TRAINING FOR ADMINISTRATION IN HEALTH
IDM HEALTH SURVEY

A Preliminary Report
The Institute of Development Management
Botswana, Lesotho, Swaziland

by

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I. INTRODUCTION

Since 1979 the Institute for Development Management has been offering 8-month courses in Health Care and Nursing Administration at the Certificate level. The two courses were introduced as a result of a recognition by Botswana, Lesotho and Swaziland that efficient health administration was necessary to improve the delivery of health services at all levels, viz hospital and other health facilities and services, both in urban and rural areas.

The aim of the course in Health Care Administration is to provide hospital administrators and senior health care personnel involved in the planning and operation of health care services with the knowledge, skill and competency required for the management of health care delivery systems in Africa, and more specifically in Central and Southern Africa. The aim of the Nursing Administration course is to provide matrons and senior nursing personnel involved in the planning and operation of health services in hospitals and other health facilities, in both public or private sectors, with the knowledge, skills, and managerial abilities to administer nursing services in Africa, especially Botswana, Lesotho and Swaziland.

Since the inception of these courses, a total of 65 individuals from the three countries have been graduated: 31 in Health Care Administration, and 34 in Nursing Administration (cf Table 1.).

Health Care Administration is a fairly new profession, not only in Africa but in the Western world as well, and like any new cadre, finds itself having problems of acceptance and
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<td>-</td>
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1 Certificate in Nursing Administration
2 Certificate in Health Care Administration
recognition by the traditional health professions, particularly the doctors and nurses. A recent evaluation of the health programmes at the I.D.M. recommended that a study be undertaken to analyze how health administrators are currently being utilized in the BLS countries, to identify the roles they might play, and to outline future training needs. This paper is a preliminary report of the results of the study carried out in accordance with that recommendation. It consists of four sections: a description of the survey itself, a summary of the results, a description of those results, and the conclusions stemming from them, and recommendations concerning the allocation of administrative tasks and for training.
II. DESCRIPTION OF THE STUDY

Objectives:

The objectives of the study were:

1. To determine the actual tasks of health services administrators currently working in the field, identifying those administrative tasks currently performed by service providers which could be carried out by the administrative cadre, thus freeing nurses and doctors for improved supervision of patient care.

2. To identify factors which facilitate or impede the effective functioning of Health Care Administrators as members of the health team.

3. To describe the tasks for which IDM training should prepare participants in health administration.

4. To estimate the potential demand for different levels of health administrators according to the size and scope of health facilities and services (including ministries, etc.), and to outline the educational and/or experience qualifications for each level.

5. To identify the training needs for administrators in health over the next five years.

Survey Plan:

The study plan called for a survey of as many as possible of the 53 members of the first three graduating classes. In addition, in order to see how the administrative load was shared

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1 Two sets of classes graduated in 1982; the second was not included in the study as it finished after the field work had been completed.
within the health team, one or two others working with the graduate were also to be surveyed at each facility; where possible, these were to include the graduate's supervisor.

Out of the 53 former I.D.M. participants only 37 were available for the study while the others could not be reached for various reasons, e.g. out of the country, or no longer working, etc. These 37 plus their supervisors and colleagues resulted in a total of 71 respondents.

Analyses have been carried out primarily on the 63 respondents actively involved in health administration at hospital or community level. Table 2 shows the distribution of respondents by practice setting, position and country.

Field work in this study was undertaken in the BLS countries between 14th September, 1982 and 15th December, 1982. Interviewing began in Botswana on the 14th of September, 1982 (pilot study in August, 1982), and continued through October 5th, 1982. In Swaziland and Lesotho it was carried out during the period 11th October, 1982, through November 15th, 1982. A list of places covered in the 3 countries appears as Appendix 1.

Survey Instruments:

Four instruments were designed for the study, three of which were used with all respondents; the fourth, given to IDM graduates only, was optional. The first consisted of a detailed listing of 80 administrative and managerial tasks carried out by someone on the health team. For each task the respondent was asked to tick off four items: 1) whether the task was included in her/his job; 2) how frequently the task must be done; 3) whether she/he had delegated it to anyone else; and if so 4) to whom (position).

After the task check-off list had been completed by
### Table 2. DISTRIBUTION OF RESPONDENTS BY PRACTICE SETTING, POSITION AND COUNTRY

<table>
<thead>
<tr>
<th>HEALTH SERVICE ADMINISTRATORS</th>
<th>Total</th>
<th>Botswana</th>
<th>Lesotho</th>
<th>Swaziland</th>
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<tr>
<td>Hospital Administrators:</td>
<td></td>
<td></td>
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<td>14</td>
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<td>6</td>
<td>3</td>
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<tr>
<td>Matrons, Asst. Matrons, etc.</td>
<td>23</td>
<td>7</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Health Care Administrators</td>
<td>19</td>
<td>6</td>
<td>11</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>56</td>
<td>18</td>
<td>25</td>
<td>13</td>
</tr>
<tr>
<td>Community Health Administrators:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Administrators</td>
<td>5</td>
<td>4</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Health Care Administrators</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>6</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Others</td>
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<tr>
<td><strong>Total</strong></td>
<td>71</td>
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<td>IDM Graduates</td>
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</tr>
<tr>
<td>Other</td>
<td>34</td>
<td>17</td>
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<tr>
<td><strong>Total</strong></td>
<td>71</td>
<td>31</td>
<td>26</td>
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</tbody>
</table>
the respondent, a semi-structured interview was conducted in which the respondent was asked to rate satisfaction with her/his job and with the administrative work of others; reasons for the ratings were queried. Specific tasks liked or disliked; ideas about reallocation of tasks and about ways of improving administration; innovations implemented, promotions and/or salary increases since graduation from IDM; opportunities for advancement; and suggestions for improving the IDM courses were also obtained, along with a small number of personal items: age, education, and salary.

Following the interview, each respondent was observed at 2 minute intervals throughout the remainder of the working day, usually for 6 - 8 hours. At each observation two items were ticked: the kind of observable activity (patient care, paper work, telephone, rounds, issuing stores, meeting with others, etc.) and where it was being carried out (office, wards, storeroom, other location in the health facility, elsewhere). Because of the large number of observations, work sampling gives a statistically valid description of the pattern of an individual's, not necessarily typical, working day, and supplements information on the distribution of activities reported by the respondent through the task check-off list. No attempt was made to record the specific purposes of the activities observed. The exercise also provided the interviewers with the opportunity to observe the flow of administrative work among the members of the health team, and the quality of their interaction.

Finally, a diary was left with IDM graduates, in which they were asked to record each activity, location, broad administrative purpose (personnel, management of physical resources, finance, etc.), and the time devoted to each during six different working days over a 2-3 week period. Diaries have been received from twenty respondents; they have yet to be fully analyzed.

