

Ministry of Health Swaziland

**GUIDELINES FOR THE OPERATION OF  
DECENTRALISED HEALTH SERVICES IN  
SWAZILAND**

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## 1. INTRODUCTION

The original Guidelines were issued in January, 1986 upon completion of the design work for the new decentralized health system entitled "Guidelines for Future Operation of Health Services in Swaziland". It contained material not directly relevant to the decentralization process. This revised and updated version focuses solely on the decentralization process and the title more accurately reflects this.

There are a number of changes from the original version. The more significant ones include:

- A definition of decentralization as it relates to the Swazi Health System
- An update on the current status of decentralization
- Clarification of supervisory relationships, authority, responsibility and accountability which have been major areas of misunderstanding
- Revised organizational structure and organograms dealing with the centre, regions and vertical programmes
- Elimination of two of the former headquarters committees – the Principal Secretary's Management Committee, and the Headquarters – Region Joint Management Committee
- Revised and updated membership and terms of reference for the remaining headquarters committees – Policy and Planning Committee, Training and Personnel Management Committee, and Budget Preparation and Management Committee
- Revised and updated membership and terms of reference for the Decentralization Task Force (incorporating the functions of the former Headquarters-region Joint Management Committee)
- A presentation of the team concept with revised and updated terms of reference for the Regional Health Management Team
- For the first time – terms of reference for the three standing Sub-Committees of the RHMTs: Planning and Budgeting Sub-Committee, Personnel and Training Sub-Committee and Information Sub-Committee
- Special attention to the vertical programmes, their organization and function within a decentralized system
- A special section on Communication considered of relevance since this has been a major problem in the implementation of decentralization. Communication guidelines are spelled out.
- Revised and updated job descriptions for the Senior Health Administrator and Regional Health Administrator

This version of the Guidelines is somewhat shorter than the original version. Material has been eliminated which is felt to be irrelevant and redundant. The remaining material is better organized and should be easier to use as a reference.

## **2. WHAT IS DECENTRALIZATION: PRINCIPLES BENEFITS AND DEFINITION FOR SWAZILAND SUPERVISORY RELATIONSHIPS**

### **2.1 International Focus on Decentralization**

Focusing on management for health services delivery at the district (regional) level has been adopted by numerous countries in recent years. Doubtlessly, this has come about due to the emphasis on primary health care popularized by the International Conference on Primary Health Care at Alma-Ata, USSR in September of 1978. The conference itself placed emphasis on interrelationships between health and development, intersectoral collaboration, the community level and community level and community participation, and – decentralization. In discussing decentralization, the conference noted:

“Only recently has attention been focused on local levels. The importance of decentralization to intermediate levels, such as provincial or district levels now has to be stressed. These levels are near enough to communities to respond sensitively to their practical problems and needs; they are equally near to the central administrative level to translate government policies into practice. They are particularly useful for harmonizing the activities of the various sectors that jointly promote development. The intermediate administrative levels thus serve as important pivots for coordinated development....”

(Alma-Ata 1978 – Report of the International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978,” World Health Organization, Geneva, 1978, page 52).

Later, in the WHO “Health for All Series,” the managerial process for national health development was addressed (1981). It was recognized that the current trend was to strengthen decision-making powers at provincial, district, and community levels, and as parallel, “appropriate community organization is needed for communities to become full partners in the health development process.” (Managerial Process for National Health Organization, Geneva, 1981, page 16).

### **2.2 Principles**

It has been suggested that certain principles underly primary health care policies which can be most effective promulgated at the district level. These are:

- Equity: (implying a fairer distribution of health care for all population groups and according to their health needs)
- Accessibility: (to health services, including the location of clinics, outreach and community based health providers)
- Promotive and Preventive Policies: (as major contributors to reducing the incidence of common disease and promotion of better health)
- Intersectoral Action: (improved health should be designated a policy objective for other sectors for district and village improvement activities)
- Community Involvement: (by families and local communities who can best identify their needs, make demands for health improvements and give political, financial and other support)

(Adapted from “Guidelines for Strengthening Primary Health Care in Districts,” Draft. Author unidentified. Attributed to WHO, Geneva, June, 1986, page 5).

### **2.3 Benefits for Swaziland**

Specific benefits which decentralization is aiming to achieve in Swaziland, have been identified as follows:

Decentralization...

- Brings decision-making closer to the people being served, and so it is more responsible to local health needs and demands, through the use of local knowledge and resources.
- Is more effective at integrating vertical programmes into PHC activities
- Is easier to bring non-governmental organizations, voluntary agencies and the private sector together
- Favors intersectoral action to promote health at the local level
- Minimize the fragmentation of medical care available to the individual by organizing efficient patient referral mechanisms
- Copes more flexibly and quickly with unexpected events and changes in local circumstances
- Motivates local staff by giving them increased involvement in decision making

(Adapted from “District Health Planning and Management - Developments Required to Support Primary Health Care”, by Smith Duane and Vaughan, Patrick, London School of Hygiene and Tropical Medicine, London, 1984).

