiting and retaining trained personnel for government service. Development programs in all ministries will be seriously jeopardized if no trained nationals are available to implement them. Interested donor agencies should be asked to participate in the study, to prepare an objective report on their findings, and to offer realistic recommendations.

The participant training objectives should be revised before Phase II begins; short-term training in local workshops, seminars, orientation meetings, and observation visits to other developing countries should be substituted for the more ambitious activities now scheduled.

MOH Administrative and Logistical Support

A. Structure of the Ministry of Health

1. Structural Problems

The following structural problems were identified in the Six-Month Status Report:

- The MOH is too centralized.
- Vertical programs (e.g., MCH, nutrition, EPI, health education, environmental health, and family planning) operate separately and are not coordinated, particularly at the district level.
- Non-government agencies and programs operate independently; few agencies coordinate their efforts with the MOH at any level.
- There is no central MOH structure through which to coordinate and direct district and rural health services.

2. Proposed Action

The following steps have been proposed:

- The MOH should be reorganized at the central level. A new post, Director of Health Services, should be created; this person should be responsible for coordinating and directing all health services, including district hospitals and the Flying Doctor Service. A deputy director should be responsible for rural health services.
- The medical director of each health service area hospital should be responsible only for health activities in his/her service area.
- The district health officer should be responsible for all health-related activities within his/her district, including the integration of vertical programs.
- The nurse-clinician should provide and coordinate preventive, promotive, and curative services through community health clinics and the network of community-based village health workers.

Under the new reorganization plan, the chain of command will be as follows:

- Director of Health Services reports to Permanent Secretary, Ministry of Health
- Deputy Director (Rural Health) reports to Director of Health Services
- District Health Officer reports to Director of Health Services
- Medical Director of health service area hospital reports to respective District Health Officer
- Supervising Nurse-Clinician reports to Medical Director of service area hospital
- Nurse-Clinician reports to Supervising Nurse-Clinician
- Village Health Worker reports to Nurse-Clinician

The Deputy Permanent Secretary should give special attention to the administrative support functions of the MOH and report directly to the Permanent Secretary.

Since direct-line responsibility for the delivery of services under vertical programs will be transferred to district health officers, the senior medical health officer and his specialist staff will be responsible only for planning, evaluating, and issuing guidelines that ensure the quality of services. Their roles and functions will be normative, not executive.

3. Progress to Date

By February 1980, the following steps had been taken:

- The Cabinet approved the general plan for reorganizing the MOH.
- The management specialist and the Planning Unit designed the proposed implementation scheme, which includes time-phased targets for establishing health service areas.

4. Schedule for Reorganization Activities

The following targets for reorganization activities were proposed:*

- Cabinet approves reorganization plan, February 1980 (achieved)
- Transfer statistical unit under Planning Unit, February 1980 (achieved)
- Appoint Director of Health Services, April 1980
- Complete mapping of health service areas, May 1980
- Complete interim HSA agreement study, May 1980
- Review and modify interim HSA agreement study during district management seminar workshop; reach agreement with district health providers on terms of interim HSA agreement, June 1980
- MOH and Cabinet review and approve interim HSA agreement, August 1980
- Establish health service areas, September 1980 (phased or total)
- Study and evaluate ongoing service area activities, September-November 1980

*

Budgets and other financial plans are discussed in the section on financial management.

- Review reorganization of MOH and service area operations at management seminar workshop; prepare action plan for CY 1981 based on findings, November 1980
- Modify and reach definitive conclusion on service area agreements and operations, March 1980
- Complete contracts between GOL and non-government health providers, May 1981
- Review progress at management seminar workshop, November 1981

5. General Findings

Substantial progress has been made since the Six-Month Status Report was issued. The MOH is being restructured at the central level. PHC activities are being coordinated and control decentralized to district and peripheral levels.

Numerous PHAL health providers have begun to participate in reorganization activities. Further implementation of the reorganization plan will require continued PHAL support.

Government and non-government health providers have displayed an impressive knowledge of and interest in the reorganization. Their answers to the evaluation team's questions were candid and forthright.

The transfer of control over administrative support functions (i.e., finance and accounting, supply, personnel, transport, communications, maintenance, etc.) from the Director of Health Services (at the central headquarters of the MOH) may be a weakness in the reorganization plan. Given the difficulties

in charging one official with all line-operation functions, the team assumed the MOH had good reasons for not making the administrative support functions the responsibility of staff reporting to the Director of Health Services.

Another weakness in the reorganization plan is the lack of district administrative and logistic support (personnel and equipment) from the health service areas. A single, newly trained administrator is responsible for all staff support functions; this person reports to the medical director of the health service area in which (s)he works.

Special attention should be given to improving and aligning administrative and logistic support to ensure that personnel responsible for these services facilitate the delivery of essential health services, particularly to rural areas.

B. MOH Information System

Inadequate instruction in the use of reporting forms, failure to collect relevant data from other GOL sources, poor equipment in the statistical unit, and lack of analyses or use of collected data in planning were discussed at the management seminar and identified as problems in the Six-Month Status Report.

1. Findings

The statistical unit employs a chief statistician and six statistical clerks. The unit chief (who is well

qualified and motivated) has occupied her position since November 1, 1979, when she replaced a WHO-trained statistician who was transferred to another ministry. This person may leave the post this June after her husband, an expatriate, completes his tour of duty. There is some evidence to support the claim that continuous leadership and guidance in the statistical unit are lacking.

Routine health data received by the statistical unit include:

- daily outpatient tally sheets by type of illness (if all hospitals and clinics reported regularly the required data, the unit would receive 117 such sheets each day);
- daily hospital discharge sheets (19 per day);
- MCH/FP reports, including information on immunizations, prenatal visits, health education sessions, family planning acceptors, etc.;
- tuberculosis follow-up reports; and,
- laboratory reports on sputum examinations for tuberculosis.

Simple cross-off-type forms requiring little written information are used. Data are reported, tabulated, and analyzed at a central facility.

Vital statistics are compiled by the National Bureau of Statistics from records kept by civil authorities, village chiefs, or headmen. The structure is weak, the reporting unreliable and incomplete. Vital statistics, such as they are, are reported in the Annual Statistical Bulletin.

The reporting requirements of private and public health facilities are weakly enforced. A personnel status report is required of each of the 117 fixed health installations. Approximately 50 percent of the installations send in reports. More private institutions than government-operated clinics report. According to project staff, of the 19 hospitals, 13 or 14 report at least once a year.

Few clinics report financial data, although the revenues of government hospital clinics are turned over once a month to the district sub-accountant's office, part of the Treasury Division of the Ministry of Finance. Government clinics and hospitals are not permitted to use revenues to offset expenditures and must depend on appropriated funds. Private hospitals and clinics retain their revenues and can apply them against expenditures. Private institutions, hospitals, and larger clinics often send the MOH an annual report that includes information on revenues and expenditures; submission of the report is voluntary. In March 1979, the PHAL sent to the MOH a summary of receipts and expenditures at non-government hospitals. Efforts are being made to institutionalize this reporting service through the PHAL.

The statistical sub-unit of the Planning Unit will be able to provide continuous leadership and direction only when a permanent qualified statistician becomes chief of the unit.

The Ministry's need for information on personnel, material resources, facility use, budgets and expenditures by service units, unit costs of services, sources of revenue, and other financial matters has not been assessed fully. An assessment is needed to determine what essential data and other financial information must be collected routinely to satisfy the planning, operational, and ongoing evaluation needs of the MOH. Special studies and surveys may be required occasionally.

The statistical sub-unit urgently needs proper equipment (calculators, typewriters, etc.).

2. Recommendations

The evaluation team recommends the following:

- The statistical manual should be completed, printed, and distributed to all health facilities. Copies should be given to all health workers who collect statistical information.
- When the manual becomes available, small district training workshops should be held for supervisors and health service area staff. Persons participating in these workshops should then train and supervise subordinate staff in the proper collection and reporting of data.
- The advantages of decentralizing the tabulation of certain data (e.g., health service statistics) to district or service area levels and the periodic submission (three or four times a year) of summary reports to the central office should be considered.
- An implementation schedule should be adopted.

