Final Report
Clinic Management

Swaziland Primary Health Care Project
USAID Project No. 645-0220

Ministry of Health
Kingdom of Swaziland

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

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January 1991
Mbabane, Swaziland
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ACKNOWLEDGEMENTS

Gratitude is expressed to regional public health matrons, clinic supervisors and nurses who acted as counterparts for the clinic management activities.

Appreciation is also extended to Robert Shongwe for his consultation on the renovation of nurses accommodations; Ernest Mnisi for supplying home visits and supervisory visits data and graphs; Fruit Phumie Dlamini for typing the report and Nozipho Nxumalo for the report cover graphics.

Entry into the position was expedited by the invaluable assistance and cooperation of my colleagues on the Project: Daniel Kraushaar, Vincent Joret, Mary Kroeger and Albert Neill.

Special recognition is given to Jewel Bazilio and the rest of the staff at Drew University International Health Institute for providing professional and personal field support.

Thanks is also extended to Dr. Margaret Price, my predecessor, for providing the brief, but thorough orientation to already implemented management interventions. Identified Clinic Management documents and country resource personnel were helpful in establishing a baseline for continued project activities.

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EXECUTIVE SUMMARY

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

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

1. Improved Service Delivery and Outreach Approaches.

1.1 Outreach Sites

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

1.2 Home Visits

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

1.3 Community Health Committees

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

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

2. Improved Skills, Conditions of Service and Supervision.

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

2.1.1 Workshop Training

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

2.1.2 Clinic - Based Training Follow-Up

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

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

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

2.3 Improved Supervision

2.3.1 Monthly Supervisory Visits

Project output indicators emphasized more frequent and positive supervisory visits to clinics. The target was stated as "at least 50% of rural clinics receiving monthly supervisory visits from regional nursing supervisors". Available information shows that there are 149 government, mission and private sector clinics. Monthly visits to 119 of these clinics would meet the project's target.

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

2.3.2 Supervisory Checklist

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

The original project paper stated that one major difficulty in expanding primary health care services was a lack of effective supervision for clinic personnel. Project input increased the supervisory skills of nurses and improved clinic operational and management support systems. Foremost among remaining problems is the lack of established posts for clinic supervisors as recommended in *Health Manpower Requirements FY 1988 - 89 to FY 1992 - 93*. Implementation of these recommendations would eliminate the need for a nursing sister in charge of a Public Health Unit to also supervise clinics in the region. The various other demands made on those in supervisory positions many times takes precedence over clinic visits.
Regions use HIS data to monitor performance and set desired targets for home visiting, outreach sites activity and supervisory visits.


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

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

1. Clinic-based training follow-up activities related to management;

2. Support/re-orientation of regional clinic supervisors and nurses to project-initiated management strategies, such as increased use of the supervisory checklist and project-produced manuals, maintenance and improvement of the drug management system and reorganization of clinics for more efficient operation;

3. Expansion of outreach services; and

4. Upgrading nurses' accommodations.
2. BACKGROUND

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

2.1 Country Profile

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

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

The highveld, covering 29% of the country, is mountainous with an average altitude of 1300 meters (3,500ft) above sea level. It receives the greatest amount of rainfall of the four regions and the climate is humid and near temperate. In winter, (May-August) freezing temperatures and snow may occur. The major economic activities of the highveld are forest and wood-pulp production and asbestos mining. Swaziland's capital city, Mbabane, is the commercial support center for this region.
The middleveld covers 26% of the country and is the most developed and densely populated area. It is hilly with large valleys and an altitude of 700 meters. The climate is sub-tropical, being warmer and drier than the highveld. Good arable land makes it the most agriculturally advanced with estate production of citrus fruit and pineapple for export. Maize is the main crop but other vegetables, bananas, cotton and tobacco are also produced. Major manufacturing enterprises exist and the second major town, Manzini, and the airport at Matsapha are located in this region.

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

The Lubombo Plateau, which borders on Mozambique, is the smallest region, covering only 8% of the country. Its altitude and climate are somewhat lower but similar to the middleveld. Subsistence agriculture and cattle ranching are the principle activities. The administrative center for this region is located at Siteki.
Swaziland has a dualistic political structure which combines the Western concept of government with the traditional, Tinkhundla system that administers Swazi Laws and Customs. The Head of State is His Majesty, King Mswati III, who is advised in the Government of the country by Cabinet Ministers responsible to a bicameral Parliament. The national development goals of economic growth, social justice, self-reliance and stability were established after the late King Sobhuza II led the country to independence from British Colonialism in 1968.

2.2 Health Sector Profile

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

Under Swaziland's decentralization policy, authority for health sector activities is delegated to the four administrative regions: Hhohho, Manzini, Shiselweni and Lubombo. Regional Health Management Teams (RHMTs) oversee a network of government, mission, private sector and traditional primary health care services.
Nationwide there are nine hospitals; nine health centers; six public health units; 149 clinics; and 161 outreach sites.
(Ministry of Health, Statistics Unit. Schneider (1989) estimates that there are some 10,000 traditional healers. p.14).

2.3 Primary Health Care Project

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

The goal of the project was to improve the health status of children under five years of age and women of childbearing age. The project's purpose was to improve and expand Swaziland's Primary Health Care System. The goal and purpose were to be accomplished by improving service delivery (training and instituting interventions such as ORT, prenatal risk identification and growth monitoring) and improving the management of health resources.
The original project design had eight components which were reduced in scope after the midterm evaluation. The subsequent Project Paper Amendment re-focused activities on the following regional and clinic level areas:

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

3. Overview of Clinic Management

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

Prior to the midterm evaluation, workshops were used widely to train personnel in Clinic Management topics. A record of workshop activity shows that approximately 700 participants attended 17 workshops related to Supervision, Drug Management and such Community outreach areas as Home Visiting/Community Profiles, Community Participation and Community Health Committee development.
These training and follow-on activities produced a number of sustainable outputs, including the following documents: (1) Clinic Drug Formulary and Handbook; (2) Supervisors and Trainers Guide for Implementation, Maintenance, Monitoring and Evaluation of the Drug Management System; (3) Clinical Reference Manual for Clinics and Health Centres; (4) Orientation Manual for Clinics, Health Centres and Public Health Units; (5) Referral Forms; and (6) Supervisory Checklist and Guidelines.

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

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

3.1.1 Clinic Level basic management interventions were aimed at improving such clinic operations as: drug/inventory management, use of project-related manuals and reorganization of clinics for efficiency.

3.1.2 Clinic/Community linkages were designed to increase access of underserved populations to health care and promote community participation in health care delivery. Major activities included: constructing or upgrading outreach shelters, increasing home visits, and strengthening community health committees.

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

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

3.2.1 Improved Skills

Clinic based training follow-up emphasizing basic management interventions.

3.2.2 Improved Conditions of service

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

3.2.3 Improved Supervision and Management Support

Monthly Supervisory Visits to clinics using supervisory checklist.

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

4.1 IMPROVED SERVICE DELIVERY AND OUTREACH APPROACHES DEVELOPED

4.1.1 Outreach Sites

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

Number of outreach sites operational

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

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

An outreach program has existed in Swaziland since the 1960's when Mrs. N.E. Bludlu, the first Public Health Matron started the concept of Mobile Clinics. (Interview, Mrs. Aylline Dlamini, Public Health Matron, 1972 - 79). Outreach sites are now an integral part of the PHC system and support the Ministry of Health's policy of providing access to health service within one hour's walking distance of users. (8-10km).