Copies of these instruments appear as Appendix II.
III. RESULTS The Nature of Managerial Work in Health

Job profiles showing the relative amounts of time spent in different broad areas of administration responsibility were developed from both the task analysis and work sampling exercises, for each of the five cadre of health administrators: Hospital Superintendent, Hospital Matron/Assistant Matron, Hospital/Health Care Administrator, Community Nursing Administrator and Community Health Care Administrator. Profiles from the work sampling are constructed as simple percent distributions of activities and of their location (Figures 1-6. See also Tables 1 and 2, Appendix III). The profiles of annual administrative load (Figures 5, 6, 7, and see also Tables 3-6, in Appendix III) are constructed from the task check-off list, weighted by the natural logarithm of the frequency with which the task is performed, and to make comparisons easier, are expressed as a ratio of the index for all administrative tasks.¹

Proportions of tasks delegated were also computed for each cadre, for all tasks and for load areas of administrative responsibility (see Table 3).

For each of the cadres the most frequently cited tasks liked and disliked, those which staff felt unqualified to do and those they wanted to see allocated to someone else were identified; suggestions for ways to improve administration were tabulated (Table 4). Scores were constructed for satisfaction with one's own adminis-

¹ This measure gives a lower weight to each performance of tasks which occur daily (and therefore a relatively higher weight to each performance of those, such as planning budgeting or staff appraisal, which occur infrequently), than would an index constructed from the simple frequencies. It makes the distribution somewhat easier to chart, and it does not affect comparisons among the several cadres.
trative role and that of others, from a simple weighted average of the categories checked by each respondent on a satisfaction scale (Table 5); the reasons given were tabulated Tables 6 and 7). For IDM graduates, three items indicating their successful utilization since graduation, and another three indicating their expectation for future advancement, were also tabulated (Table 8), as were their recommendations to IDM for improvement in the current courses in health administration.

Results of these analyses are discussed separately for each cadre. The Tables and Figures appear at the end of this Chapter.

A. The Hospital Superintendent

Data from both the task check-off list and the work sampling exercise show that doctors give a major proportion of effort to direct patient care. On an annual basis, they give far more effort to patient care than to any area of administration (see Figure 5, and also Table 2 in Appendix III). On a single day of observation, close to 40% of their time was spent in patient care, either directly or on rounds (see Figure 1); nearly 50% of their activities were carried out in the wards or clinics (Figure 3).

Communication, by telephone, mail, conversation, or meetings, is an important aspect of the work of the Medical Superintendent. On an annual basis, it is the single most frequent category of administrative work reported. On the day of observation, conversations, direct and by telephone, and meetings constituted close to a quarter of the observations, while an additional but unknown fraction of the surprisingly large 33% of time spent on paper work undoubtedly must be counted as communication.
In an annual basis considerable effort too goes into personnel management, much of it in conflict resolution. Relatively little attention is devoted to the management of either physical or financial resources, or to planning; an important proportion of these tasks is delegated, often to the Health Care Administrator (see Table 3). And there is a hint in the data that the more paper work the HCA does, the greater the amount of time the doctor spends in patient care.

From the interview, too, it is clear that the doctors are concerned and conscientious about patient care. Many feel inadequate in their administrative role, and do not enjoy it. Personnel management, especially conflict resolution, was frequently mentioned among the tasks they disliked or felt inadequately prepared for. Several expressed a desire to delegate this to someone else, although they had not been successful in doing so. They do not like to prepare statistical reports or other written materials, nor to make annual estimates and plans. Some have successfully delegated much of this work to the Health Care Administrator; others would like to delegate but have not been able to do so.

On balance, the doctors are fairly dissatisfied with present administrative roles, their own and those of others, particularly in Swaziland (see Table 5). They would prefer to do less administration but are not confident of the administrative abilities of their colleagues. Shortages of staff and other resources constitute the second most important set of factors contributing to their dissatisfaction. They do not share a consensus, however, on what might be done to improve administration.

B. The Hospital Matron

Both the task analysis and the work sampling exercise
show that Matrons, although bearing a major responsibility for supervising patient care, are spending a considerably smaller proportion of their time on this than are the physicians. A great deal of their time is spent in paperwork, personnel management, and communication, and far more time is spent in the office than in the wards or clinics, on rounds or in the direct supervision of care (see Figures 2, 4 and 6). Some very frankly express enjoyment of every aspect of administration, preferring this to patient care.

Much of the time spent on personnel management and in direct communication is on conflict resolution, which they do not enjoy. They are very much aware that many of the problems they are having in personnel management demand greater skills in communication, and rate this as one of their most important training needs. Many do not enjoy and feel unqualified for the management of financial and physical resources (notably housekeeping and office management), and feel that these tasks should be allocated to others. A number have been successful in delegating these to other staff, including the Health Care Administrator. Again, many recognize a need for more training in budgeting and finance, estimating future needs, and programme planning and evaluation, if they are to fulfill their responsibilities in these areas.

Since graduation 70-75% have been given new responsibilities or have successfully initiated change. Only 40% have received promotion or salary increases, but 40% expect promotion in the future, while 50% expect to have opportunity for further training. A number would like to see IDM's course in Nursing Administration upgraded to Diploma level.

Generally the Matrons are fairly satisfied with their own administrative role and that of others, although
most recognize the need for improved working relationships among the members of the team of health administrators, and for additional training in communication and in certain administration skills.

C. The Hospital Health Care Administrator

From both task analysis and work sampling, it is clear that the health care administrator spends a great deal of time dealing with others - on the telephone, in conversation and meetings, and through letters and reports. She/he also spends most of her/his time in the office, doing paper work, although a reasonable amount of time is spent away from the facility on errands of various kinds. Finances and physical resources management are considerably more important in the work of this cadre than in that of either the physician or the nurse administrator. Personnel management of clerical and industrial staff is also fairly important. As this cadre is able to delegate very little of this administrative load, there was much complaint about over work.

Most of the Health Care Administrators enjoy the general nature of their duties, although a number found specific tasks onerous. Many felt unqualified for the level of financial administration, and of estimating, planning and budgeting which was expected of them. Some wanted these handled by someone else; others wanted additional training to equip them in these areas. Discipline and conflict resolution, too, were aspects of personnel management for which many expressed the need for additional training.

Since graduation a large proportion in all three countries have been given new responsibilities, and have successfully initiated changes, but relatively few report
receiving promotions or salary increases. This is particularly true in Lesotho. Moreover, few expect promotion in the future, although approximately 40% do expect opportunities for further training. A number would like to see better selection and preparation of participants in the Health Care Administrators' course, and more effective follow-up of the graduates by IDM faculty, to facilitate their acceptance as respected members of the health administration team. Some want to see the course upgraded to Diploma level.

Morale among this cadre is very low; they report considerable dissatisfaction with their own administrative role, and with the administrative roles of others, particularly in Lesotho. Poor working relationships, poor delegation and/or division of responsibility, and little opportunity for advancement are the reasons most often given for this dissatisfaction. In addition a small number feel unqualified for or incompetent in their present job. To improve administration they suggested training in administration for all members of the health administration team, an improved organizational structure, and better communication and human relations.

D. Community Nursing Administrator

Only seven of this cadre were among the survey respondents, reflecting the concentration of IDM training in the early years on hospital management. The greater emphasis on community health proposed for the coming years should lead to a larger fraction of IDM graduates in community/District/Regional posts.