3. Proposed Schedule

The proposed schedule for implementing the recommendations is as follows:

March 1980	Assess equipment needs (Planning Unit and project staff)
March 1980	Appoint permanent professional chief of the statistical sub-unit in time to participate in April study
April 1980	Begin study of management and information needs (Planning Unit, RHDP staff, MOH controller of accounts; PHAL and LIPA; outside consultant (e.g., WHO)
June 1980	Put needed equipment in place; study management information and complete design of management information system; review results of study and design of information system at district management workshops
July 1980	Begin work on revised statistical manual
September 1980	Complete manual
September- November 1980,	Field-test new management information system and manual
November 1980	Review progress to date, recommendations, and modification plans for regional workshops at management seminar workshop
January-May 1981	Conduct workshops
June 1981	Take regulatory action to strengthen reporting requirements

July 1981-ongoing

Determine special study and survey needs; evaluate new system

November 1981

Hold management seminar workshop; review progress, problems, recommendations, and modifications of management information system; prepare action plan for 1982

C. MOH Financial Management System.

1. Problems

The Six-Month Status Report identified several financial management system problems. The MOH's financial system is operated by personnel recruited from the Ministry of Finance (MOF), over which the MOH has no control. A minimum of the MOF's budgeting and accounting requirements are met; the MOH lacks both the budgeting data and control it needs to plan, operate, and evaluate.

Budgeted funds and line-item expenditures are categorized and reported under five broad sub-headings (called programs), namely, "Administration," "Hospital Services," "Mental Health," "Public Health," and "Leprosy Control." Financial data cannot be disaggregated for specific districts, health service areas, institutions, or activities.

Revenues collected from MOH sources are low. Collections from non-government health facilities are substantially higher. Private institutions receive financial support from the MOH only

when costs rise substantially and outside contributions decrease or when they are having trouble meeting their operating expenses. There is no standard fee schedule for services.

Participants at the management seminar workshop noted the poor morale, motivation, and performance of finance staff at the central headquarters and at field installations. These characteristics are attributed to low pay, poor qualifications, and the lack of advancement opportunities. The lack of direct-line authority in the MOH (personnel are recruited from the MOF) hinders proper supervision and control. The Ministry has problems recruiting and retaining good finance staff. Clinical personnel are often overburdened with financial matters because of the shortage of clerks. The chief accountant position has been vacant for nearly three years because there are not enough suitably qualified applicants. Employees of private and non-government agencies reportedly receive double the salaries of MOH staff.

There is minimum coordination and control of donor activities. Government and non-government institutions conduct disparate activities.

There is a general lack of control over and concern about the expenditures of and revenues collected from government-operated health facilities. The problem stems from the over-centralized allocation and control of MOH funds (under a MOF-dominated system); operating units have few incentives for efficient, cost-effective budgeting.

2. Findings

Information needed to begin institutional budgeting will be available by the last quarter of 1980. Institutional budgeting could be implemented partially in 1980-1981 and fully in 1982-1983, assuming no unforeseen bureaucratic or political obstacles arise.

The Cabinet decided in mid-February 1980, that a controller of accounts should be assigned to and paid by the MOH. Other MOH finance staff will remain employees of the MOF.

In 1979, of the total R946,320 allocated for drugs, approximately R571,000--over 60 percent--were spent for drugs at the Queen Elizabeth II Hospital. In addition, 33 percent of the MOH payroll went to Queen Elizabeth II Hospital employees, 30 percent of whom work for the MOH.

The recurrent MOH expenditure rose from 2.14 million Rand in 1976-1977 to 4.0 million Rand in 1979-1980--a 100 percent increase. Revenues increased from R257,000 in 1976-1977 to R381,000 in 1979-1980--an increase of approximately 50 percent.

The Ministry's budget and finance unit employs nine officials: one account controller, one senior accountant, three assistant accountants, four accounting clerks, and a part-time financial advisor. The post of chief accountant is vacant.

3. Recommendations

The evaluation team recommends the following action:

- The MOH must employ, control, and supervise a core group of qualified budget and financial personnel.
- The MOH should encourage the PHAL and the Lesotho Institute of Public Administration (LIPA) to participate in planning to achieve full institutional budgeting by 1982-1983.
- Fee schedules should be standardized, at least for health units within a service area, for non-government and government-operated facilities.
- Salaries should be standardized for health workers in both government and non-government health institutions; the MOH should contribute more than 4 percent of the operating budget of non-government institutions. The PHAL estimates that the MOH's annual contribution would be less than R320,000.

D. MOH Drug and Medical Supply System

1. Findings

The following observations are based on a study of available reports and on discussions held during the evaluation team's visit.

Although rural health facilities in Lesotho seem to be better supplied with drugs and essential medical supplies than similar facilities in many developing countries, there are serious problems with the supply systems at both central and peripheral levels.

The MOH recently issued a National Formulary of generic drugs; it eliminates most combination drugs to promote rationalized

drug use and to reduce costs.* A "Formulary Committee" was appointed to monitor the formulary.

The Lesotho Dispensary Association (LDA), which supplies most of the drugs used in PHAL facilities, expects to be awarded a GOL contract to manage the newly created National Drug Stockpile Organization (NDSO). This organization will be expected to handle purchasing, inventory control, and peripheral distribution problems. The NDSO will absorb the functions of the central medical stores in Maseru.

The National Drug Stockpile Organization began constructing a manufacturing, warehousing, and office complex in Mafeteng in August 1979; the facility is nearly complete and manufacturing has begun.

The NDSO began in February 1980 a pilot drug distribution program in which St. Joseph's Hospital, an accessible, mission-operated facility in the lowlands in Roma, and a government-operated hospital in Mokhotlong, a mountain facility accessible only by secondary roads (a 10-12-hour trip), participate.

2. Recommendations

The evaluation team recommends the following action:

- All drugs received through bilateral assistance, UNICEF, etc., or donated to the MOH should be added to NDSO stock. Individual

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"Drug List for Lesotho," Ministry of Health, February 1979.

institutions should continue to receive separate donations, but they should send the "Lesotho Drug List" to their donors and request that donations conform to this list.

- The National Laboratory should maintain quality control over LDA-produced drugs.
- The skills of dispensary staff should be upgraded through regional training courses. Health science faculty from the University of Lesotho should provide more formal training.
- The LDA/NDSO should be designated the sole legal coordinator for drug and medical procurement, manufacturing, storage, and distribution. The organization will control the system used by all facilities and programs incorporated into the MOH's expanded program of rural health services.
- In collaboration with the MOH and PHAL, the LDA/NDSO should institute an equitable drug and medical supply payment scheme for all facilities and programs.

E. MOH Maintenance System

1. Findings

The maintenance of MOH facilities is now the responsibility of the Minister of Works. Simple MOH equipment (other than vehicles) is repaired at a small equipment maintenance shop in Maseru; more complex repair work is done by commercial expatriate firms. Much equipment is in need of repair; repair and maintenance are complicated because little standardized equipment is used.

2. Recommendations

The evaluation team proposes the following action:

- To the extent feasible, the MOH should procure standard medical equipment for all health facilities. It should select equipment that can be serviced and repaired in the country or in South Africa. The availability and cost of spare parts should be considered when purchasing equipment.
- The Ministry should give high priority to upgrading its equipment maintenance shop. Technical assistance will be required. A suitable donor agency could be contracted to pay for the sophisticated training additional equipment maintenance technicians will need.
- The first step in upgrading maintenance of facilities and equipment should be the inventory and status assessment of MOH and PHAL facilities. Short-term technical assistance may be required.

F. MOH Transport and Vehicle Repair System

1. Findings

The Ministry owns a fleet of 62 vehicles, 35 of which were purchased with international or bilateral aid; the vehicles carry AX registration plates. The GOL's other 27 vehicles carry LX plates.