The outreach sites concept is institutionalized throughout the country. Data from the Health Information System (HIS) show 161 government, mission and private/industry distributed regionally in the following way: Lubombo 50; Manzini 62; Hhohho 28 and Shiselweni 21.

Of the 84 project-assisted sites, 81 (96%) are reporting activity data on the HIS.

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

Constraints

Lack of transportation, shortage of clinic staff and impassable roads during rains led to cancellation of some visits. When the one vehicle was in for repairs or otherwise not available there was no backup system. In one region, the transport was not available for three months during which time no visits were made.
<table>
<thead>
<tr>
<th>Region</th>
<th>Health Care Facility</th>
<th>Number of Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hhohho</td>
<td>Piggs Peak PHU</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>Mbabane PHU</td>
<td>14</td>
</tr>
<tr>
<td>Manzini</td>
<td>King Sobhuza II PHU</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Mankayane PHU</td>
<td>11</td>
</tr>
<tr>
<td>Lubombo</td>
<td>Siteki PHU</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Good Shepherd</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Sithobela HC</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Ndzevane Refugee</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>St Philips</td>
<td>3</td>
</tr>
<tr>
<td>Shiselweni</td>
<td>Hlatikhulu PHU</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Nhlangano PHU</td>
<td>4</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>84</td>
</tr>
</tbody>
</table>
LUNDZI OUTREACH SITE

Shelter Construction and Celebration
4.1.2 HOME VISITS

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

Proportion of clinics doing regular home visits.

Home visits, like the outreach sites program, expand Maternal Child Health and other Primary Health Care Services to rural populations. Where feasible, clinic nurses visit homesteads within their catchment area to identify health problems, give health education messages and follow-up specific clients, for example, defaulters. Prior to the midterm evaluation, the Primary Health Care Project sponsored workshops on home visiting/community profiles for nurses in all four regions. These sessions included field experiences in conducting visits, developing community profiles and estimating and mapping clinic catchment areas. Participants were expected to initiate a home visiting program in their respective clinics using the Ministry of Health's Household Health Folder, which was revised during the training. On clinic visits made by the Clinic Management Associate, there was evidence that a number of clinics continue to make visits, maintain the record system and update and display their catchment area maps.
Baseline data on the proportion of clinics conducting home visits before the inception of the Primary Health Care Project were not available. It was not stated how many additional clinics should make home visits in order to reach the target of a 40% increase by the end of the project. However, data obtained from a survey of clinics in the Lubombo Region (March 1990) and reports from the Health Information System give the status of activity in this area. The major findings related to the project output indicators are presented below.

Home Visit Survey - Lubombo Region

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

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

Home visit reporting is now integrated into the HIS. The graphs on pages 18 - 21 show the number of visits reported by each of the four regions in the 10 month period January - October 1990.
The Hhohho Region, for example, reported the following number of visits: 19, 10, 92, 141, 105, 96, 138, 107, 106, and 41, for a total of 855, or an average of 86 visits per month.

The line and bar graphs on pages 22 and 23, respectively, compare the regions with each other. For example, in May, Manzini reported 143 visits, while Hhohho, Lubombo and Shiselweni reported 105, 76 and 22, respectively. Total home visits and range of visits by region are shown in Table 2. A total of 2,305 visits were made throughout the country during the period, or an average of 231 visits per month. The monthly average by regions is as follows: Hhohho - 86; Manzini - 56; Lubombo - 64 and Shiselweni - 25.

Range of Visits

Hhohho, Manzini and Lubombo made the lowest number of home visits (10, 6, and 0, respectively) in the months of January and February, while Shiselweni made the lowest number, 7, in September. Regions made the most visits April - June as follows: Hhohho (April) - 141; Manzini (May) - 142; Lubombo (March and April) - 130; and Shiselweni (June) - 36. While it is beyond the scope of this report to present a detailed analysis and interpretation of data, regions could of use the HIS data to plan realistic targets and address factors related to changes in home visit activity.
Table 2
Total Home Visits and Range of Visits by Regions
January - October 1990

<table>
<thead>
<tr>
<th>Regional</th>
<th>Total Visits</th>
<th>Range</th>
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<tbody>
<tr>
<td>Hhohho</td>
<td>855</td>
<td>10 - 141</td>
</tr>
<tr>
<td>Manzini</td>
<td>556</td>
<td>6 - 143</td>
</tr>
<tr>
<td>Lubombo</td>
<td>643</td>
<td>0 - 130</td>
</tr>
<tr>
<td>Shiselweni</td>
<td>253</td>
<td>7 - 32</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,307</strong></td>
<td></td>
</tr>
</tbody>
</table>

- Range - represents a month when the lowest number of visits were made in that region and a month when highest number of visits made. Example: Manzini's lowest number of visits was 6 (February) while the highest number was 143 (May).
In addition to regional data, individual clinic home visiting performance can also be obtained from the HIS. Of the 90 clinics that submitted information, 42 (47%) of them reported making home visits. The percent of clinics making visits in each region/subregion is shown in Table 3 and the complete list appears in Appendix E. The Table shows that 75% of the clinics in Hhohho South make home visits, followed by Mankayane sub-region - 73%; Shiselweni - 63%; Hhohho North - 57%; Lubombo - 34% (Earlier Survey - 45%); and Manzini sub-region - 21%. It should be emphasized that the results are based on available data for months of January - October 1990.

Table 2
Percent of Clinics Making Home Visits

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

90  42

- Not all the clinics reported (nationwide - 47% of clinics make visits
- Data reported earlier on survey was 45%
Summary

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

Sustainability

There is a system is place to sustain and support home visiting as an important outreach component of Primary Health Care. Where it is not practical for nurses to make visits, Rural Health Motivators can supplement this activity. As described by Dr. Makhubu in the booklet, Nurses' Guidelines for Working with Rural Health Motivators, the community-based workers "follow up defaulters when asked to do so by nurses in cases of T.B., Family Planning, Immunization and other services that are provided in clinics" (p17).
HOME VISITS - 1990
HHOHHO REGION

NO OF VISITS

MOH (Stats unit)
HOME VISITS - 1990
MANZINI REGION

NO. OF VISITS

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

MOH (Stats unit)

BEST AVAILABLE COPY
HOME VISITS - 1990
SHISELWENI REGION

NC OF VISITS

MOH (Stats unit)
HOME VISITS - 1990
BY REGIONS

NO. OF VISITS

REGIONS

- HHOH HO - MANZINI - LUBOMBO - SHISELWENI

MOH (Stats unit)

BEST AVAILABLE COPY
HOME VISITS - 1990
BY REGIONS

NO. OF VISITS

MOH (Stats unit)

BEST AVAILABLE COPY
4.1.2 COMMUNITY HEALTH COMMITTEES

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

Proportion of clinics with functioning community health committees.

(Document Only).

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

While community health committees are an integral part of Swaziland's Primary Health Care System, their activity level varies considerably. At the time of the Second Annual Review of Primary Health Care (1987), committees were functioning in only one-third of the 30 clusters sampled. Of those committees sampled, 10% met weekly, 27% met monthly, 20% met as needed and 43% had never met.
In the early stages of the Primary Health Care Project, substantial support in the form of workshops was given to strengthening community development activities, including community health committees. Over 1,000 persons attended 15 Community Participation, Community Health Committee and Community Leader workshops. A survey of health committee functioning was also done at a Basic Management Workshop (1986, February 7-12) and a list of active and inactive committees was obtained, but there was no evidence that the results were tabulated or used in any way. The same Same Survey Form was used to document the current functioning of health committees. Additional information was obtained from Africa Magongo, Health Education Unit, who conducted a survey of committee functioning in the Lubombo South clinics.