The pattern of activities of the nursing administrator differs from that of the Hospital Matron in several respects, the most notable of which is the small fraction
of time spent in direct contact with patient care in the clinics and health centers. On an annual basis, they report spending approximately as much time in communication as do the Hospital Matrons, but communication represented by far the largest single activity observed in the work sampling exercise; as would be expected, much of this communication took place many from the nurse's office, out in the community. Compared to the Hospital Matron, relatively little time is spent on paper work or in the management of financial and physical resources. Much of their work, both in the supervision of patient care and in administration, is delegated to others, in the clinic and health centers.

Like the Hospital Matrons, they tend to enjoy personnel management and communication; they do not like to deal with disciplinary problems or conflict. They do not like nor feel qualified to handle finances, and are more successful at getting someone else to relieve them of much of this function. They too feel that administration would be improved by additional training for all members of the health administration team. However, they also stress the need for a greater allocation of resources to rural health, and for greater decentralization in decision-making.

Since graduation they have had considerable success in implementing change and in undertaking new responsibilities. Relatively few have received promotion or salary increases, but nearly all expect promotion in the future. On the whole they are well satisfied with their own administrative role, and very satisfied with that of others with whom they work.
E. Community Health Administrator

With only two respondents this cadre is too small for detailed analysis, although both task analysis and work sampling show clearly the importance of paper work and communication in this position. Compared to the Hospital Health Care Administrator they spend relatively less time in the management of finance and considerably more in the management of physical resources. They report the highest level of satisfaction with their own roles of any of the cadre, and are very pleased with the administrative roles of those with whom they work.
Figure 1. **PERCENT DISTRIBUTION OF ACTIVITIES, BY POSITION:**

**HOSPITAL SUPERINTENDENTS, NURSING ADMINISTRATORS,**

**HEALTH CARE ADMINISTRATORS.** BOTAWEA, LESOTHO,

**SWAZILAND**

Nr. observations: 10,410

Activities:

1. Paper work
2. Communication: telephone, meetings
3. Service: patient care, rounds (Hospital Superintendent,
   Nursing Administrator) issuing stores, vehicles, etc.
   (Health Care Administrator)
4. Other, including travel.
Figure 2. PERCENT DISTRIBUTION OF ACTIVITIES, BY POSITION AND PRACTICE SETTING (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND

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<th>Nursing Administrators</th>
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<td>Hospital (23)</td>
<td>Hospital (19)</td>
</tr>
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<td>Community (5)</td>
<td>Community (2)</td>
</tr>
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</table>

Nr. observations: 7,950

Activities:
1. Paper work
2. Communication
3. Service
4. Other
Figure 3. PERCENT DISTRIBUTION OF LOCATION OF ACTIVITIES, BY POSITION: HOSPITAL SUPERINTENDENT, NURSING ADMINISTRATOR, HEALTH CARE ADMINISTRATOR. BOTSWANA, LESOTHO, SWAZILAND

Hospital Superintendents (14)  Nursing Administrators (28)  Health Care Administrators (21).

Locations:
1. Office, desk
2. Service point: wards, clinic (Hospital Superintendent, Nursing Administrator); storeroom, depot, etc. (Health Care Administrator)
3. Other location in the facility
4. Elsewhere

Nr. observations: 10,410
Figure 4. PERCENT DISTRIBUTION OF LOCATION OF ACTIVITIES, BY POSITION AND PRACTICE SETTING (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND

Nursing Administrators (28) Health Care Administrators (21)
Hospital (23) Community (5) Hospital (19) Community (2)

Nr. observations: 7950
Locations:
1. Office
2. Service point
3. Other-in facility
4. Elsewhere.
Figure 5. JOB PROFILES: DISTRIBUTION OF ADMINISTRATIVE LOAD BY POSITION: HOSPITAL SUPERINTENDENT, PRINCIPAL NURSING OFFICER, HEALTH CARE ADMINISTRATOR. (LOG-FREQUENCY WEIGHTED INDEX)

Areas of Responsibility:
1. Patient care
2. Personnel
3. Physical resources
4. Finances
5. Communication
6. Planning

Log-frequency weighted index

Hospital Superintendent (14)

Hospital Matron, etc./Community Nursing Administrator (28)

Health Care Administrator (21): Hospital, Community
Figure 6. JOB PROFILES: DISTRIBUTION OF ADMINISTRATIVE LOAD BY PRACTICE SETTING: HOSPITAL, COMMUNITY (LOG-FREQUENCY INDEX)

Areas of Responsibility:
1. Patient care
2. Personnel
3. Physical resources
4. Finances
5. Communication
6. Planning
Figure 7. **JOB PROFILES: DESCRIPTION OF ADMINISTRATIVE LOAD BY PRACTICE SETTING AND POSITION: NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS ONLY. (LOG-FREQUENCY WEIGHTED INDEX)**

Log-frequency weighted index

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<th>COMMUNITY (7)</th>
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<td>3</td>
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<tr>
<td>Nursing Administrator</td>
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<td>4</td>
</tr>
<tr>
<td>Health Care Administrator</td>
<td>6</td>
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1. patient care
2. personal management
3. manage. phy. rec.
4. fin. manage
5. commun.
6. planning
Table 3. PROPORTION OF TASKS DELEGATED TO ANOTHER, BY BROAD AREA OF ADMINISTRATIVE RESPONSIBILITY

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<th>Medical Supt.</th>
<th>Matron Nurs. Ad.</th>
<th>Health Care Ad.</th>
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<tr>
<td>Personnel</td>
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<td>Physical resources</td>
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<td>0.26</td>
<td>0.24</td>
<td>0.28</td>
<td>0.25</td>
<td>0.25</td>
<td>0.26</td>
<td>0.43</td>
<td>0.20</td>
</tr>
<tr>
<td>Planning</td>
<td>0.30</td>
<td>0.44</td>
<td>0.32</td>
<td>0.13</td>
<td>0.22</td>
<td>0.15</td>
<td>0.64</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>0.36</strong></td>
<td><strong>0.43</strong></td>
<td><strong>0.41</strong></td>
<td><strong>0.26</strong></td>
<td><strong>0.36</strong></td>
<td><strong>0.26</strong></td>
<td><strong>0.58</strong></td>
<td><strong>0.27</strong></td>
</tr>
</tbody>
</table>

**RELATIVE PROPORTION**

| Patient Care          | 1.36  | 0.81          | 1.72             | 0.0             | 1.56                 | 0.0  | 2.78                | 0.0 |
| Administration:       |       |               |                  |                 |                      |     |                     |     |
| Personnel             | 0.81  | 0.78          | 1.22             | 0.33            | 1.11                 | 0.31 | 1.69                | 1.39|
| Physical resources    | 1.28  | 1.86          | 1.58             | 0.89            | 1.39                 | 0.97 | 2.06                | 0.22|
| Finances              | 1.00  | 2.17          | 1.03             | 0.72            | 0.97                 | 0.75 | 1.19                | 0.0 |
| Communication         | 0.72  | 0.67          | 0.78             | 0.69            | 0.69                 | 0.72 | 1.19                | 0.56|
| Planning              | 0.83  | 1.22          | 0.89             | 0.36            | 0.61                 | 0.42 | 1.78                | 0.0 |
| **Total**             | **1.00** | **1.99**       | **1.14**         | **0.72**        | **1.00**             | **0.72**| **1.61**           | **0.75**|