Regulations require that LX (i.e., government-provided) vehicles be maintained by Ministry of Works plant and vehicle pool workshops, located in Maseru, Hlotse, Mokhotlong, Quacha's Nek, and Mohale's Hoek. Nonetheless, several departments in other government ministries operate independent maintenance facilities for their AX-registered vehicles.

Services at Ministry of Works repair facilities are notably poor, probably because of inefficient management and operation.

2. Recommendations

The evaluation team suggests the following action:

- An independent MOH vehicle maintenance and repair workshop should be authorized as soon as possible to service all vehicles, regardless of their AX or LX registrations. The efficiency of the primary health care program will depend to a large extent on the implementation of this important first step.

G. MOH Communication System

Five health-related radio communications networks now operate in Lesotho; the Ministry of Health, Catholic Church Radio Network (CARITAS), Lesotho Evangelical Church Services (LEC), Seventh Day Adventist Church Health Services (SDA), and Anglican Church Services maintain one network each. Of the 129 sets available, 92 (or 71 percent) are in areas served by health facilities.

1. Problems

The major problems of the radio communications networks are:

- No standardized equipment is used.
- Many of the radio sets are old, a significant number should be replaced. No standby or alternative equipment is available for use while sets are being repaired.

- Most clinics and some hospitals use small four-stroke power generators to charge storage batteries in radios. Petrol and oil needed for the generators are supplied irregularly.
- Linkages between radio networks are limited because there is no common frequency.
- Operators are not well trained. Sets and antennae are not serviced regularly. The Ministry of Health made an agreement with the Ministry of Transport and Communication to repair facilities, but that ministry does not give a high priority to such work.

2. Findings

It is obvious that given the expanded rural health services program, the MOH needs a well coordinated radio network. A long-distance network linking Maseru with the 17 health service areas and a short-distance network linking the hospital in each service area with its major peripheral units are needed. Such networks will be costly, and they will require the use of standardized equipment, a well operated independent radio equipment maintenance shop, and spare sets for temporary replacements.

Power sources pose considerable problems, particularly for peripheral units. Several persons have recommended replacing the fuel generators with solar power generators. Although their initial cost would be higher, solar generators have a minimum life of 15 years; fuel generators last only five years.

3. Recommendations

Because the communications field is specialized, the evaluation team did not feel qualified to make specific recommendations.

Rural Health Development and Training

A. General Background

Lesotho has expressed its commitment to the primary health care program. The Third Five-Year Plan (Volume II) includes explicit information on rural health development and on the training of nurse-clinicians and village health workers.

The plan to improve and expand rural preventive, promotive, and curative health services requires an integrated three-tiered delivery system that is appropriate to Lesotho's needs and that requires only those resources that are available. Lesotho has already been divided into 17 health services areas, each served by a government or non-government hospital. Each hospital and its satellite clinics will be organized and staffed with a new cadre of health workers responsible for delivering appropriate health services to the villages.

Outpatient departments will be added to the hospitals in Leribe, Teyateyaneng, and Mohale's Hoek. Each such department will have office space for a nurse-clinician, a public health nurse, a health inspector, and a health education class.

The Lesotho Flying Doctor Service serves 10 isolated mountain clinics. Using aircraft chartered from Lesotho Airways, a Flying Doctor and a public health nurse visit each clinic twice a month. The Flying Doctor sees between 70 and 100 patients, many of whom are seen by a resident nurse in the interim. The Lesotho Flying Doctor Service has participated in pilot projects to train village health workers; resident nurses and health assistants at clinics have also offered their services to these programs and have cooperated with the Flying Doctor Service.

Lesotho plans to train 125 nurse-clinicians for service in rural clinics, where they will give minor medical treatment to many patients, especially those in isolated mountain areas, until a doctor arrives. The training program will begin in September 1980.

B. Nurse-Clinician Training

1. Support

A draft of the Lesotho "Nurse-Clinician Act of 1980"* has been submitted to a legal draftsman; this act will legalize the practice of nurse-clinicians. The MOH foresees no difficulty in getting the Cabinet to approve the act.

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See Appendix H.

The Nurse-Clinician Act provides for "the creation, definition, and regulation of the practice of a primary health care profession, the Nurse-Clinician, in the Kingdom of Lesotho," and for a "Nurse-Clinician Council." It includes sections on definitions, qualifications, scope of work, relationships, licensing, supervision, continuing education, training, discipline, the Nurse-Clinician Council, and rules and regulations.

The act defines a nurse-clinician as "a dual-qualified nurse who has completed an advanced course, at least twelve months long, that is approved by the Council and who has demonstrated to the satisfaction of the Council that (s)he is competent in the function to be performed."

Salaries for GOL (Civil Service) nurses are lower than those of PHAL nurses. Nurse-clinicians assigned to remote areas will probably be paid the equivalent of senior nurses' salaries--an incentive to accept assignment in a rural area.

The evaluation team could not find any concrete proposals on the salary scale for nurse-clinicians. A pay scale on a level with the salaries of senior GOL nurses should be adopted before the training program begins. The salaries should be commensurate with the nurse-clinicians' preparation and responsibilities. Salaries for all GOL nurses should compare favorably and be competitive with salaries for PHAL nurses.

2. Functions, Duties, and Responsibilities

The nurse-clinician's four primary curative and clinical responsibilities will be:

- To diagnose and treat 80 percent to 90 percent of the common medical problems brought to clinics.
- To organize, conduct, and evaluate child health care services to identify high-risk children; to manage common ailments referred by the school system; and to give immunizations.
- To provide prenatal, natal, and postnatal services to manage the common problems associated with pregnancy and reproduction.
- To provide family planning services.

The nurse-clinician will work with PHNs, district medical officers, VHWs, and other health professionals to encourage participation in health education programs offered at curative clinics and in villages. As part of the preventive approach to health care, the nurse-clinician will help design health education programs on various topics, such as common illness and disease prevention, nutritional preventive care, environmental sanitation, health during pregnancy, etc. She will conduct immunization programs to eradicate disease and family planning services to encourage child-spacing. She will also help design a method for evaluating the health status of the community and for implementing change.

The nurse-clinician will be responsible for two promotive activities. She will conduct one-on-one, small group, and home discussions to promote improved environmental, nutritional, and bodily health. She will also train, supervise, and evaluate the performance of VHWS.

The nurse-clinician will work with the VHW and the community to design:

- communications systems;
- emergency transport systems;
- safe human and solid waste disposal systems;
- adequate domestic water supply systems; and,
- community projects to solve health-related problems.

The nurse-clinician will assume several administrative duties. She will be required to manage service areas of 5,000-10,000 persons, and to organize and manage health facilities. The second task involves several sub-tasks. The include:

- establishing the work site (i.e., choosing the facility for the clinic or adapting an existing structure; making sure water and electricity (or alternate sources of energy) are available; arranging for the maintenance of the facility; selecting VHW training sites and sites for community education programs);
- ordering, storing, rotating, and replenishing all needed medical, drug, and miscellaneous supplies;

- filing and maintaining patient records;
- filing and maintaining financial records;
- designing a communications system and finding a means to maintain it;
- designing a transportation system for carrying out clinic functions, supervising VHWs, and providing emergency transport; and,
- coordinating district and village activities to promote schemes for primary health care programs in the community.

The nurse-clinician will be supervised either by a district medical officer or a supervisory nurse-clinician. The nurse-clinician will supervise the village health worker(s).

Participants at the management seminar workshop summarized the functions of the nurse-clinician. They described her duties and responsibilities as follows:

- The nurse-clinician will be responsible for providing and coordinating the preventive, promotive, and curative services offered through health clinics to the community. She will be responsible for training and supervising VHWs. She will also be required to supervise any other staff members assigned to the health clinic (e.g., a nurse-assistant, an auxiliary nurse, a health inspector, a scrubber, a watchman). The nurse-clinician will report to a supervisory nurse-clinician or, in her absence, to the medical director of the hospital in her health service area.