Survey results are shown in Table 4 below and the list of active committees are included in Appendix F. The percent of active committees by region/subregion are as follows: Hhohho South - 100%; Hhohho North - 78%; Mankayane - 55%; Shiselweni - 50%; Lubombo - 45% and Manzini - 21%. Of the 93 total clinics reporting, 47 (51%) of them have active community health committees.
Table 4
ACTIVE COMMUNITY HEALTH COMMITTEES
1990

<table>
<thead>
<tr>
<th>Regions/Sub-Regions</th>
<th>Total Clinics Reporting</th>
<th>No. Clinics with Committees</th>
<th>% of Clinics with Committees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Khohho</td>
<td>9</td>
<td>9</td>
<td>100%</td>
</tr>
<tr>
<td>South</td>
<td>9</td>
<td>7</td>
<td>78%</td>
</tr>
<tr>
<td>North</td>
<td>19</td>
<td>4</td>
<td>21%</td>
</tr>
<tr>
<td>Manzini</td>
<td>11</td>
<td>6</td>
<td>55%</td>
</tr>
<tr>
<td>Lubombo</td>
<td>29</td>
<td>13</td>
<td>45%</td>
</tr>
<tr>
<td>Shiselweni</td>
<td>16</td>
<td>8</td>
<td>50%</td>
</tr>
<tr>
<td>Total all Regions</td>
<td>93</td>
<td>47</td>
<td></td>
</tr>
</tbody>
</table>

Overall Percentage of Clinics with Active Health Committees = 51%

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

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

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

Number of clinics with drug management system operational.

The following manuals were produced with technical and financial support from the Primary Health Care Project: Clinical Reference Manual (April, 1987); Orientation Manual (April, 1987); Drug Formulary (February, 1985) and Supervisors and Trainers Guide - Drug Management System (December 1989). The Clinical Reference Manual provides diagnosis and treatment protocols for the most common health problems seen at rural clinics. The Drug Formulary accompanies the Drug Management System and provides guidelines for safe practices in ordering, storing, prescribing and dispensing essential drugs. The Supervisors and Trainers Guide - Drug Management System, as the name implies, is an instructor's manual for orientation, in-service or on-the-job training in drug management. The manual was distributed in September 1990 and there is no evidence of its use as yet.

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

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

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

Recommendation

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

Review the orientation manual’s usefulness and revise accordingly.
4.2 Improved Motivation of Health Workers Brought about by Improved Skills, Improved Conditions of Service and Improved Supervision.

4.2.1 Training

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

Number of nurses trained in Clinic Management including drug management.

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

Prior to the midterm evaluation, the project used workshops to train nurses in the above management topics. Project records show that nearly 700 participants attended 17 workshops in the areas of drug management, clinic management and outreach activities. These workshops were followed by the systematic implementation of related clinic and community level interventions. Monthly and quarterly project reports indicate that the training target in terms of absolute numbers was reached before the midterm evaluation.
To review the sustainability of those workshop trainings and management inputs, visits were made to five clinics in Hhohho South and twelve clinics in Mankayane. These 17 clinics were found to be effectively implementing the drug management system as well as other innovations introduced by the project. The five clinics in Hhohho South and eight of the twelve clinics in Mankayane also have well functioning ORT Corners established by the National ORT program. Likewise, the ORT Unit at Mankayane Hospital was properly maintained.

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

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

a. Proper positioning of the EPI refrigerator, ORT Corner, growth monitoring equipment (Salter Scales/Frames) and consulting room set-up

b. Arranging paperwork according to the filing system established by Dr. Joret (memo - V. Joret to M. Edmondson - March 10, 1990). The project supplied files, filing cabinets, where needed, and built-shelves for more efficient organization of record keeping materials. The Clinic Management Associate and clinic supervisor assisted with the implementation of the system and in some cases (Lubombo Region) delivered files to clinics in the interval when there was no Training Backstop for the project.

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

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

b. Oral Rehydration Therapy (ORT)
   Management of ORT Corner; maintenance of equipment and supplies; instructions to caregivers; and record keeping - review of Assessment and Treatment Form where participants had attended National ORT training.
Most of the follow-up activities were concentrated in the Lubombo Region where participant training took place from February - January 1990. Fifty seven trainees (32 staff nurses; 25 nursing assistants) from 26 clinics (Appendix H) were visited with the Clinic Supervisor or designate. Some clinics were visited two or more times due to the late arrival of ORT and weighing equipment which in some cases, delayed the implementation of skills learned in the training. Once equipment was in place, clinics were re-visited to observe trainee skills, reinforce teaching and respond to questions or problems.

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

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

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

Number of Nurses Accommodations Upgraded.

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

The method of work used to approach this activity was first to hold a series of meetings with the then Assistant Health Planner, Planning Unit, Ministry of Health, to review the status of housing repairs occurring under the Rural Clinics Renovation Project (RCRP) and identify the best use of project funds.
Secondly, a detailed, prioritized list of basic repair requests with cost estimates was obtained from the regions. Finally a planning meeting was held with Project and Planning Unit representatives responsible for this activity to establish a mechanism for implementation.

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

At the end of the Project, basic repairs have been completed on 30 of the 52 houses for which requests were made. (List of Accommodation Upgraded - Appendix I). Basic renovations included repair of roofs, gutters, broken windows, doors, installation of locks and painting. The Project also provided: Curtain materials for about 20 houses; kitchen cupboards where nurses were sharing facilities; and a water tank for one clinic where the water shortage was critical.
In spite of the tremendous Project input into upgrading nurses’ accommodations, there are still acute housing problems. It was beyond the scope of the project to deal with plumbing, electrical and appliance needs, which also need urgent attention.

The Government is aware of the housing situation at rural clinics and has a plan for its improvement. One of the program priorities designed to strengthen rural clinic services during the Fourth National Development Plan period (1983/84-1987/88) was to construct 74 staff houses. More recently, the Health Sector - Development Plan 1990/91 - 1992/93, reaffirmed the Ministry of Health’s commitment to continue its major clinic renovation and upgrading program. Priority will be given to "the renovation of rural clinics throughout the country" and "construction of staff housing at clinics for nursing staff who are currently forced to share rooms or sleep on clinic floors". (Health Sector - Development Plan - 1990/91 - 1992/93, p.88).
At least 80% of rural clinics receiving monthly supervisory visits from regional nursing supervisors.

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

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

There are eleven Nursing Sisters or Staff Nurses serving as clinic supervisors as follows: Hhohho - 5; Manzini - 3; Lubombo - 2; and Shiselweni - 1. All supervisors make an annual schedule of their planned monthly clinic visits. However, other priority commitments often lead to cancellations.
According to the job description for Nursing Sister - Clinic Supervisor, visits are to be made monthly to Government and Mission clinics and more often if there are special problems. Supervisors are also expected to visit private and industry facilities to provide EPI and Family Planning Supplies/Information and to follow-up on health statistics record keeping.