Number of Respondents  
63  14  28  21  23  19  5  2

1 This expresses the ratio of the proportion of a given task delegated to the proportion of all administrative tasks delegated, e.g. total proportion of patient care delegated is 0.49, and total proportion of all administrative tasks delegated is 0.36. The ratio is 0.36, which means that patient care is delegated 1.36 times as often as all administrative tasks.
Table 4. SUGGESTIONS FOR IMPROVING ADMINISTRATION

<table>
<thead>
<tr>
<th>SUGGESTIONS:</th>
<th>Nr.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional training in administration for colleagues:</td>
<td>31</td>
</tr>
<tr>
<td>Refresher courses for senior officers (19)</td>
<td></td>
</tr>
<tr>
<td>Workshops, in-service training for senior officers (7)</td>
<td></td>
</tr>
<tr>
<td>Adequate orientation to staff roles (4)</td>
<td></td>
</tr>
<tr>
<td>Evaluation and feedback by supervisors (1)</td>
<td></td>
</tr>
<tr>
<td>Improved working relationships:</td>
<td>28</td>
</tr>
<tr>
<td>Better cooperation, coordination, communication, teamwork (13)</td>
<td></td>
</tr>
<tr>
<td>Clear job descriptions, adherence to job descriptions, improved delegation of tasks, allocation of duties (8)</td>
<td></td>
</tr>
<tr>
<td>Involvement of all senior staff in administration (1)</td>
<td></td>
</tr>
<tr>
<td>Time for meetings, discussion, problem-solving (3)</td>
<td></td>
</tr>
<tr>
<td>Change in attitudes, professional respect, recognition (3)</td>
<td></td>
</tr>
<tr>
<td>Organizational structure:</td>
<td>5</td>
</tr>
<tr>
<td>Clear organizational structure (1)</td>
<td></td>
</tr>
<tr>
<td>Decentralization (5)</td>
<td></td>
</tr>
<tr>
<td>Staffing:</td>
<td>14</td>
</tr>
<tr>
<td>More staff, reduced work load (7)</td>
<td></td>
</tr>
<tr>
<td>More qualified administrative personnel (3)</td>
<td></td>
</tr>
<tr>
<td>Specific staff needs: Personnel Officer, Health Care Administrator, Housekeeper, etc. (4)</td>
<td></td>
</tr>
<tr>
<td>Facilities, material resources:</td>
<td>4</td>
</tr>
<tr>
<td>Better transport (4)</td>
<td></td>
</tr>
<tr>
<td>Improved facilities for patient care (1)</td>
<td></td>
</tr>
<tr>
<td>Increased resources (2)</td>
<td></td>
</tr>
<tr>
<td>Don't know:</td>
<td>1</td>
</tr>
<tr>
<td>All Suggestions</td>
<td>83</td>
</tr>
</tbody>
</table>
### Table 5. Job Satisfaction Scores by Practice, Setting, Positions and Country

<table>
<thead>
<tr>
<th>Practice, Setting Position</th>
<th>Personal Satisfaction</th>
<th>Satisfaction with Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Botswana</td>
</tr>
<tr>
<td>Hospital:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superintendent</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td>Matron, Asst. Matron, etc.</td>
<td>2.0</td>
<td>2.4</td>
</tr>
<tr>
<td>Health Care Administrator</td>
<td>1.6</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1.9</td>
<td>2.2</td>
</tr>
<tr>
<td>Community:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Administrator</td>
<td>2.2</td>
<td>-</td>
</tr>
<tr>
<td>Health Care Administrator</td>
<td>3.0</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>2.4</td>
<td>2.5</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>2.0</td>
<td>2.3</td>
</tr>
</tbody>
</table>

1 Weighted average of satisfaction category (administrative tasks only):

3 = Very satisfied
2 = Fairly satisfied
1 = Somewhat dissatisfied
0 = Very dissatisfied
Table 6. **REASONS GIVEN FOR SATISFACTION OR DISSATISFACTION WITH OWN ADMINISTRATIVE ROLE**

<table>
<thead>
<tr>
<th>SATISFACTION</th>
<th>DISSATISFACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reasons:</strong></td>
<td><strong>Reasons:</strong></td>
</tr>
<tr>
<td><strong>Nr.</strong></td>
<td><strong>Nr.</strong></td>
</tr>
<tr>
<td><strong>Working Relationships:</strong></td>
<td><strong>Working Relationships:</strong></td>
</tr>
<tr>
<td>Good cooperation, communication</td>
<td>Poor communication, cooperation</td>
</tr>
<tr>
<td>Good support from supervision</td>
<td>Poor supervision, no feedback</td>
</tr>
<tr>
<td><strong>Division of Responsibility, Job Description</strong></td>
<td><strong>Division of Responsibility, Job Description</strong></td>
</tr>
<tr>
<td>Independence, initiative, decision-making role</td>
<td>Role not understood by others; no or inadequate job description; recognition wanted; additional responsibilities, participation in decisions wanted.</td>
</tr>
<tr>
<td><strong>Personal Competence, qualifications:</strong></td>
<td><strong>Personal Competence, qualifications:</strong></td>
</tr>
<tr>
<td>Confident in applying skills</td>
<td>More training, additional qualification needed, not prepared for present job</td>
</tr>
<tr>
<td><strong>Opportunity for Advancement</strong></td>
<td><strong>Opportunity for Advancement</strong></td>
</tr>
<tr>
<td>No barriers to advancement</td>
<td>Promotion, salary increase wanted</td>
</tr>
<tr>
<td><strong>Other:</strong></td>
<td><strong>Other:</strong></td>
</tr>
<tr>
<td>None given</td>
<td>Heavy work load, staff shortages, inadequate resources, travel demands, time pressures, etc.</td>
</tr>
<tr>
<td><strong>All Reasons</strong></td>
<td><strong>All Reasons</strong></td>
</tr>
<tr>
<td>12</td>
<td>54</td>
</tr>
</tbody>
</table>

1 Relatively fewer respondents who were satisfied gave reasons.
Table 7. REASONS GIVEN FOR SATISFACTION OR DISSATISFACTION WITH ADMINISTRATIVE ROLES OF OTHERS

<table>
<thead>
<tr>
<th>SATISFACTION</th>
<th>DISSATISFACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons:</td>
<td>Nr.</td>
</tr>
<tr>
<td>Working Relationships:</td>
<td></td>
</tr>
<tr>
<td>Good human relations, good communication, cooperation.</td>
<td>8</td>
</tr>
<tr>
<td>Good supervision</td>
<td>1</td>
</tr>
<tr>
<td>Division of Responsibility, Job Description:</td>
<td>5</td>
</tr>
<tr>
<td>Good division of responsibility, good delegation, understanding of role by others</td>
<td></td>
</tr>
<tr>
<td>Competent colleagues, respect for ability of colleagues</td>
<td>4</td>
</tr>
<tr>
<td>Other:</td>
<td>0</td>
</tr>
<tr>
<td>None given</td>
<td></td>
</tr>
<tr>
<td>All Reasons</td>
<td>18</td>
</tr>
</tbody>
</table>