- The supervisory nurse-clinician will be responsible for teaching, supervising, motivating, and evaluating the performance of all nurse-clinicians in her area. She will also ensure that all health clinics within her district function effectively. The supervisory nurse-clinician will report directly to the medical director of the service area hospital.

Seminar participants recommended the appointment of an "Admissions Committee" on which would sit the chief matron; the senior medical officer of health; a district medical officer; a private hospital medical superintendent; a matron of a government hospital; a matron of a private hospital; a representative of the PHAL; a mental health representative; and nurse-clinician training staff.

3. Selection

Guidelines for selecting nurse-clinician trainees were prepared at the management seminar workshop. The candidate must be a dual-qualified (registered) nurse and have worked at least two years in a rural area. Her past work performance must be satisfactory. She must be interested in functioning as a nurse-clinician, and be willing to accept the assignment deemed appropriate for her. She must be bonded for the three years she will occupy her assigned post, and she must be willing to return to the rural areas to work.

Preference should be given to candidates now working in rural areas. State-enrolled nurses interested in nurse-clinician

training should be allowed to upgrade their education to acquire the status of state registered nurses; this will qualify them for the nurse-clinician course.

Available nurse-clinicians should be assigned to rural clinics, and only after positions at rural clinics are filled should they be assigned to outpatient departments.

4. Training

A competency-based curriculum will be used to train the nurse-clinician. The graduate will acquire only those skills and the information she needs to perform her job effectively. The content of the course will relate directly to the expected job performance.

A job description listing what the nurse-clinician or village health worker will be expected to do has been written. This job description was used to identify the objectives for the program. Learning activities deemed appropriate for preparing students to meet the objectives were then recommended. A final evaluation of the students and of the training program will be made to determine how well the students meet the objectives.

The nurse-clinician training program will last 12 months; it will be followed by a three-month preceptorship. The training program will be divided into three phases: module, rotation, and preceptorship.

During the module phase, students will master module skills and knowledge. This phase will last six months and take place

in Maseru. During the rotation phase, students will acquire clinical management skills as they are rotated through a series of outpatient clinics. This phase will also last six months. During the closely supervised three-month preceptorship, students will practice all the skills they have learned in actual job situations. At this time, the nurse-clinician will begin to train and supervise village health workers.

MEDEX training modules designed by the project contractor are now being adapted for use in the program. Appropriate teams of physicians and nurse-volunteers are adapting the modules to Lesotho's specific health promotion, prevention, and disease needs.* A MOH-appointed curriculum committee should review the final drafts of the modules for specificity and applicability to Lesotho.

Several professionals in a variety of health institutions visited by the evaluation team indicated their willingness to teach the nurse-clinician course. The project staff and the Lesotho nurse who will be the counterpart to the nurse-clinician advisor will conduct the program. (Outstanding graduates of the first nurse-clinician class will join later the faculty.)

Well qualified faculty with appropriate knowledge, skills, and supervisory ability should be employed to ensure that the

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The diseases most often treated in clinics and hospitals in Lesotho are acute respiratory illnesses; skin diseases; gastrointestinal diseases; genito-urinary diseases; nutritional diseases; tuberculosis; influenza; measles; cardiovascular diseases; and trauma.

school functions well and that graduates are as acceptable as state registered nurse-midwives.

A prefabricated building will be erected on the grounds of the Queen Elizabeth II Hospital. District hospitals, mission hospitals, and rural clinics will be used for practical clinical experiences. The facilities visited by the evaluation team will serve this purpose well.

The preparation of legislation on the practice of nurse-clinicians has taken more than two years and is now nearly complete. The government may want to add the provision that the Nurse-Clinician Council function as the "Nurse Examination Board of Lesotho" because the existing Nurse Examination Board of Botswana, Lesotho, and Swaziland may no longer meet Lesotho's need for prepared nursing staff. Questions on state board examinations usually are not reviewed for relevance by members of the regional nurse examination boards (NEBBLS).

The enactment of suitable enabling legislation on nurse-clinicians deserves top priority. Its passage will eliminate embarrassment of and legal problems for new trainees beginning their careers.

C. Nurse-Assistant Training

The nurse-assistant training program began in 1976 as a cooperative effort of the Private Health Association of Lesotho

and the Ministry of Health. It involves three PHAL programs and one MOH program. All last one year and use the same course outline and syllabus. The three PHAL programs were funded by USAID as part of the LRHDP. The MOH program at the Queen Elizabeth II Hospital was funded by the MOH.

More than 106 nurse-assistants have been trained; 55 are now in training. The original goal was to train 165 nurse-assistants to replace nurses training as nurse-clinicians. A majority of those trained now work in hospitals and clinics under the supervision of a registered or enrolled nurse.

No more nurse-assistants should be trained than can be employed. Their job description should be completed as soon as possible.

D. Village Health Worker Training

Village health workers are seen as frontline health workers in remote rural areas, especially mountain districts. They are trained and supervised by nurse-clinicians.

A VHW workshop was held at the Ts'akoholo Health Center, March 26-27, 1977. The participants, a multidisciplinary group from the MOH and PHAL, discussed assessing, planning, and implementing a VHW program. They also discussed the selection of candidates, the preparation of job descriptions, and remuneration for services. Seven PHAL hospitals and five government hospitals have trained village health workers, most of whom have been selected by villagers.

1. Duties and Responsibilities

The VHW's duties and responsibilities include:

- Assisting the village in developing and maintaining safe water supply and sanitation systems.
- Identifying village health needs and facilitating use of resources to meet these needs:
 - assisting the health team in controlling outbreaks of diseases;
 - assisting the village chief in collecting vital statistics; and,
 - cooperating with extension workers.
- Promoting good nutrition and recognizing and following up under-nourished children.
- Promoting MCH care, including ante-natal, prenatal, and child care and family planning.
- Identifying and managing common clinical problems:
 - assisting in the follow-up of patients.
- Preventing and managing vomiting and diarrhea (dehydration).
- Promoting personal hygiene and healthful living.
- Recognizing, referring, and following up tubercular and leprosy patients.
- Providing first aid.

2. Selection

The guidelines for selecting candidates for the VHW program were prepared at a curriculum adaptation workshop held in mid-January 1980.

The selection process should incorporate traditional village mechanisms. The VHW should be selected by the community and be acceptable to the villagers, village leaders, and the candidate's family. A reasonable number (determined by the chief and the community) of villagers should be present on the day the candidate is nominated.

The candidate should be mature, able to work part time, and interested in and motivated toward a health-oriented job. (S)he should be healthy, having no illness or handicap that would impede his/her ability to work. The candidate must be willing to provide health services to every villager without exception. The candidate should be a permanent resident of the community and be able to read and write Sesotho. His/her moral integrity should be unquestionable.

Candidates selected by physicians, matrons, or village chiefs have not been as good as those selected by the villagers themselves.

3. Training

Committees are reviewing, revising, and adapting the MEDEX VHW modules to make them conform to the VHW job description

and to Lesotho's health needs. An MOH curriculum committee should review and approve the final draft modules.

Generally, collaboration and cooperation between the MOH and PHAL in planning the VHW training program have been excellent.

All VHWS observed and interviewed by the evaluation team were in non-government institutions. The team audited one class of approximately 25 student-VHWS at Paray Hospital (in the mountains). Conducted by a nurse-instructor, this class covered VHW functions and responsibilities.

While performing their tasks, VHWS are supervised closely by a nurse-clinician. It is the nurse-clinician's responsibility to refresh their knowledge, help them improve their skills, and encourage them to fulfill the expectations of the villagers.

4. Compensation

Some VHWS now receive a small sum for their services, others are compensated in kind. All VHWS (and their families) receive free medical care. Villagers on VHW farms occasionally offer assistance. Some VHWS are unpaid volunteers.