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

Table 5

<table>
<thead>
<tr>
<th>Region</th>
<th>Government</th>
<th>Mission</th>
<th>Private</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hhohho</td>
<td>9</td>
<td>9</td>
<td>17</td>
<td>35</td>
</tr>
<tr>
<td>Manzini</td>
<td>15</td>
<td>12</td>
<td>25</td>
<td>62</td>
</tr>
<tr>
<td>Lubombo</td>
<td>12</td>
<td>9</td>
<td>12</td>
<td>33</td>
</tr>
<tr>
<td>Shiselweni</td>
<td>16</td>
<td>3</td>
<td></td>
<td>19</td>
</tr>
<tr>
<td>Total</td>
<td>52</td>
<td>33</td>
<td>64</td>
<td>149</td>
</tr>
</tbody>
</table>

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

Note: Public Health Units and Health Centres are excluded.

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

Table 6

<table>
<thead>
<tr>
<th>Region</th>
<th>Total Clinics</th>
<th>Total Reporting</th>
<th>Percent Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hhohho</td>
<td>35</td>
<td>16</td>
<td>46</td>
</tr>
<tr>
<td>Manzini</td>
<td>62</td>
<td>28</td>
<td>45</td>
</tr>
<tr>
<td>Lubombo</td>
<td>33</td>
<td>29</td>
<td>88</td>
</tr>
<tr>
<td>Shiselweni</td>
<td>19</td>
<td>16</td>
<td>84</td>
</tr>
<tr>
<td>Total</td>
<td>149</td>
<td>89</td>
<td></td>
</tr>
</tbody>
</table>

Data Available for 89 of 149 Clinics = 60%

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

A review of the individual clinic data sheets showed that only 5 (6%) of the 89 clinics were visited each of the 10 months January - October. However, a number at clinics received several visits in a given month and then were not visited for one or more months. (Appendix-J Individual clinic supervisory visits).
Table 7 shows that supervisory visits ranged from 0-30, with 43% of the clinics being visited 1-5 times in the 10 month period. Clinics visited in the 21 - 25 and 26 - 30 categories represent the five clinics (6%) that were visited monthly.

Table 7

Supervisory Visits - January - October 1990

Frequency Distribution of Supervisory Visits

January - October 1990

<table>
<thead>
<tr>
<th>No. of Times Visited</th>
<th>No. of Clinics</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>26 - 30</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21 - 25</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>16 - 20</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>11 - 15</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>6 - 10</td>
<td>24</td>
<td>27</td>
</tr>
<tr>
<td>1 - 5</td>
<td>38</td>
<td>43</td>
</tr>
<tr>
<td>0</td>
<td>10</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>89</td>
<td>100%</td>
</tr>
</tbody>
</table>
If clinics received 10 or 11 visits in the 10 months period, it might be assumed that this averages a visit per month over a 10 month period. This is not the case, however, as illustrated in the following example of one clinic’s report; January - 5; February - 4; June and July - 1 visit each; and no visits the other months. Conversely, clinics reporting 12 - 30 visits in the period, have received a number of consecutive visits monthly (one clinic - 3 visits in one month) usually since March.

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

Review and update recommended posts for clinic supervisors as stated in Health Manpower Requirements FY 1986 - 87 to FY 1992 - 93.

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

Analyze factors related to the inequitable pattern of supervisory visits, whereby some clinics are visited more frequently than others.
CLINIC SUPERVISION VISITS - 1990
HHOHHO REGION

NO. OF VISITS

JAN  FEB  MAR  APR  MAY  JUN  JUL  AUG  SEP  OCT  NOV  DEC

MOH (Stats unit)
CLINIC SUPERVISION VISITS - 1990
MANZINI REGION

MOH (Stats unit)

BEST AVAILABLE COPY
CLINIC SUPERVISION - 1990
LUBOMBO REGION

NO. OF VISITS

MOH (State unit)
CLINIC SUPERVISION VISITS - 1990
BY REGIONS

MOH (Stats unit)
4.2.4. Supervisory Checklist

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

The Clinic Supervisory Checklist started as an Action Plan at the first supervisors meeting in January 1987. It was pretested at six clinics in the Lubombo Region and updated at a June 1987 Supervisory Workshop. Based on identified shortcomings, it was again revised (January 1988) and the accompanying guidelines were developed. The tool was to be used for evaluation, training needs assessment and supervision. It was also to provide the basis for Annual General Meeting and Regional Health Management Team reports and for awarding the "Best Clinic" trophy. Additionally, it was the designated source of data for a number of Project indicators.

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

1. Completed checklists from Lubombo, Shiselweni Region and the Mankayane sub-region were reviewed. Discussions were held with supervisors to identify problem areas.

2. Input was obtained from matrons and other participants attending a management course at the Institute of Development Management; Clinic Supervisors; Program Coordinators; and PHC Project team members.

3. An ad hoc committee composed of three clinic supervisors and the clinic management associate drafted, then finalized the revision based on input.

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

Recommendation

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

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

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

Sr. Hope Msibi, Clinic Supervisor, Hhohho South, and Staff Nurse Matilda Jele assumed responsibility for following through on unfinished tasks related to distribution of outreach sites furniture and feedback on revised checklist, respectively.
Robert Shongwe's report given by the Clinic Management Associate related to setting up an on-going communication mechanism between the Planning Unit, Ministry of Health, and Regional nurses on housing needs.

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

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

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


APPENDIX A

Position Description
Project Outputs
POSITION DESCRIPTION

CLINIC MANAGEMENT ADVISOR
Swaziland Primary Health Care Project

TITLE: CLINIC MANAGEMENT ASSOCIATE

DUTY STATION: Mbabane, Swaziland

SUPERVISOR: CHIEF OF PARTY

DURATION: JANUARY 1 - DECEMBER 31, 1992

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

RESPONSIBILITIES:

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

1. Assist in planning, implementation and evaluation of clinic-based training together with the team's MCH Physician and Nurse Midwife. Responsibility in the training and follow-up would be for simple clinic management interventions.

2. Follow-up of clinic staff in facilities where clinic-based training has taken place emphasizing clinic management interventions to assure that all trainees are followed up at appropriate intervals post training.

3. Organize logistic components of clinic-related activities including drug management, referral and transportation for lab samples, communications, clinic supervision.

4. Follow-up activities at the clinic level during clinic visitations and training including support of the referral system, drug management and clinic supervision activities.

5. Follow-up of the Communications Consultancy Report to implement, if appropriate, recommendations.

6. Within the bounds of the national health education strategy work through the RHMT’s to collaborate with the national Health Education Unit to define the roles and functions of the returning Regional Health Educators who are expected to carry out training of clinic nurses in health education of clients and follow-up recommendations resulting from the Health Education Survey.

7. Give assistance and guidance to the Health Education consultant in developing TB, hypertension, MCH, FP health education methods.
8. Work with the Health Planning Unit and the Project's Administrative Assistant to upgrade clinic nurses houses in line with the priorities of the RHMT's.

9. Using the Supervisory Checklist, monitor home visits made by rural clinics, establishment and maintenance of Community Health Committees and the frequency of clinic supervisory visits. Data obtained from the Checklist would be used as indicators for the monitoring the PHC Project as well as be used at the MCH.

TEAM FUNCTIONING:

The incumbent is expected to work together with the Project's MCH Physician and the Nurse Midwife as a member of an informal team focusing on clinic-based activities. Secondly, this person is expected to coordinate her activities with the Decentralization/Transportation Associate (A1 Neill) at the RHMT level.