1 Relatively fewer respondents who were satisfied gave reasons.
Table 8. PERCEPTION OF CAREER PROSPECTS OF I.D.M. GRADUATES, BY POSITION, COUNTRY

<table>
<thead>
<tr>
<th>Position, Country</th>
<th>No. of respondents</th>
<th>Success Since IDM Graduation</th>
<th>Expectation of Advancement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>New responsibilities</td>
<td>Successful changes</td>
</tr>
<tr>
<td>Numbers Position:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron/Nurse Administrator</td>
<td>20</td>
<td>14</td>
<td>15</td>
</tr>
<tr>
<td>Health Care Administrator</td>
<td>17</td>
<td>14</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Country:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td>14</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Lesotho</td>
<td>14</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Swaziland</td>
<td>9</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>28</td>
<td>27</td>
</tr>
<tr>
<td>Percentages Position:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Matron/Nurse Administrator</td>
<td>20</td>
<td>70</td>
<td>75</td>
</tr>
<tr>
<td>Health Care Administrator</td>
<td>17</td>
<td>82</td>
<td>71</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>78</td>
<td>75</td>
</tr>
<tr>
<td>Country:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Botswana</td>
<td>14</td>
<td>57</td>
<td>71</td>
</tr>
<tr>
<td>Lesotho</td>
<td>14</td>
<td>93</td>
<td>79</td>
</tr>
<tr>
<td>Swaziland</td>
<td>9</td>
<td>78</td>
<td>78</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>76</td>
<td>73</td>
</tr>
</tbody>
</table>
IV. POTENTIAL DEMAND FOR TRAINED PERSONNEL IN THE BLS COUNTRIES

The study has clearly shown that there is a definite need for training of administrative personnel in health. This need was also identified in the former studies done in health in the BLS countries, e.g. Cote (1978). The BLS countries are all working towards achieving the WHO objective of 'health for all by the year 2000'. The countries hope to achieve the said objective by expanding their health services, especially in rural areas where most of their populations live.

The countries also hope to give quality care to their populations and this can only be achieved if all the health experts concentrate on areas of their greatest competence and training. Because the work load is enormous in the BLS countries, the need for supportive staff cannot be over emphasized. For example, Swift (1974), showed the population per physician and per nurse as follows for the BLS countries:

<table>
<thead>
<tr>
<th>COUNTRY</th>
<th>POPULATION PER PHYSICIAN</th>
<th>POPULATION PER NURSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Botswana</td>
<td>12,500</td>
<td>1,624</td>
</tr>
<tr>
<td>Lesotho</td>
<td>22,000</td>
<td>3,341</td>
</tr>
<tr>
<td>Swaziland</td>
<td>9,000</td>
<td>1,161</td>
</tr>
</tbody>
</table>

The foregoing clearly shows that the doctors and nurses in these countries cannot efficiently manage health care facilities without the help of other administrative personnel in health. Moreover, the countries themselves
have recognised the need for such assistance, hence their utilization of IDM’s training courses in health care and nursing administration, established in 1979-80. The need for continued training of personnel in health administration remains crucial.
V. **RECOMMENDATIONS**

Recommendations arising from this study of health services administration are presented below, organized around four themes:

A) The allocation of administrative responsibilities within the health team;

B) Organizational structure and career paths in health administration;

C) Training needs in administration for the health sector;

D) Specific modifications and/or additions to IDM training courses in administration for health care.

A. **Allocation of Administrative Responsibilities**

In these recommendations, no attempt is made to specify the allocation of individual tasks nor to propose detailed job descriptions for the several members of the administrative team. The focus is, rather, on the allocation of responsibility among broad areas of administration and on the over-all pattern of administrative duties of each of the three principal cadres of the health team: the Medical Superintendent, the Hospital Matron/Community Nursing Administrator, and those called, for want of a more appropriate title, Health Care Administrators, in both hospital and community.

1. **Medical Superintendent**

1.1 The survey shows that Medical Superintendents tend to be concerned and conscientious in giving high
priority to patient care. It is recommended that they be supported in this concern and be encouraged to delegate to the Health Care Administrator, under adequate supervision, as much of the following as is feasible in a given situation:

1) the management of physical resources: transport, buildings and grounds, supplies and equipment, etc.

2) financial management: accounting, payrolls, annual estimates, etc.;

3) the preparation of statistical and other reports, record systems, etc.

1.2 Because the survey shows that many of the Medical Superintendents feel inadequate in their administrative role, it is recommended that the relevant Ministries arrange for programs of in-service training, workshops, etc., for physician/administrators, to improve skills and increase self-confidence in this role.

2. Matron/Nursing Administrator

2.1 From the survey it appears that many of the Matrons/Nursing Administrators are giving a higher priority to administration than to the supervision of patient care. This cadre should ordinarily be encouraged to give more attention to the supervision of nursing care in hospital and community, and to delegate, under adequate supervision, a greater proportion of the administrative load to the Health Care Administrators. Responsibilities which could be delegated include:
1) the management of physical resources: housekeeping, office management, maintaining inventories, maintenance and repair of vehicles and equipment, etc.;

2) the preparation of statistical and other reports, record systems, etc.;

3) the supervision of clerical and industrial staff, and the routine maintenance of all employee records.

2.2 In those instances, however, where administrative nursing staff show particular interest in and aptitude for administration, a limited number could be encouraged to take further training in health administration, at the Diploma or even the Masters level. (See recommendations concerning organizational structure and career paths in health administration).

2.3 Much of the time of the Matrons/Nursing Administrators is spent in communication, but the relatively high priority they give to conflict resolution and the low morale of many Health Care Administrators suggests that this communication is not as effective as it could be. It is recommended that Matrons/Nursing Administrators be encouraged to take advantage of the existing 2-week IDM course in communication, with emphasis upon human relations. It is also recommended that the relevant Ministries organize in-service training and/or workshops in conflict resolution for members of the health administration team.

3. Health Care Administrators

The survey has found that, despite wide-spread concern
about the role of Health Care Administrators, the
great majority of this cadre, since graduation from
IDM, have been given new responsibilities and have
successfully implemented new initiatives. Nearly
one half have received a salary increase or promo-
tion, except in Lesotho where only one has been
promoted. Nevertheless, few anticipate promotion
in the future. The level of dissatisfaction is
very high among this cadre, stemming from their
perception of inadequate professional recognition
despite their new responsibilities, and of limited
opportunities for advancement, together with poor
working relationships among the members of the
health team. Although they are currently making a
contribution to the improvement of health services
in the BLS countries, their full potential cannot
be realized unless their morale problem can be
solved. The solution will not be easy for the
problem has a history which may be difficult to
overcome. However, to move toward a solution, it
is recommended that:

3.1 The nature and scope of their duties and their
reporting relationships be clarified, if not for
the entire cadre, then in accordance with the reali-
ties of a specific position, in order to minimize
conflict among the members of the health team.