Village health workers should be awarded a certificate or a badge when they complete their training. This will enhance their status as essential primary health care workers, and promote their recognition throughout the community. (This step should

be taken immediately; it should not depend on a policy decision). VHWs should receive at least minimum compensation for their services. They are crucial to the primary health care system and should have some incentive for working in isolated rural areas.

Conclusion

Both Lesotho and the United States, members of the World Health Organization, are committed to the WHO goal of "Health for all by the year 2000." These countries are working together to achieve this goal; they realize that health care services must be designed to meet Lesotho's specific health needs and that to be effective, the services must be made available throughout rural Lesotho, where more than 95 percent of the population lives.

The general plan to provide health care services through trained nurse-practitioners and village health workers--two new categories of health workers--is sound professionally, an appropriate approach which has achieved success in many parts of the world and which is gaining universal acceptance.

Despite initial delays, project staff enthusiastically assumed their tasks of advising and assisting the Ministry of Health in improving its capacity to plan for and administer a primary health care system consistent with Lesotho's declared health goal. Significant progress was made following the creation of a planning unit within the Ministry of Health. The unit is understaffed now, but the Ministry intends to hire soon additional health planning specialists.

The private health sector, which provides a significant proportion of the health services in rural areas, is willing to

cooperate with the government to achieve its goal, and it has participated in preliminary seminar workshops on major problems. The Ministry has begun to implement the solutions recommended by the seminar participants.

The MEDEX curriculum modules, a unique contribution to the project facilitating the goals of the project team, have been accepted and are being adapted for specific use in Lesotho.

A few major problems remain. The management support systems of the MOH are weak; Lesotho is unable to retain trained personnel because general service conditions (salaries, postings, incentives or inducements, etc.) are less favorable than those in the private sector; approval and implementation of the organization plan have been delayed, hindering efforts to administer all rural health services through a single authorized official or group. The government is aware of these problems and is making an effort to resolve them.

The evaluation team was impressed with the country's achievements during Phase I and recommended that Lesotho initiate as planned the training and development activities scheduled for Phase II.

APPENDICES

Appendix A

LIST OF PERSONS CONTACTED

APPENDIX A

2

LIST OF PERSONS CONTACTED

Frank Correll, US AID Mission Director

Ken Sherper, US AID Assistant Director

Byron Bahl, US AID Program Officer

Steve Norton, US AID Project Officer

Les Wright, LRHD Project team

Bill Emmett, LRHD Project team

Pam Prescott, LRHD Project team

Jeff Smith, LRHD Project team

Jeff Smith, LRHD Project team

Mi Thabana, Permanent Secretary, Ministry of Health

Mi Kotsokone, Senior Public Service, Office of the Prime Minister

Dr. Ngakane, Senior Medical Officer of Health, Lesotho Flying Doctor Service

Mr. Borotho, Chief Planning Officer, Ministry of Health

Mrs. Moletsi, Chief Tutor

Mr. Pekeche, Executive Secretary, Private Health Association of Lesotho (PHAL)

Sr. Virginia, Director PHAL, Head Catholic Secretariat Medical Work

Sr. Rose, Vice-chair, Nursing Council

Dr. Verhage, PHC Physician, Morija

Dr. Bottern, PHC Physician, Roma

Dr. Glass, PHC Physician

Ms. Seipobi, Maternal and Child Health, Ministry of Health

Mrs. Thakhisi, Chief Public Health Nurse

Mr. Petlane, Director Health Education Unit, Ministry of Health

Mr. Sello, Deputy Public Service Health

Mrs. Raketla, Nurse Trainer/Counterpart

Mr. Winston, Psychiatric Assistant

Dr. Germond, PHY Physician Moriga
Sr. Philomena, Roma Hospital
Mr. Monyake Public Service, Ministry of Finance
Mr. Sejanamane, Public Service Planning
Mr. D. Verkugi, Mafeteng Hospital
Dr. Berkman, Peko VHW Training
Mr. Makototoko, Leribe PHN
Mr. L. Banons, Director, Thaba Tseka Project
Mr. R. Knowles, Administrator, Thaba Tseka Project
Gary Kline, Alternate Energy Engineer, Thaba Tseka Project
Dr. J. Loetcher, Paray Hospital
Mrs. Loti Loetcher, Lab Technician, Paray Hospital
Sr. Annunciata, Nurse Assistant Trainer and Matron, Paray Hospital
S/N Nthasbisent, VHW Coordinator
Mr. Thakholi, Director, Mohlanapong Clinic
Rev. Thakholi
S/N Moliehi Ramone, Mohlanapong Clinic

Appendix B

LIST OF DOCUMENTS REVIEWED

APPENDIX B-ic

2

LIST OF DOCUMENTS REVIEWED

Second Five-Year Plan, 1975-1980 (health chapter).

Third Five-year Plan, 1980-1985 (draft).

"Lesotho Background Notes," Department of State, March 1979.

Report on Management Seminar/Workshop, Mazenod, November 1979.

Lesotho Rural Health Development Project Paper 690-0058, January 1979.

"Drug List for Lesotho," Ministry of Health, February 1979.

Study of the Plant and Vehicle Pool Service, O'Sullivan et al., June 1978.

Report of Visit to Lesotho, UNICEF Regional Vehicle Management Advisor, September 1978.

Report to Transport Sub-Workshops, A.S. Haynes (UNICEF Vehicle Management Consultant), November 1979.

Report of the Task Force on Personnel Management in the Public Service, December 1978.

Appendix C

STATEMENT OF WORK

LESOTHO RURAL HEALTH DEVELOPMENT
(632-0058)

Project Description: The Lesotho Rural Health Development Project (LRHDP) has been designed to (1) upgrade the planning, administrative, and management competence of the Ministry of Health (MOH) to the level required to develop and maintain a national health services delivery system, and (2) establish and institutionalize new cadres of health workers required for the rural component of Lesotho's national health services delivery system.

The LRHD Project consists of two phases. Phase I, which is of 18 months duration, involves the upgrading of the planning, administrative, and management capacity of the MOH. Phase II is of 36 months duration and includes the training and fielding of personnel for rural health services under the plans developed in Phase I as well as the institutionalization of this training.

Under the LRHDP, USAID is funding four long-term technicians: a health planner (four years); a management specialist (four years); a physician trainer (four years); and a family nurse clinician trainer (four years). The health planner and management specialist arrived at the beginning of Phase I in February 1979, while the physician and nurse trainer arrived six months later.

The physician and nurse trainer were originally scheduled to arrive at the beginning of Phase II after completing several months in short-term consultancies. During the contract development phase it was determined that (1) it would be difficult to recruit the same individuals for both the short and long-term assignments, thereby threatening continuity in development of the training component; and (2) these technicians were needed in Phase I to begin curriculum development if the training in Phase II was to be accomplished as planned. Therefore, the consultancy time has been added to the trainer technicians' tour of duty which includes the 36 months of Phase II.

Phase II of the LRHDP, as designed, is contingent on the accomplishments of Phase I in developing an administrative support system for rural health services.

During the first six months of Phase I the Health Planner and Management Specialist were to evaluate and analyze the planning, management, and logistical problems of the MOH and prepare a formal report which made recommendations for the strengthening and development of a planning, management and administrative capacity that would more adequately support a rural health system. The sixth month report has been completed.

The project technicians' report was based on MOH health policy objectives. These objectives include:

- A. Division of the country into Health Service Administration Areas (HSAs) to localize administration and logistics for rural health services including care and prevention of common communicable diseases, environmental health, health education, and MCH/FP programs.
- B. Extending and expanding basic integrated curative and preventive services to rural areas through upgrading diagnostic, treatment, and community health skills of existing registered nurses through a one-year training course (nurse clinician training).
- C. Utilizing nurse assistants to carry out more routine hospital duties.
- D. Expanding the personnel system to include personnel such as HSA administrators, to release physicians and nurses from non professional duties, and other maintenance and logistical personnel.
- E. Extension of logistical and support facilities to HSAs to provide local access to supplies and equipment maintenance.
- F. Expanding primary health care through the training and use of Village Health Workers (VHW).