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

TRAVEL:

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

MISCELLANEOUS

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

SUPERVISION

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

BEST AVAILABLE COPY
PROJECT OUTPUTS

1. Improved Service Delivery and Outreach Approaches Developed
   1.a. Number of outreach sites operational.
   1.b. Clinics doing regular home visits.
   1.d. Use of manuals developed implemented by PHC.
       Drug Formulary.
       Clinic Reference Manual.
       Clinic Orientation Manual.
   1.d.2 Drug Management System operational.
   1.e Functioning community health committees.

2. Improved skills and Motivation of Health Workers, Brought about by
   Improved Transport and Communications and Improved Supervision and
   Management support
   2.a.5 Clinic re-organized, including privacy curtains, filing
       systems, patient flow measures.
   2.b.9 Number of new health education materials developed.
   2.d. Conditions of service improved
   2.d.1 Nurses accommodation upgraded.
   2.d.4 Clinic Supervisory visits addressing conditions of service.
   2.f. Monthly Supervisory visits.
   2.f.1 Use of Supervisory Checklist.

12 March 1990
As a team, V. Joret, R. Kroeger and M. Price will maintain a clinic focus. Since training remains a priority, training done in this area will primarily be clinic-based and in-service including development of skills of regional trainers. For this clinic-level work funds have been allocated here as well as in the clinic-level sections of the work plan. Focus and priorities at this time are:

(1) Management skills including those related to inventory management, work scheduling, supervision, managing drug and vaccine stock among others at the clinic level.

(2) Nursing skills in community outreach, health education, problem solving, and basic outreach services to be implemented at the clinic level.

### ACT! 

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<thead>
<tr>
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<tr>
<td>1</td>
<td>Training regional trainers at clinic-based</td>
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<td>3</td>
<td>Provide clinic-based training to clinic nurse</td>
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<td>Finalize and evaluate nursing orientation</td>
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</tr>
<tr>
<td>6</td>
<td>Generals maintenance and repair training</td>
<td>4,000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
<td>4000</td>
</tr>
<tr>
<td>7</td>
<td>Complete 101 manuals for clinic management</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
<td>500</td>
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<td>500</td>
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<td>10</td>
<td>Development of nursing incentives</td>
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</tr>
</tbody>
</table>

### EXPLANATORY NOTES

- **12A, 12B**: To be implemented on a pilot basis before being implemented on a larger scale.
- **12A**: Funds available in 1990.
- **12D**: Funds available in 1991.
- **12E**: Funds available in 1992.
- **12F**: Funds available in 1993.
- **12G**: Funds available in 1994.
- **12H**: Funds available in 1995.
- **12I**: Funds available in 1996.
- **12J**: Funds available in 1997.
- **12K**: Funds available in 1998.

### Notes

- The clinic represents the front line of preventive, promotive and curative health services in Swaziland. It reflects the total MOH policy towards health and the community on the one hand, and the community's response to those policies on the other.
- Clinic staff are faced with the impact of traditional beliefs and practices, limited knowledge and negative attitudes which can impede their efforts. In many instances, the staff are also faced with such environmental constraints as poor housing, lack of potable water, lack of basic sanitation, absence of means of communication, inadequate or non-functioning equipment and lack of essential supplies. Many staff also lack the skills required for them to perform their basic functions.
APPENDIX B

Outreach Sites
OUTREACH SITES

SHISELWENI REGION (11)

HLATIKHULU PHU

S/N Alexia Masuku

1. Quomintaba
2. Tiedze - I
3. Tiedze - II
4. Mlindaswe
5. Zindwendweni
6. Ngololweni
7. Kholwane

NHLANGANO PHU

S/N Muriel Tshabalala

8. Mfenyane
9. Vulamehlo
10. Othandweni
11. Dudusini
SITHEKI FHU (7)  Sr. Elizabeth Nyoni
1. Ndumo
2. Maphubu
3. Hlane
4. Nisibulubhuku
5. Sulutane
6. Mlatizeni
7. Umlomwana

SITUDELA HEALTH CENTRE (9)  Matron Zwane
1. Sh. Paul's (Classroom)
2. Nhlaleni
3. Tshihila
4. Esiweni
5. Engwatoni
6. Sitsatsaweni
7. Kashoba
8. Ngcina

SITUBOLELA HEALTH CENTRE (9)  S/N Elizabeth Langwenya
1. Nkonjwa (rooms)
2. Gucuka (class)
3. Maloma (room)
4. Kukhanyeni
5. Makwebi (school)
6. Mhosi (tree: started structure
7. Mahhoshe (tree)
8. Mphaphathi
9. Lume

ST PHILIPS (3)  Sr. Raphael Sharkey
1. Ndobandoba
2. Maloma
3. Ngudzeni

NDZEVANE REFUGEE (2)  Sr. Paulina Mdziniso
1. Mbuthu
2. Dlakadla
### HHOHO REGION (22)

#### SOUTH (14)

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

#### NORTH (8)

1. Mbeka  
2. Zandondi  
3. Nkomazi  
4. Nkambeni  
5. Ngomane  
6. Mavula  
7. Ludlawini  
8. Mzimnene

Near School  
School  
(Gushede)  
School  
School
### MANZINI

1. Mkhulamini  
2. Ntabamhloshana  
3. Mampembeni  
4. Lesibovu  
5. Mbuluzi  
6. Bulunga I  
7. Bulunga II  
8. Mbekelwini  
9. Lzitha  
10. Thulwane

### MAHKAYANE

1. Sivendle  
2. Bhabwini  
3. Luzelwini  
4. Mlindzini  
5. Dilini  
6. Mafutseni  
7. Ticantfwini  
8. Dzanyana  
9. Gugwini  
10. Lunyaweni  
11. Mnini

Total PHC Project - Assisted Sites 84

---

10 July '90

marg/outrsits

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APPENDIX C

Lundzi Outreach Site-Speech
and
Newspaper Article
To: Your Royal Highness, Prince Mthembu,  
Indvuna Magagula,  
Headmaster Zwane,  
Regional Health Administrator, Miss Hbuli,  
Sr. Harriet Kurene, Acting Matron,  
Esteemed Members of the Lundzi Community  
Honoured Guests

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

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

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

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

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

Siswati Interpreter  
Mr. W.M. Jele
Communities must also take part in health projects

BY MHLENGI MBATHA

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

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

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

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

Dr Edmondson said the 1983 National Health Policy of Swaziland stipulates that the improvement of the health status of the nation calls for a partnership between government and communities, a step the Lundzi community has taken by building itself a health outreach structure.

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

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

“To date, there are 75 sites throughout the country receiving support at a total cost of approximately £50 000. The construction of outreach sites is a self-help, community initiated programme and under strict guidance of nursing personnel in the region.”
APPENDIX D

Survey Questionnaire
CLINIC NAME: ____________________________

1. Outreach Site
   Number: ____________________________
   Name: ____________________________
   Structures built:
   Furniture: ____________________________

2. Home Visits
   Frequency: ____________________________
   How often by:
   Nurse: ____________________________
   Nursing Assistant: ____________________________
   Is there a clinic record of home visits?
   [YES] ----------- [NO] -----------
   If the clinic has not made home visits, state the reasons WHY
   (Example: No transportation, clinic too busy, etc.)