3.2 An identification be made of a clear career path
for this cadre, which is parallel to the normal
career path for administrative cadre in other sec-
tors (see Recommendation 4.1, 4.2 and 5.1 concerning
organizational structure and career paths in admin-
istration); the existence of such a path should
provide an incentive for improved performance.

3.3 As recommended in previous sections, the Medical
Superintendent and Matron/Nursing Administrator should be encouraged to delegate responsibility to this cadre for the management of physical resources, financial management, the preparation of statistical and other reports, the supervision of clerical and industrial staff, and routine personnel matters. Provision should be made for adequate supervision of the Health Care Administrator, and for in-service training where necessary. Workshops and refresher courses, both in technical administration and in human relations, are also recommended for this cadre.

B. Organizational Structure and Career Paths in Health Administration

A definite administrative career structure exists within the civil service of each of the three governments, and prior to their designation as Health Care Administrators, this cadre took its place within that structure. Additional training in the administration of health services, while better preparing them to function in that sector, need not take them outside the existing civil service career structure. Consequently it is recommended that:

4.1 An appropriate career path for administrators in the health sector be identified which parallels that of those working in other sectors. Although this could theoretically result in the movement of administrators trained in health care to posts outside the sector, were adequate attention given to factors presently affecting the morale of this cadre, there would be no particular incentive for them to make such a move, while the improved performance which could be expected from the existence of opportunities for advancement could outweigh a small number lost to health.

4.2 Titles be given to this cadre which more appropriately
reflect their position within the existing administrative career structure of the civil service. (See Recommendation 5.1 for an outline of the several administrative levels within the health sector and their corresponding levels within the civil service).

4.3 The survey shows that the majority of Health Care Administrators are younger, less experienced, and have had less education than the other members of the health administration team, and will in general, therefore, need to be supervised by a more senior person. In the Ministries and in those services and facilities where there is a senior administrative officer, that individual would normally supervise the work of a junior certificate-level Health Care Administrator. However, where no senior officer is present, a condition characterizing by far the majority of the posts filled by HCA's, it is recommended that the HCA be supervised by the Medical Superintendent through the Matron/Nursing Administrator.

4.4 Opportunities for further training in Health Services/Hospital Administration, at the graduate, diploma or Masters level, be made available to a limited number of suitably qualified and experienced Health Care Administrators and Nursing Administrators, to fill senior administrative posts in the larger hospitals, special services, and the Ministries as occasion arises.
C. Training Needs in Administration for the Health Sector

5.1 In the light of the structure of health services in the BLS countries and the nature of the administrative load in hospital and community, following is a table showing some of the personnel for whom training in administration is recommended to improve their ability to carry out their duties. The specific level of training would depend upon their background, experience and responsibilities:

<table>
<thead>
<tr>
<th>Level, Scope of service</th>
<th>Position</th>
<th>Suggested Qualifications and level of training</th>
<th>Civil Service Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ministerial</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Senior Administrator in Health</td>
<td>Bachelor in Public Administration/ Bachelor in Health Administration</td>
<td>Principal Administrative Officer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Master in Health Administration/ Master of Public Health</td>
<td>Senior Administrative Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diploma in Health Administration</td>
<td>Administrative Officer</td>
</tr>
<tr>
<td>2. Administrators for special services/ categorical programmes</td>
<td></td>
<td></td>
<td>Assistant Administrative Officer</td>
</tr>
<tr>
<td>3. Assistant Administrator</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital: Referral</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Medical Superintendent</td>
<td>Physician, seminars/workshops on administration</td>
<td>Principal Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>2. Matron/Nursing Administrator</td>
<td>Graduate Nurse plus appropriate experience, plus Certificate, Diploma or Degree in Administration</td>
<td>Senior Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>3. Hospital Administrator/Secretary</td>
<td>Bachelor in Public Administration/ Bachelor in Health Administration</td>
<td>Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>4. Assistant Administrators, reporting to the Hospital Administrator</td>
<td>Certificate or Diploma in Health Care Administration</td>
<td>Administrative Officer</td>
<td></td>
</tr>
<tr>
<td><strong>Hospital: Rural and Speciality</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Medical Superintendent</td>
<td>Physician, seminars/workshops in administration</td>
<td>Principal Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>2. Matron/Senior Sister</td>
<td>Graduate Nurse plus appropriate experience, plus Certificate, Diploma or Degree in Administration</td>
<td>Senior Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>3. Assistant Administrator, reporting to the Hospital Superintendent</td>
<td>Bachelor in Administration/ Diploma in Health Administration</td>
<td>Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>OR Assistant for Administration, reporting through Matron</td>
<td>Certificate in Health Care Administration</td>
<td>Senior Administrative Officer</td>
<td></td>
</tr>
<tr>
<td><strong>District/Regional</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Regional Medical Officer</td>
<td>Physician, seminars/workshops on administration</td>
<td>Principal Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>2. Nursing Administrator/Public Health Nurse</td>
<td>Graduate Nurse plus Public Health Nursing plus experience, plus Certificate, Diploma or Degree in Administration</td>
<td>Senior Administrative Officer</td>
<td></td>
</tr>
<tr>
<td>Level, Scope of service</td>
<td>Position</td>
<td>Suggested Qualification and level of training</td>
<td>Civil Service level</td>
</tr>
<tr>
<td>-------------------------</td>
<td>----------</td>
<td>---------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>District/Regional (Continued ..... )</td>
<td>3. Assistant Administrator</td>
<td>Diploma in Administration</td>
<td>Administrative Officer</td>
</tr>
<tr>
<td></td>
<td>4. Assistant for Administration, reporting to Nursing Administrator</td>
<td>Certificate in Health Care Administration</td>
<td>Assistant Administrative Officer</td>
</tr>
<tr>
<td></td>
<td>5. Health Inspector</td>
<td>Certificate in Health Care Administration</td>
<td>Senior Administrative Assistant</td>
</tr>
<tr>
<td>Health Centers/ Large Clinics/ Specialty Clinics</td>
<td>1. Senior Sister</td>
<td>Graduate Nurse-Midwife, plus Certificate or Diploma in Administration</td>
<td>Senior Administrative Officer</td>
</tr>
<tr>
<td></td>
<td>2. Assistant for Administration, reporting to the Senior Sister</td>
<td>Certificate in Health Care and Administration</td>
<td>Senior Administrative Officer</td>
</tr>
<tr>
<td>Smaller Clinics</td>
<td>1. Senior Sister, Staff Nurse, Enrolled Nurse</td>
<td>Certificate in Nursing Administration</td>
<td>Senior Administrative Assistant</td>
</tr>
</tbody>
</table>
5.2 In the light of the need and potential demand for trained administrative personnel in health in the BLS countries, it is recommended that as a minimum the three countries plan to train the following numbers of Nursing and Health Care Administrators at the Certificate level at IDM over the next five years.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
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<td></td>
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<td>6</td>
<td>6</td>
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<td>4</td>
<td>4</td>
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<td>10</td>
<td>10</td>
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<td>50</td>
</tr>
<tr>
<td>Lesotho</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>5</td>
<td>5</td>
<td>5</td>
<td>25</td>
</tr>
<tr>
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<td>12</td>
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<td>2</td>
<td>2</td>
<td>2</td>
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<tr>
<td>Total</td>
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<td>7</td>
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<td>7</td>
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<td>45</td>
</tr>
<tr>
<td>Swaziland</td>
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</tr>
<tr>
<td>Nursing Administrator</td>
<td>6</td>
<td>6</td>
<td>6</td>
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<td>30</td>
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<tr>
<td>Admin. Asst. for Health Care</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<td>15</td>
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<tr>
<td>Total</td>
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<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>45</td>
</tr>
<tr>
<td>Nursing Administrator</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>17</td>
<td>85</td>
</tr>
<tr>
<td>Admin. Asst. for Health Care</td>
<td>19</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>9</td>
<td>54</td>
</tr>
<tr>
<td>Total</td>
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<td>26</td>
<td>26</td>
<td>26</td>
<td>26</td>
<td>140</td>
</tr>
</tbody>
</table>