During the seventh month of Phase I the project technicians (HP and MS) presented this report to the MOH for review and comments. The report, in addition to the analyses described previously, contained recommendations for (1) intermediate priorities in accomplishing the objectives; (2) the allocations of resources to meet the objectives; (3) standards for measuring progress; and (4) planning and evaluation for the intermediate and long-term objectives of the system. This planning exercise was also designed to determine if project and MOH objectives remain in accord.

To assist the MOH in strengthening its capacity in planning and administration, the LRHDP includes long-term training for nine participants in management, health services administration, health planning, and health manpower training. In addition 24 months of short-term training is provided for in-country workshops and seminars. Long-term participants are expected to be selected by the MOH and the project team during the

first year of the LRHDP and begin training between the 12th and 24th months of the project.

In Phase II, the Health Planner (HP) and Management Specialist (MS) will continue to assist the MOH in developing and implementing an administrative structure to support rural health services while the trainer technicians will implement the nurse clinician (NC) and VHW curriculums designed in Phase I. The training will be institutionalized to enable the MOH to continue training after the project ends. The MOH anticipates that a total of 125 NCs and 1000 VHWs will be required to staff rural health facilities and to deliver primary health care. The LRHD Project is expected to train 55 NCs and 166 VHWs during the life of the project.

In addition, the MOH will require 165 Nurse Assistants (NAs). According to the Project Paper, the NAs will assume many of the tasks performed by nurses in the rural clinics and hospitals while the nurses are absent for NC training. Subsequently, the NAs will provide support to the nurse clinicians.

While the NA training program is outside the scopes of work of the project technicians, it is included in the evaluation for two reasons: (1) it was partially funded under the LRHDP; and (2) the NA, as proposed in the Project Paper, plays an important manpower role in rural health services.

As the LRHDP is designed, Phase II is contingent on the accomplishments and potential of the MCH to plan, manage, and administer a rural health delivery system including the institutionalization of training programs for new cadres required for service delivery. The evaluation will determine if the project is prepared to proceed to Phase II and recommend changes or the modifications required to accomplish project goals and objectives. The evaluation will involve measurement of the MOH's capacity to plan, implement, and manage an expanded, reorganized system for the delivery of rural health services. It will also measure the quality and implementation potential of the project technicians' analyses and recommendations (sixth month report) as well as the MCH's response to the report.

Based largely on evaluation recommendations, a decision will be made to either (1) proceed to Phase II, (2) delay implementation until further necessary pre-program development occurs, (3) modify the project and its objectives to more realistically reflect what can be achieved, or (4) terminate the project.

STATEMENT OF WORK

Technical services are required to perform an evaluation of Phase I of the Lesotho Rural Health Development Project (LRHDP).

The evaluation requires nine person-weeks of service for three technicians (a health planner, a health administrator, and a nurse clinician educator).

The evaluation is designed to determine the capacity of the Lesotho Ministry of Health (MCH) to implement Phase II of the LRHDP. The evaluation involves analyses of the MCH's planning, administrative, and management capabilities to expand integrated preventive and curative health services into rural areas and to support institutionalization of training programs for rural health cadres. Specific areas of investigation are included under individual scopes of work for each of the technicians.

Based largely on the recommendations of the evaluation team, a decision will be made to either (1) proceed to Phase II, (2) delay implementation until further necessary pre-program development occurs, (3) modify the project and its objectives to more realistically reflect what can be achieved, or (4) terminate the project.

The evaluation team is expected to prepare a draft report of the evaluation (including the rationale for the recommendation concerning the future of the project) to be discussed with the LRHDP Project Team, the University of Hawaii project backstop, USAID/Lesotho, and the MCH, prior to their departure from Lesotho. A collaborative decision (evaluation team, LRHDP team, USAID, and the MCH) on the future of the project needs to be made immediately following the evaluation to allow time to modify the project if necessary before Phase II or to terminate the project in an orderly manner, if so recommended, in the six remaining months of Phase I.

Phase I ends September 1980. The Evaluation Team must arrive NLT January 26, 1980, in order to accomplish the SOWs and to permit USAID/Lesotho to make a final decision on the future of the project by March 1, 1980.

The Evaluation Team should spend NTE two days in consultation with AID/Washington on the background of this project prior to departure for Lesotho. The University of Hawaii project backstop officer will be in Lesotho prior to and during the stay of the evaluation team.

A. Scopes of Work

1. Health Planner (HP) (J.K. - S)

Duration of Services - three weeks

Qualifications - Masters Degree in Public Health or Health Planning. The HP should have at least ten years experience in health planning on a national or state level with a minimum of four years experience in a developing country in a health planning capacity or be a physician with comparable experience and training in health planning.

Responsibilities

The HP will serve as the Evaluation Team Leader with responsibility for the preparation and presentation of the draft evaluation to USAID and the MOH. As a member of the evaluation team, the HP will be responsible for evaluating:

- 1 a. the planning capacity of the MOH
- 2 b. MOH response to the analyses and recommendations in the sixth month Status Report prepared by the project team.
- 3 c. the quality and quantity of planning undertaken to conform to the Status Report recommendations
- 4 d. implementation plans for the development of HSAs based on plans for expanding patient care, improving population access, and health support services
- 5 e. the relationship between PHAL and the MOH in the planning of HSAs and the coordination of non-government and government services
- 6 f. health services planning based on epidemiological data for Lesotho
- 7 g. participant selection and placement.

2. Health Administrator (HA) (J. Kennedy)

Duration of Services - three weeks

Qualifications - Masters Degree in Health Planning, Health Administration, or Public Health. Experience should include management or administration of a national health program with extensive rural health services in a developing country or be a physician with comparably experience and training in health administration.

Responsibilities

The HA will evaluate the following areas of the LRHDP:

- a. the capacity of the MOH to provide administrative and logistical support to an expanded rural health service
- b. MOH response to recommendations in the Status Report pertaining to administration and logistical support for rural services
- c. planning for administration of HSAs
- d. statistical services of the MOH
- e. records and reporting systems
- f. budgeting procedures and allocations for rural and urban services
- g. development of operational policies and procedures for rural health services
- h. coordination of training of rural health personnel and development of administrative procedures for HSA.

3. Nurse Clinician Educator/Family Nurse Practitioner (FNP) (D.B.)

Duration of Services - three weeks

Qualifications - Masters Degree in Nursing with FNP certification. Experience should include teaching and curriculum development in a US FNP program and experience in developing countries. The NCE/FNP will evaluate the following components of the LRHDP:

- a. the MOH capacity to train and field additional categories of health workers
- b. Nurse Clinician Training
 1. support - legal and remunerative
 2. proposed role as related to training plans and future administrative structure of the MOH
- c. - Nurse Assistant Training
 1. current role and proposed role in Project Paper
 2. coordination of PHAL and MOH training programs

d. Village Health Worker Training

1. status of VHW in MOH
2. training plans for VHW curricula
3. coordination between PHAL training and MOH proposed program
4. plans for utilization of non-government VHWs in LRHDP

e. relationship of training programs (NC, NA, VHW) to the major health problems of Lesotho