3. Manuals
   Are there copies of:
   Yes No How Many?
   a. Drug Formulary Manual            ____________________________
   b. Clinic Reference Manual           ____________________________
   c. Clinic Orientation Manual         ____________________________
   Frequency of use of each Manual:
   Frequently ____________________________
   Infrequently ____________________________
   a. Drug Formulary Manual            ____________________________
   b. Clinic Reference Manual           ____________________________
   c. Clinic Orientation Manual         ____________________________

4. List the Clinic Nurses accommodations (name of site) in most need of repair.
   Make a list of the basic repairs that would upgrade the accommodations.

5. Supervisor's Checklist
   Copy of checklist in clinic? [YES] -------- [NO] --------
   How often did the supervisor
   visit you clinic in 1988? .------------------.
   Number of visits in 1988 .------------------.

3outsitl

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### SWAZILAND PRIMARY HEALTH CARE PROJECT

**Home Visits - Lubombo Region**

M. Edmondson  
March 19, 1990

**Clinics Making Home Visits (Clinic Staff)**

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Frequency (weekly)</th>
<th>Clinic Record</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Once</td>
<td>Twice</td>
</tr>
<tr>
<td>1. Lomahasna</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>2. Mpaka Railway</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>3. Ndzevane</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>4. Siteki Nazarene</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>5. Siteki PHU</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>6. Siphofaneni</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>7. St. Philips</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>8. Tambuti</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>9. Simunye</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>10. Mpolonjeni</td>
<td>Not stated</td>
<td></td>
</tr>
<tr>
<td>11. Tambankulu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Bholi</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Ubombo Ranches</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Clinics Not Making Home Visits**

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

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

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

* Follow-up:

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

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

Summary:

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

Clinics Making Home Visits
**Individual Clinics Making Home Visits (Total - 42)**

**and Number of Visits Made**

**January - October 1990**

**Hhohho**

<table>
<thead>
<tr>
<th>Sub-region</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>6 of 8</td>
<td>75%</td>
</tr>
<tr>
<td>North</td>
<td>4 of 7</td>
<td>57% (data incomplete)</td>
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</tbody>
</table>

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

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

**Manzini**

<table>
<thead>
<tr>
<th>Sub-region</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manzini</td>
<td>4 of 19</td>
<td>21%</td>
</tr>
</tbody>
</table>

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

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

**Lubombo**

<table>
<thead>
<tr>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 of 29</td>
<td>34%</td>
</tr>
</tbody>
</table>

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

(Home visits reported by Refugee clinics where not included)

**Shiselweni**

<table>
<thead>
<tr>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 of 16</td>
<td>63%</td>
</tr>
</tbody>
</table>

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

*Only 7 of the clinics in Hhohho North reported.*
APPENDIX F

Active Community Health Committees
Active Clinic Health Committees

Hhohho

South - 9 of 9 = 100%
1. Sigangeni
2. Nkaba
3. Lobamba
4. Motshane
5. Ekuphileni
6. Florence (on HIS - Listed Manzini)
7. St. Mary’s
8. Malandzela
9. Salvation Army

North - 7 of 9 = 78%
1. Bulandzeni
2. Herefords
3. Mangweni
4. Ntonjeni
5. Horo
6. Endzingeni
7. Balegane

Manzini

Manzini Sub-Region - 4 of 19 (Gov’t, Mission, NGO’s) = 21%
1. Bhekinkosi (Nazarene)
2. Mliba (Nazarene)
3. Sigcineni (Gov’t)
4. Sigombeni (Red Cross)
Mankayane Sub-Region - 6 of 11 (Gov't, Mission = 55%)
1. Mahlangatsha
2. Gebeni
3. Ncabaneni
4. Musi
5. Mangcongco
6. Cana

Lubombo - 13 of 29 (Gov't, Mission, Industry) = 45%
1. Sithobela Rural Health Centre
2. St. Philips
3. Sinceni
4. Ikwezi
5. Lubuli
6. Mpolonjeni
7. Siphofaneni
8. Shewula Nazarene
9. Bholi
10. Tabankulu
11. Vuvulane
12. Lomahasha
13. Gilgal

Shiselweni - 8 of 16 = 50%
1. Gege
2. Zombodze
3. Ntshanini
4. Dwaleni
5. Matsanjeni
6. J.C.I.
7. Nkweni
8. Phunga

Total Number of Clinics - 93
Total Number with Active Community Health Committees - 47
Percent of Clinics With Active Committees - 51%

BEST AVAILABLE COPY
Summary - Active Health Committees by Region

Region

1. **Hhohho**
   - South - 9 of 9 = **100%**
   - North - 7 of 9 = **78%**

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

3. **Lubombo**
   - Lubombo - 13 of 29 = **45%**

4. **Shiselweni**
   - Shiselweni - 8 of 16 = **50%**

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APPENDIX G

Clinic Based Training
Follow-up Form
CLINIC FOLLOW-UP VISIT

Region ____________________
Clinic ____________________

Date visited ____________________
Visited by ____________________

Clinic staff/dates

Attended Training

Follow-Up Activities

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

2. Immunization/Growth Monitoring
   a. Activities placed for avoid
       Congestion-separate sick
       from well children
   b. Immunization schedule
   c. Use of disposable/reusable syringes
       disposal methods
   d. Use of salter scale
   e. Road to health card
3. Oral Rehydration Therapy (ORT)
   a. Corner functioning/frequency of use
   b. Equipment maintained - table, two benches, ORT Chart, plastic cups, spoons, buckets, measuring cups.

4. Manuals
   a. Drug Formulary
   b. Clinical Reference
   c. Clinic Orientation

5. Drug Management System

6. Community level activities
   a. Supervision of RHMs
   b. Home visits
   c. Community health education
   d. Community health committee

7. Supervisory Visits
   a. Supervisory Checklist used on visits
   b. Visits addressing conditions of service

8. Nurses' accommodation

9. Other

Comments/Actions
APPENDIX H

Trainees
Clinic Based Follow-up
SWAZILAND PRIMARY HEALTH CARE PROJECT

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

1. Siteki PHU

Hazel Sembe
Laurene Mlambo
Dumisile Mavuso (relief nurse Tikhuba)

Trainers
S/N Nomsa Magagula
S/N Thandie Ndabandaba

2. Tikhuba

Elsie Nkalabatsi - Nursing Assistant
(S/N relief from Siteki PHU)

3. Lutuli

Anna Dlamini
Elizabeth Simelane

4. Gilgal

Venanciama Dlamini
Lillian Shongwe

5. Lomahasha

Nelisiwe Mamba
Dudu Masilela
Ruth Nyoni

6. St Philips

Priscilla Gina
Sr. Raphael Sharkey
Janet Yeboah

7. Sithobela Health Centre

Beauty Dlamini
Mildred Dlamini
Fortunate Magagula
Netty Fakudze
Khetsiwe Thwala

Trainer - Thembie Dlamini
(transfered Sinceni Clinic)

BEST AVAILABLE COPY
8. *Siteki Nazarene*
   Sibongile Mdlalose
   June Stewart

9. *Sinceni*
   Sindile Gamedze
   Trainer - Thembie Dlamini (now Staff Nurse at clinic)

10. *Vuvulane*
    Tobhie Mndzebele
    Phephile Nsibandze

11. *Mpolonjeni*
    Otilia Mlotsa
    Dinah Gele

12. *Siphofaneni*
    Veronica Vilakati
    Elizabeth Nxumalo
    Dudu Ndizimandze

13. *Good Shepherd*
    Sibongile Vilakati
    Maureen Mayenge
    Rose Matsenjwa (PHU)