1 These numbers represent estimated demand for the types of nursing and Health Care Administrators that are currently being trained, and do not include the additional categories of health personnel suggested for training. If it were available, some of these potential candidates would qualify for a diploma level course.
D. Modification to the IDM Administrative Training Programme

The research showed that there were wide disparities in the background and experience of participants and in their performance on the job after graduation. Respondents suggested that candidates with no experience in the health sector should be given more preparation. There was a strong demand for a diploma course and for further training in specialized areas. Many expressed a need for more emphasis on certain aspects of the training programme.

Curriculum modification and expansion

6.1 In order to provide an administration training course that is appropriate for persons with higher qualifications and to qualify health and nursing administrators for positions of greater administrative responsibility, it is recommended that diploma courses in Nursing and Health Services Administration be established. Both certificate and diploma courses should have a common core, plus appropriate numbers and levels of additional short courses or modules. Those completing the certificate would be able to qualify for the diploma on completion of the required additional modules. However, candidates with appropriate backgrounds could enter the diploma course directly.

6.2 In order to accommodate the diverse backgrounds and responsibilities of the health administration cadre, it is recommended that, in addition to the core, participants be offered a choice among the modules they take in order to qualify for a certificate or diploma. The choice would include modules that are outside the health administration programme, such as
financial management. The participants should receive a paper qualification for the successful completion of a module so that a person requiring training in only one specialized area would be encouraged to attend even if she/he were not aspiring to a certificate or diploma.

6.3 It is recommended that some new short courses, or modules, be established, such as hospital records, pharmaceutical management, health team operations and inter-relationships, etc. It is suggested that not every module be offered every year. Special attention should be given to identifying either new or on-going courses that are needed to upgrade the skills of HCA graduates.

6.4 Certain areas need to receive greater emphasis in the health administration training programme. In some areas, it will require a new course or additions to an existing course, in others, a different orientation. It is recommended that the following areas be strengthened: community health organization and management, finance and budgeting, human relations, planning and evaluation, including health statistics and epidemiology. In recruiting staff the IDM should make a special effort to seek personnel with a strong background in the organization and delivery of community health services.

Selection of Candidates

6.5 It is recommended that participants coming into the certificate course who have minimal or no background in health should be given a pre-induction course. This would enable them to benefit more from the programme and would reduce the need for providing this compensation in classes that are also attended by
persons already familiar with health services.

6.6 It is recommended that persons with administrative responsibilities at the levels of enrolled nurses, health assistants and pharmaceutical technicians also be considered for admission to training for the certificate course. For either the certificate or diploma course, admission of special services administrators (EPI, family planning, handicapped services, laboratory management, etc.) and Health Inspectors should be considered.

6.7 In order to ensure that the IDM programme supports the potential for a career ladder for the health administration cadre, it is recommended that the qualification for entry into the diploma course be either CHA/CNA plus experience and recommendation, or the equivalent background in health and administration, or the appropriate academic qualifications.

REFERENCES


# APPENDIX I

**FIELD WORK UNDERTAKEN IN THE BLS COUNTRIES BETWEEN 14TH SEPTEMBER, 1982 and 15TH DECEMBER, 1982**

## BOTSWANA

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>14.9.1982</td>
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<td>3</td>
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<tr>
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</tr>
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<td>20.9.1982</td>
<td>Kanye</td>
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</tr>
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<td>21.9.1982</td>
<td>Kanye</td>
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</tr>
<tr>
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</tr>
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**Total:** 31

## SWAZILAND

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</tr>
<tr>
<td>14.10.1982</td>
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<td>18.10.1982</td>
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<td>19.10.1982</td>
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**Total:** 14
**Field Work Undertaken in the BLS Countries between 14th September, 1982 and 15th December, 1982**

**LESOTHO**

<table>
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<td>Maseru</td>
<td>2</td>
</tr>
<tr>
<td>29.10.1982</td>
<td>Maseru</td>
<td>2</td>
</tr>
<tr>
<td>1.11.1982</td>
<td>Quthing</td>
<td>2</td>
</tr>
<tr>
<td>2.11.1982</td>
<td>Mohale's Hoek</td>
<td>2</td>
</tr>
<tr>
<td>4.11.1982</td>
<td>Maseru</td>
<td>2</td>
</tr>
<tr>
<td>5.11.1982</td>
<td>Morija</td>
<td>2</td>
</tr>
<tr>
<td>8.11.1982</td>
<td>Leribe</td>
<td>2</td>
</tr>
<tr>
<td>9.11.1982</td>
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<td>2</td>
</tr>
<tr>
<td>10.11.1982</td>
<td>Mapoteng</td>
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</tr>
<tr>
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<tr>
<td>12.11.1982</td>
<td>Roma</td>
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<tr>
<td>15.11.1982</td>
<td>Morija</td>
<td>2</td>
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</table>

**Total:** 26
APPENDIX III.

Table 1. **ADMINISTRATIVE\(^1\) LOAD (LOG-FREQUENCY WEIGHTED INDEX)\(^2\) BY PRACTICE SETTING AND POSITION**

<table>
<thead>
<tr>
<th>Practice Setting, Position</th>
<th>Number of Respondents</th>
<th>Number of Administrative tasks checked</th>
<th>Proportion of Maximum number of tasks ((\times 100))</th>
<th>Log-frequency weighted index ((\div 1.24)^3)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital:</strong></td>
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<td></td>
<td></td>
<td></td>
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<td>14</td>
<td>450</td>
<td>40</td>
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<td>Matron, Asst. Matron, etc.</td>
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<td>732</td>
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<td>0.87</td>
</tr>
<tr>
<td>Health Care Administrator</td>
<td>19</td>
<td>816</td>
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<td>1.27</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>1998</td>
<td>45</td>
<td>0.99</td>
</tr>
<tr>
<td><strong>Community:</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Administrator</td>
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<td>221</td>
<td>55</td>
<td>0.94</td>
</tr>
<tr>
<td>Health Care Administrator</td>
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<td>52</td>
<td>1.43</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>304</td>
<td>54</td>
<td>1.07</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>63</td>
<td>2302</td>
<td>46</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Medical Superintendent</strong></td>
<td>14</td>
<td>450</td>
<td>40</td>
<td>0.81</td>
</tr>
<tr>
<td>Matron, Nursing Admin.</td>
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<td>953</td>
<td>40</td>
<td>0.89</td>
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<td>Health Care Administrator</td>
<td>21</td>
<td>899</td>
<td>54</td>
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<td>Total</td>
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<td>46</td>
<td>1.00</td>
</tr>
<tr>
<td><strong>Hospital Administrator</strong></td>
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<td>1998</td>
<td>45</td>
<td>0.99</td>
</tr>
<tr>
<td>Community Health Admin.</td>
<td>7</td>
<td>304</td>
<td>54</td>
<td>1.07</td>
</tr>
<tr>
<td>Total</td>
<td>63</td>
<td>2302</td>
<td>46</td>
<td>1.00</td>
</tr>
</tbody>
</table>