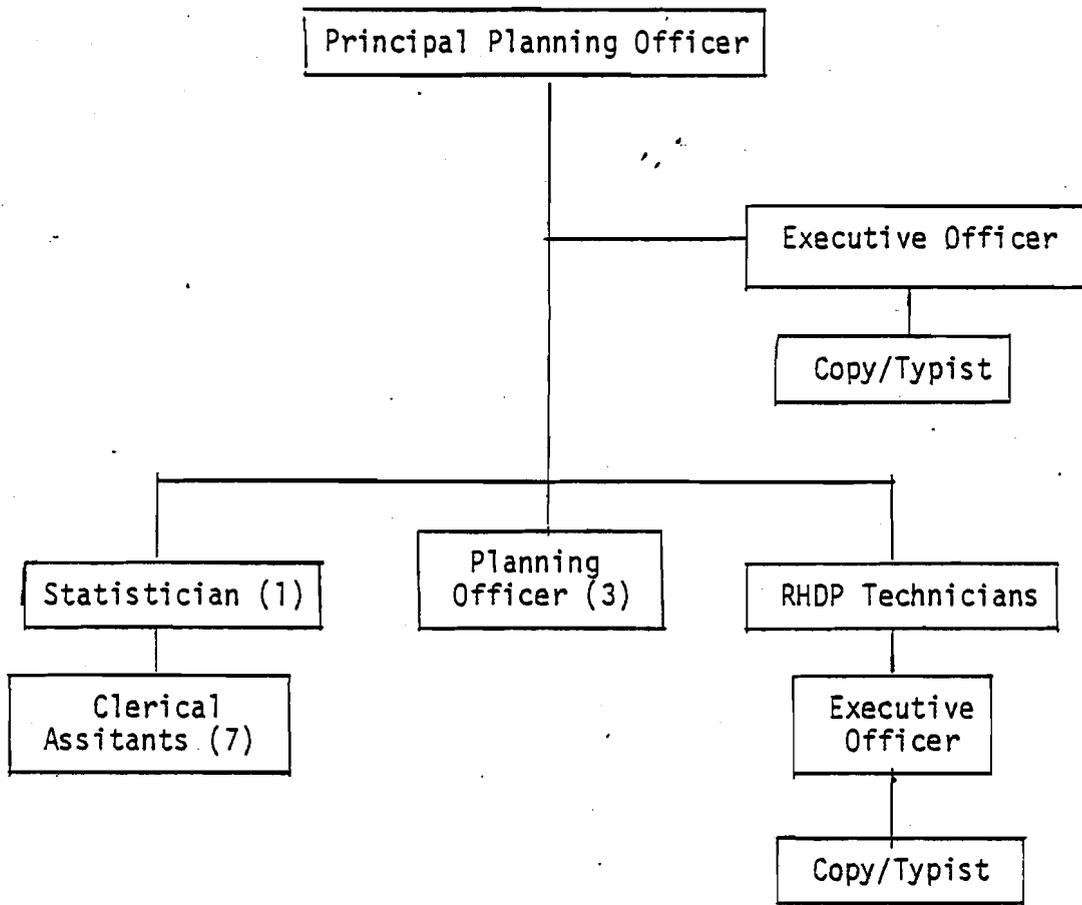
f. coordination between the planning/administrative components and training component of the LRHDP.

Appendix D

MOH PLANNING UNIT: AN ORGANIZATION CHART

KINGDOM OF LESOTHO MINISTRY OF HEALTH

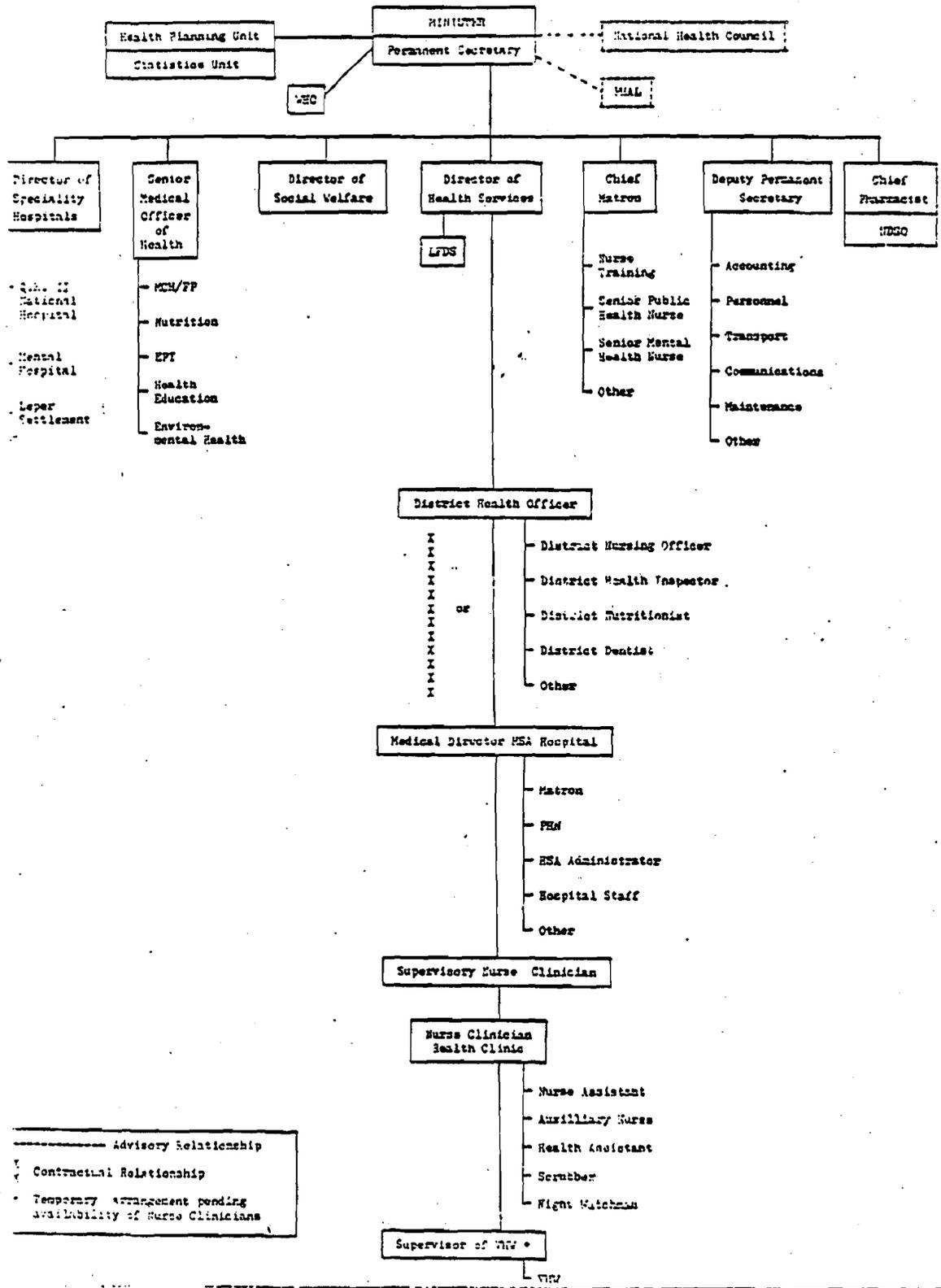
ORGANIZATION OF THE MINISTRY OF HEALTH
KINGDOM OF LESOTHO



Appendix E

REVISED REORGANIZATION PLAN OF MOH

PROPOSED NEW REORGANIZATION PLAN TO SUPPORT PRIMARY HEALTH CARE
 HAZENOD MANAGEMENT WORKSHOP SUB-COMMITTEE ON PERSONNEL



Appendix F
DESCRIPTION OF PHAL

DESCRIPTION OF PHAL

After six months of preparation (following several years of loose association), the Private Health Association of Lesotho (PHAL) was formed (and registered) in March, 1974. Charter members include the Anglican, Catholic, Evangelical and Seventh-Day Adventist Churches. Membership is open to any non-governmental Church or organization involved in health services in Lesotho and recognized by the Ministry of Health of the Lesotho Government.

The basic goals of PHAL are to improve and expand health services in Lesotho by the coordination of all members' health activities and to integrate and coordinate the same with the Ministry of Health.

Specific activities to date include:

1. participation with Government in the formation of a National Health Plan;
2. surveying member institutions to determine total drug and medical supply needs;
3. solicitation of drug and medical supply donations on a cooperative basis;
4. initiation of a dental project at interested member health facilities;
5. study of and preparation for a program to train nurse assistants.