14. *Bholi*
    Happiness Maziya
    Mildred Zwane
    Trainer - Patricia Gina

15. *Shewela Nazarene*
    Beauty Magagula
    Ruth Nsibandze

16. *Ndzevane Refugee*
    Elizabeth Matsebula
    Pedro Fumo
    Lydia Gumedze
    Pauline Mdziniso

*BEST AVAILABLE COPY*
17. **Ikhwezi Joy**  
Gertrude Gamedze  
(S/N - working alone)

18. **Manyeveni** (Malindza/Mpaka Nazarene)  
Busisiwe Dlamini  
Irma Lukhele

19. **Mpaka Railway**  
Minah Mathabela  
Albertina Matsenjwa

20. **Simunye**  
Khosi Mhlonga  
Sizakele Magagula

21. **Simunye/Ngomane** (separate clinic - administered by Simunye)  
Emma Nhlapo

22. **Tambankulu**  
Angeline Simelane  
Sr. Julia Ndlangamandla

23. **Ebenezer**  
Phyllis Mamba/Nursing Assistant

24. **Sigcaweni**  
Sellina Magagula  
Gugu Maarja

25. **Ukumbo Ranches**  
Elizabeth Lukhele S/N  
Maggie Dlamini S/N

26. **Mpaka** (Malindza) **Refugee**  
Christine Mutube S/N  
Jenny March S/N
No Trainees

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

Did Not Complete Training

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

10 July '90

WARG/LUBREG

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Clinic Management Associate

Clinic Visits - January - December 1990

January 15

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

Lubombo Region

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

January 18

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

Shiselweni

Hlatikulu PHU
Nhlangano HC
Zombodze - Clinic-based Training Site

January 25 -26

Hhohho South - Sister Hope Msibi, Clinic Supervisor

Nkaba
Motshane
Lobamba
St. Mary's
Salvation Army

March 27 and 29

Shiselweni - Dr. T. Braeken, PH Medical Officer

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

August 7 Sister E. Nyoni

Joyce Mtimavalye UNFPA Project

Lubombo

Simunye
Tshaneni
Mhlume
Shewula Nazarene
Lomahasha
Tabankulu
Vuvulane

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

Lubombo

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

September 5 - Dr. V. Joret

Hhohho North

Emkhuwzeni HC - Reconnaisance visit - Hhohho Region clinic based training site.

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

Manzini Region - Mankayane

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

BEST AVAILABLE COPY
9 April

Accompanied by Sr. Elizabeth Nyoni, Siteki PHU

Tikhuba
Ebenezer
Good Shepherd
Siteki PHU

14 and 15 May

Accompanied by S/N Hamsa Magagula, Trainer, Siteki PHU.

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

12 - 15 June

Accompanied by S/N Elizabeth Langwenya, Sithobela Health Centre.

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

19 - 21 June

Accompanied by Mr. A. Nyoni, FHC Project.

Tabankulu
Shewula Nazarene
Lomahasha
Ubombo Ranches
Mpaka Railway
Malindza (Mpaka) Refugee
Simunye/Ngomane
Vuvulane
Ndzevane Refugee
Sigcaweni
Manyeveni
2 clinics. Tikhuba and Ebenezer Good Shepherd - visited twice
- visited three times

Visited, but no trainees

Mpaka Collieries (Emaswati Coal)
Tshaneni
Mhlume
Big Bend Sugar

11 July '90
17rptref
APPENDIX I

Nurses Accommodations Upgraded
### Shiselweni (11) Lubombo (11)

<table>
<thead>
<tr>
<th>Shiselweni</th>
<th>Lubombo</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ka-Phunga</td>
<td>Tikhuba</td>
</tr>
<tr>
<td>Kwene</td>
<td>Vuvulane</td>
</tr>
<tr>
<td>Lebumisa</td>
<td>Ebenzer</td>
</tr>
<tr>
<td>Hluti</td>
<td>Siteki Nazarene</td>
</tr>
<tr>
<td>Ndzamoni</td>
<td>Sigcaweni</td>
</tr>
<tr>
<td>Nhlonzini</td>
<td>Shewula</td>
</tr>
<tr>
<td>Nhletheni</td>
<td>Manyeveni</td>
</tr>
<tr>
<td>Masebeni</td>
<td>Siteki, PHU</td>
</tr>
<tr>
<td>Malandile</td>
<td>Sinceni</td>
</tr>
<tr>
<td>Zombodze</td>
<td>Bholi</td>
</tr>
<tr>
<td></td>
<td>Lubuli</td>
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</tbody>
</table>

### Ranch (14): South (9)

<table>
<thead>
<tr>
<th>Mission (2)</th>
<th>Ngealweni</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nhlati</td>
<td>Nkuluni</td>
</tr>
<tr>
<td>Lobamba</td>
<td>Mafutseni</td>
</tr>
<tr>
<td>Malandela (Under Mankini)</td>
<td>Mankayane Sub-Region (4)</td>
</tr>
<tr>
<td>Motshane</td>
<td></td>
</tr>
</tbody>
</table>

### North (9) **Nurse & Nursing Assistant**

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<th>Ngealweni</th>
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<td>Nkuluni</td>
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<tr>
<td>Lobamba</td>
<td>Mafutseni</td>
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<tr>
<td>Malandela (Under Mankini)</td>
<td>Mankayane Sub-Region (4)</td>
</tr>
<tr>
<td>Motshane</td>
<td></td>
</tr>
</tbody>
</table>

1. Sigangeni     2. Dwalile
3. Lobamba       4. Mahlangatsha
4. Malandela     5. Luvenge
5. Mafutseni     6. Mangocondo
7. Mankayane Sub-Region 8. Nqabaneni
8. House No. 12151
9. Total accomodations to be upgraded - 52 - 30 completed

**Shiselweni - Work coordinated in the region with PWD**

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

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

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

---

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APPENDIX J

Supervisory Visits
### Appendix

#### Individual Clinic Supervisory Visits

**January - October 1990**

<table>
<thead>
<tr>
<th>Region</th>
<th>Clinic (16)</th>
<th>No. of Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lobamba</td>
<td>29 (Visited Monthly)</td>
</tr>
<tr>
<td></td>
<td>Sigangeni</td>
<td>27 (Visited Monthly)</td>
</tr>
<tr>
<td></td>
<td>Bulandzeni</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Nkaba</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Ndzingeni</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Horo</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Herefords</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Mangweni</td>
<td>9</td>
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<tr>
<td></td>
<td>Motshane</td>
<td>8</td>
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<tr>
<td></td>
<td>Mshingishingini</td>
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<tr>
<td></td>
<td>Salvation Army</td>
<td>6</td>
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<tr>
<td></td>
<td>Ekupheleni</td>
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<tr>
<td></td>
<td>Ndvwangeni</td>
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<tr>
<td></td>
<td>Malandzela</td>
<td>4</td>
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<tr>
<td></td>
<td>Mbabane Family Life</td>
<td>3</td>
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<tr>
<td></td>
<td>St. Mary’s</td>
<td>2</td>
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**172**