1 Administrative tasks only; does not include patient care.

2 The log-frequency weighted index is the sum of the number of tasks performed, weighted by the natural logarithm of the annual frequency with which each is undertaken. This procedure reduces the weight given to each performance of a daily task, such as bookkeeping, thus giving relatively greater weight to tasks such as budgeting which are carried out only a few times per year.

3 Dividing by 1.24, the log-frequency weighted index for all administrative tasks for all respondents, transforms this to a relative measure, for greater ease of interpretation.
<table>
<thead>
<tr>
<th>Broad Area of Administrative Responsibility</th>
<th>Total</th>
<th>Medical Superintendent</th>
<th>Matron/Nursing Administrator</th>
<th>Health Care Administrator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
<td>2.57</td>
<td>4.76</td>
<td>3.41</td>
<td>0</td>
</tr>
<tr>
<td>Administration:</td>
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</tr>
<tr>
<td>Personnel</td>
<td>1.66</td>
<td>1.56</td>
<td>1.85</td>
<td>1.23</td>
</tr>
<tr>
<td>Physical resources</td>
<td>0.92</td>
<td>0.58</td>
<td>0.69</td>
<td>1.44</td>
</tr>
<tr>
<td>Finance</td>
<td>0.61</td>
<td>0.29</td>
<td>0.20</td>
<td>1.54</td>
</tr>
<tr>
<td>Communication</td>
<td>2.06</td>
<td>2.01</td>
<td>2.08</td>
<td>2.08</td>
</tr>
<tr>
<td>Planning</td>
<td>0.65</td>
<td>0.63</td>
<td>0.61</td>
<td>0.73</td>
</tr>
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<td>All Administration</td>
<td>1.00</td>
<td>0.81</td>
<td>0.89</td>
<td>1.28</td>
</tr>
</tbody>
</table>
Comparison of three indices of relative administrative load:
1. Proportion of maximum number of tasks for particular area of responsibility, expressed as a ratio of the proportion of all administrative tasks;
2. Relative number per respondent weighted by frequency with which the task must be performed;
3. Relative number per respondent weighted by the natural logarithm of the frequency. All respondents.

Area of responsibility:
1. Patient care
2. Personnel management
3. Physical resources: drugs, transport, buildings, etc.
4. Finance
5. Communication: reports, letters, meetings
6. Planning
### Table 3. JOB PROFILES: ADMINISTRATIVE LOAD (LOG-FREQUENCY WEIGHTED INDEX) FOR BROAD AREAS OF RESPONSIBILITY, BY PRACTICE SETTING

<table>
<thead>
<tr>
<th>Broad Area of Administrative Responsibility</th>
<th>Total</th>
<th>Hospital Administrators (MD, NA, HCA)</th>
<th>Community Health Administrators (NA, HCA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
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<td>2.68</td>
<td>1.75</td>
</tr>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Personnel</td>
<td>1.66</td>
<td>1.70</td>
<td>1.35</td>
</tr>
<tr>
<td>Physical resources</td>
<td>0.92</td>
<td>0.87</td>
<td>1.38</td>
</tr>
<tr>
<td>Finance</td>
<td>0.61</td>
<td>0.63</td>
<td>0.24</td>
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<tr>
<td>Communication</td>
<td>2.06</td>
<td>2.07</td>
<td>2.01</td>
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<tr>
<td>Planning</td>
<td>0.65</td>
<td>0.66</td>
<td>0.61</td>
</tr>
<tr>
<td>All Administration</td>
<td>1.00</td>
<td>0.99</td>
<td>1.07</td>
</tr>
</tbody>
</table>

### Table 4. JOB PROFILES: ADMINISTRATIVE LOAD (LOG-FREQUENCY WEIGHTED INDEX) FOR BROAD AREAS OF RESPONSIBILITY, BY PRACTICE SETTING AND POSITION

<table>
<thead>
<tr>
<th>Broad Area of Administrative Responsibility</th>
<th>Hospital Matrons, etc.</th>
<th>Hospital Health Care Administrators</th>
<th>Community Nursing Administrators</th>
<th>Community Health Care Administrators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Care</td>
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<td>0</td>
<td>2.45</td>
<td>0</td>
</tr>
<tr>
<td>Administration:</td>
<td></td>
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</tr>
<tr>
<td>Personnel</td>
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<td>1.55</td>
<td>1.59</td>
<td>0.73</td>
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<tr>
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<td>1.38</td>
<td>0.96</td>
<td>2.42</td>
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<tr>
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<td>0.43</td>
</tr>
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<td>2.06</td>
<td>1.92</td>
<td>2.26</td>
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<tr>
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<td>0.78</td>
<td>0.75</td>
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<td>All Administration</td>
<td>0.87</td>
<td>1.27</td>
<td>0.94</td>
<td>1.43</td>
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</table>
### Table 5. DISTRIBUTION OF OBSERVATIONS BY LOCATION, POSITION, PRACTICE SETTING AND COUNTRY

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<th>Total Observations</th>
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<th>Lesotho</th>
<th>Swaziland</th>
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<td></td>
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<td>Other-in facility</td>
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<td>90</td>
<td>42</td>
</tr>
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<td></td>
<td>198</td>
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<td>55</td>
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<tr>
<td>Other-in facility</td>
<td></td>
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<td>61</td>
<td>28</td>
</tr>
<tr>
<td>Elsewhere</td>
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<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
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Table 6. DISTRIBUTION OF OBSERVATIONS BY ACTIVITY, POSITION, PRACTICE SETTING AND COUNTRY

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Figure 1. PERCENT DISTRIBUTION OF ACTIVITIES, BY POSITION, PRACTICE SETTING, AND IDM TRAINING (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND

Nursing Administrators (28)
Hospital (23) Community (5)
IDM graduates (15) Not IDM graduates (8) graduates (5)

Health Care Administrators (21)
Hospital (19) Community (2)
IDM graduates (16) Not IDM graduates (3) graduates (1) graduates (1)

Activities:
1. Paper work
2. Communication
3. Service
4. Other

Nr. observations: 7950
APPENDIX IV.

Figure 2. PERCENT DISTRIBUTION OF LOCATION OF ACTIVITIES, BY POSITION, PRACTICE SETTING, AND IDM TRAINING (NURSING ADMINISTRATORS, HEALTH CARE ADMINISTRATORS). BOTSWANA, LESOTHO, SWAZILAND

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Locations:

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