A nine-person Board of Trustees meets at least quarterly to conduct the business of PHAL. A full-time Executive Secretary is being recruited by the Christian Medical Commission of the World Council of Churches. In the meantime, a part-time Executive Secretary administers the affairs of PHAL on a day-to-day basis.

PHAL member institutions include eight hospitals, forty-six clinics, and a number of dispensaries. Three of the hospitals have nurse training

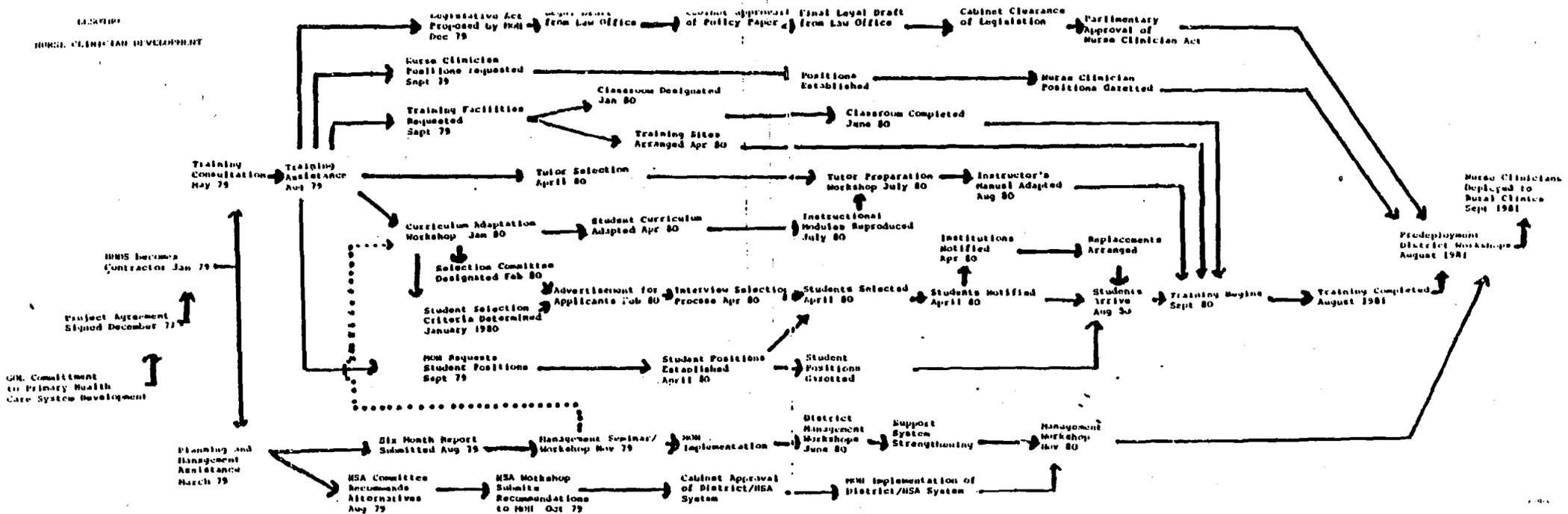
programs and two have programs in midwifery. One member has a dental and eye clinic.

Twelve doctors, one pharmacist and about 140 nurses are employed by PHAL members. Slightly in excess of 40% of hospital admissions are to PHAL member institutions and about 70% of out-patient attendances at hospitals and clinics are at PHAL facilities.

Appendix G

NURSE-CLINICIAN DEVELOPMENT SCHEDULE

MINISTRY
RURAL HEALTH DEVELOPMENT



BEST AVAILABLE COPY

Appendix H

LESOTHO NURSE-CLINICIAN ACT OF 1980
(Draft)

APPENDIX H

LESOTHO NURSE CLINICIAN ACT OF 1980
(Draft)

AN ACT to provide for the creation, definition, and regulation of the practice of a primary health profession: the Nurse Clinician in the Kingdom of Lesotho.

1. This Act may be cited as the Nurse Clinician Act 1980.

2. In this act--

- Definitions
- A. "Nurse Clinician" means a dual-qualified nurse who by virtue of advanced formal training and examination, has shown competence to perform specific health - related functions beyond those normally defined as the practice of nursing.
 - B. "Council" means the Nurse Clinician Council created in this act.
 - C. "Minister" means the Minister of Health and Social Welfare.

- Qualifi-
cations
3. A Nurse Clinician must be a dual-qualified nurse who has completed an advanced course, at least 12 months in length, that is approved by the Council and who has demonstrated to the satisfaction of the Council that (s)he is competent in the functions to be performed. No person not meeting these qualifications may use the title of Nurse Clinician or undertake to perform or offer to perform for money or otherwise these functions. No Nurse Clinician may undertake to perform functions in which (s)he has not demonstrated competence to the satisfaction of the Council.

- Scope
4. A Nurse Clinician may perform under prescribed supervision those functions in which (s)he has demonstrated competence and in which (s)he is able from time to time as prescribed to demonstrate continuing proficiency.

- Relation-
ships
5. The Nurse Clinician will at all times perform his/her expanded functions under the professional supervision of a licensed Medical Doctor. (S)he may work as a colleague of or in professional supervisory role with other nurse clinicians and dual-qualified nurses. (S)he may exercise professional supervision over other categories of health-related professionals and para-professionals.

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- Licence 6. Licensure of the Nurse Clinician shall be under the authority of a Council appointed by the Minister.
- A. Licensure shall be on a biannual basis with fee to be prescribed by the Minister.
 - B. The Nurse Clinician shall be licensed to practice under the auspices of the health care institution which shall have satisfied the Council that it will provide adequate professional supervision of the Nurse Clinician.
 - C. The Council shall prescribe procedures for transfer of the license from one approved institution to another approved institution as may be required by relocation of the Nurse Clinician.
- Supervision 7. The Council shall prescribe minimum levels of professional supervision under which a Nurse Clinician may practice.
- Continuing Education 8. The Council shall prescribe minimum levels of continuing education required for relicensure of the Nurse Clinician.
- A. Continuing education shall be acceptable only as provided by sources approved for this purpose by the Council.
 - B. The Council shall establish procedures for the demonstration of continuing competence in the functions to be performed as well as in additional functions, as competence in these shall be achieved.
- Training 9. The Council shall prescribe minimum standards for the training of Nurse Clinicians and may grant approval to specific courses for the training of Nurse Clinicians.
- Discipline 10. The Council may remove certification from a Nurse Clinician for cause.
- A. Decertification may be for such period of time as the Council may determine according to the circumstances of the case of permanently for conviction of an offense or for what the Council has adjudged after due inquiry to have been negligence in the performance of professional functions or for any misconduct in connection therewith.
 - B. The Council may order such other professional discipline, including close supervision, as it may deem appropriate.

- C. No such action may be taken without the opportunity for a hearing on the subject before the Council, except that a temporary suspension of certification pending such a hearing may be made by the Council if it is so determined as required to protect the health and safety of the people.

11. A Nurse Clinician Council shall be created to perform duties under this Act.

A. It shall be appointed by the Minister and shall operate under his authority.

B. It shall be composed of fifteen members and shall include:

- 1. The Permanent Secretary for Health Ex Officio as Chair.
- 2. The Director of Health Services, Ex Officio.
- 3. The Chief Matron, Ex Officio.
- 4. Dual-Qualified Nurses.
- 5. Licensed Medical Doctors.
- 6. Nurse Clinicians
- 7. Representatives of the National Training Program for Nurse Clinicians.
- 8. Such others as Minister shall determine.

C. Except that positions for Nurse Clinicians shall be filled by additional representatives of the National Training Program for Nurse Clinicians until the first Nurse Clinicians have been certified.

D. Members of the Council shall serve four-year terms.

E. Except that upon creation of this Council, positions shall be designated as one-, two-, three-, or four-year initial terms.

F. The Council shall be appointed within 60 days of the promulgation of this Act.

Rules 12. Rules for the implementation of this Act may be made by the Council with the approval of the Minister.