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

**Summary Report list - 176 visits.**
## Individual Clinic Supervisory Visits

<table>
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<tr>
<th>Region</th>
<th>Sub-region (18)</th>
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<td>Manzini</td>
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<td>Bhekinkosi</td>
<td>16</td>
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<tr>
<td></td>
<td>Mafutseni</td>
<td>14</td>
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<tr>
<td></td>
<td>Mliba</td>
<td>13</td>
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<td></td>
<td>Malkernes Family Life</td>
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<td>Family Life Association</td>
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<td>Ekudzeni</td>
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<td></td>
<td>Swazican</td>
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<td>St. Juliana’s</td>
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<td></td>
<td>Kwaluseni</td>
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<td>Emoyeni</td>
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<td></td>
<td>Kabudla</td>
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<td></td>
<td>Sicelewini</td>
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<td></td>
<td>Swaziland Railway</td>
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<td>St. Theresa’s</td>
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<tr>
<td></td>
<td>Nomhlanhla</td>
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<td></td>
<td>Esigombeni</td>
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<td></td>
<td><strong>Sub-total</strong></td>
<td><strong>124</strong> Manzini</td>
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<tr>
<td></td>
<td></td>
<td><strong>125</strong> Mankayane</td>
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*Summary Report Lists 263*
<table>
<thead>
<tr>
<th>Sub-region</th>
<th>No. of Visits</th>
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<tr>
<td>Luyengo</td>
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<td>Musi</td>
<td>26 (Visited Monthly)</td>
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<td>Cana</td>
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<td>Bethlehem</td>
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**Total:** 124
## Individual Clinic Supervisory Visits

**10 month Period**

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<th>Clinic/Site</th>
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<td>Lubombo</td>
<td>Malindza Manweveni</td>
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<tr>
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<tr>
<td></td>
<td>Gilgal</td>
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<td>Ubombo Ranches</td>
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<td></td>
<td>Lomahasha</td>
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<tr>
<td></td>
<td>Siteki Nazarene</td>
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<td></td>
<td>Bholi</td>
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<tr>
<td></td>
<td>Mpolonjeni</td>
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<td></td>
<td>Vuvulane</td>
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<td>Lubuli</td>
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<td>Ikwezi</td>
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</tr>
<tr>
<td></td>
<td>Simunye</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Shewula</td>
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<tr>
<td></td>
<td>Tikhuba</td>
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<td></td>
<td>Malindza Refugee</td>
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<td>Ndzevane Refugee</td>
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<td>Siphofaneni</td>
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<td>Tambuti</td>
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<td></td>
<td><strong>Total</strong></td>
<td><strong>99</strong></td>
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</table>

St. Philips
Ebenezer
Sithathaweni
Mbaka Colliers
Tambankulu
Mill Clinic
Mhlume
Mananga College
Dr. Martin's
Flame

*Summary Sheet 104*
### Indiidual Clinic Supervisory Visits

**January - October 1980**

<table>
<thead>
<tr>
<th>Region</th>
<th>Clinic(s)</th>
<th>No. of Visits</th>
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<tbody>
<tr>
<td>Shiselweni</td>
<td>Hluti</td>
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<td>Zombodze</td>
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<td>Mhlosheni</td>
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<tr>
<td></td>
<td>Bethany</td>
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</tr>
<tr>
<td></td>
<td>Our Lady of Sorrows</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Nkwene</td>
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<td></td>
<td>Gege</td>
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<td></td>
<td>Ntshanini</td>
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<td>Phunga</td>
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<td>Mahlandle</td>
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<tr>
<td></td>
<td>J.C.I.</td>
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<td>Dwaleni</td>
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<td>Nhletsheni</td>
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</tbody>
</table>

*77

*Summary Sheet = *80

**BEST AVAILABLE COPY**
APPENDIX K

Supervisory Checklist
**SUPERVISORS CHECKLIST FOR CLINICS**

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

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

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

<table>
<thead>
<tr>
<th>AREAS</th>
<th>DATE</th>
<th>RATING</th>
<th>REMARKS/ACTION</th>
<th>DATE</th>
<th>RATING</th>
<th>REMARKS/ACTION</th>
<th>DATE</th>
<th>RATING</th>
<th>REMARKS/ACTION</th>
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</thead>
<tbody>
<tr>
<td>1. PATIENT CARE MANAGEMENT</td>
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<td></td>
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</tr>
<tr>
<td>Maternal Health/Family Planning (MH/FP)</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>1.1 Complete Medical and obstetric and/or FP history and physical examination</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>1.2 Risk identification and referral</td>
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</tr>
<tr>
<td>1.3 Tetanus Toxoid status</td>
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<tr>
<td>1.4 Sexually transmitted Disease (STD) screening/protocol</td>
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<td>1.5 Neonatal immunization</td>
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<tr>
<td>1.6 Relevant FP interview examination, counselling</td>
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<td>1.7 Annual PAP SHEAR</td>
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<tr>
<td>1.8 Required data correctly entered on antenatal, delivery and FP Cards/registers</td>
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</tbody>
</table>

2. Child Welfare

Immunization

2.1 Adequate supply of vaccines/diluents
2.2 Current immunization schedule
2.3 Sterile syringe/needle for each injection
2.4 Proper injection technique
<table>
<thead>
<tr>
<th>AREAS</th>
<th>DATE</th>
<th>RATING</th>
<th>REMARKS/ACTION</th>
<th>DATE</th>
<th>RATING</th>
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<th>DATE</th>
<th>RATING</th>
<th>REMARKS/ACTION</th>
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<tr>
<td>2.5 Operation/maintenance of Cold Chain</td>
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<td>2.5.1 Temperature</td>
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<td>2.5.2 Vaccine Placement/rotation</td>
<td></td>
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</tr>
<tr>
<td>2.6 Prompt diagnosis, tracing and reporting of communicable disease outbreaks.</td>
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<td></td>
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<tr>
<td>Growth Monitoring/Nutrition</td>
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</tr>
<tr>
<td>2.7 Proper weighing equipment, procedure and plotting.</td>
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<td>5.6 Ordering, Storing, Dispensing and controlling drugs by established procedures</td>
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Summary of Findings / Action Taken:

Suggestions for Improvement:

Clinic / Staff Strengths:

Other:

Date(s) of Discussions with Staff:

June 1989 - 1st Edition
Revisions: Oct-Dec 1990
October 1990 - Clinic Supervisors and
Clinic Management Associate
Swaziland PHC Project
APPENDIX L

Debriefing Agenda
and
Participant List
SWAZILAND PRIMARY HEALTH CARE PROJECT

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

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

AGENDA

9:30am Devotion - Sr Mabilisa

9:40am Opening Remarks - Dr. John Ngubeni, Medical Officer for Public Health.

9:50am Overview of major clinic management associate handover activities - M. Edmondson.

10:00-10:40am Status Reports (tea break - 10:15)

1. Outreach sites - Sr. M. Jele

2. Nurses accommodations - M. Edmondson and Robert Shongwe, Planning Unit.


4. Follow-up of clinic based training - M. Edmondson and Sr. Kunene.
CONTINUED MONITORING OF PRIMARY HEALTH CARE PROJECT INPUTS IN REGIONAL WORKPLANS - HHOHO PRESENTATION:

10:40-11:00am  Highlights of I.D.M. course(s) for Matrons and usefulness in improving Management skills - Matron E. Mndzebele.

11:00-12:00pm  Evaluation of Hhohho Regional Workplan - Sr. H. Kunene

12:00pm  Lunch
### SWAZILAND PRIMARY HEALTH CARL PROJECT

**PUBLIC HEALTH MATRONS AND SUPERVISORS MEETING - HANDOVER ACTIVITIES**

Dr. M. Edmondson  
Clinic Management Associate

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<td>I. L. Ngubeni</td>
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<td>M.V. Shabalala</td>
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