### **2.4 Definition for Swaziland**

One way to define decentralization in the Swaziland Health services is on a functional basis; that is, to define exactly which functions should take place at the two levels – central and regional. Decentralization introduces a new level of management in the regions, and the regional management functions must be clearly defined vis-à-vis the central function.

The regional Health Administrator and Regional Health Management Team is “responsible for planning, budgeting, monitoring and supervising all health facilities and services within the region, for both government and mission services”.

This entails a division in the total management of all health services in the county and a delegation of some functions from the central level to the regional level. In some cases these functions are shared, with responsibilities at both levels.

According to the present state of the art, these functions are assigned as follows:

#### **Functions at the Central (Headquarters) Level**

##### Policy Formulation

Establishment of national policies, goals, priorities and strategies for national health development, negotiation with international and national donors, and relations with other ministries.

##### Policy Guidance

Communication and monitoring of policies which have been formulated to the RHMTs, programme managers and others who are required to execute policy

### Resource Allocation

Formulating and negotiating (with the central agencies) the national health budget and health personnel establishment, and allocating budgets and personnel to the regions

### Technical Supervision and Support

Providing technical supervision, support, back-up and research for the delivery of health services and implementation of programmes at the regional level

### Monitoring Administrative Procedures

Ensuring the financial, personnel, and other administrative procedures are being followed according to governmental practice and Ministry of Health guidelines

## **Functions at the Regional Level**

### Planning

Conducting needs assessments, planning and evaluation of all health activities in the region

### Allocation of Resources

Budgeting and controlling the use of resources in the region including finance, personnel, transport, communication, facilities and equipment, housing and materials.

### Coordinating, Monitoring and Supervising

Coordinating (both within the health sector and intersectorally), monitoring and supervising all health activities in the region

In brief, the RHMTs have now become the pivotal level in running the health services of the country within the policy guidance and budget limits set by headquarters, and with the technical supervision and support Headquarters.

These functions are defined in more detail in the role descriptions for the central committees, Decentralization Task Force, and Regional Health Management Team; and in the job descriptions for the Senior Health Administrator and Regional Health Administrator contained in these [guidelines](#).

## **2.5 Supervisory Relationships – Authority, Responsibility and Accountability**

The problem of authority, responsibility and accountability, and the division between technical and administrative areas, persists in the decentralize system. “Just who is responsible for what?” and “Who reports to whom?” are questions often asked.

There are three basic issues: (1) supervision, (2) responsibility and accountability, (3) channels of communication.

Many organizations utilize a distinct ion between professional and technical responsibility and authority. It is not an unusual situation.

First it is important to recognize that any professional or technical activity is bound to have administrative aspects if only because it must be provided with supplies, be financed, etc., and the two areas are highly interdependent. When attempts are made to separate these two interlocking areas of activity conflicts arise.

In this situation the ideal solution is for the two sides to recognize the reality of the situation – the interdependence of their functions – and to work together cooperatively.

The executive or operational authority of the RHMT rests with its individual members who are warrant holders and/or heads of units or departments. It is these individuals who together perform the executive management

function of the RHMT, and their decisions are frequently interdependent and interactive. In this situation, the role of one superior boss is not possible. The solution is two-fold:

- (1.) The individuals must operate as a team, making their decisions cooperatively as an Executive Management Committee would. For efficient operation, this team must have a leader. Here, the RHA plays the critical role as team leader. His/her concern is to create the atmosphere for cooperative decision-making.
- (2.) Each technical (professional) head who is a member of the RHMT is responsible to the RHA on all administrative matters, while at the same time receiving technical supervision from his or her technical head, who is the Regional Senior Medical Officer under the new proposed organizational plan (see section 5). For example, the Regional Public Health Matron receives administrative supervision from the RHA and technical supervision from the Regional SMO. The same holds true for the Regional Health Inspector, Regional Health Educator, and hospital/health centre medical officers.

A perennial problem has been who is responsible for conducting the annual performance appraisal. Under this new organizational design the RHA and Regional SMO will serve jointly as the Reporting Officers for those officers who they jointly supervise, the one for administrative supervision, the other for technical supervision. These positions include the Regional Health Educator and Senior Medical Officers and Medical Officers in the hospitals and health centres. The Countersigning Officers would be the Senior Health Administrator and the Director of Health Services.

In the case of these joint reviews the RHA is to be in overall charge. He/she has the responsibility to see that the appraisal is completed by the RHA and the SMO. The RHA is to rate on all aspects of performance; the SMO is to rate those aspects which have a technical component. These are:

- Knowledge of the job
- Performance of duties
- Numerical ability
- Drive and Determination
- Overall assessment

The tasks of any post and the skills required can be divided into three areas: (1) conceptual, (2) administrative, and (3) technical. For posts in lower grades the tasks done and skills required are mainly technical. At increasingly higher grades there is more emphasis on conceptual (policy forming, coordination) and administrative skills. (For example, the technical work of individual RHMT members must be planned and budgeted and frequently requires coordination; and the plans and budgets must be monitored and evaluated. These are administrative functions for which the RHA is responsible).

At the lower grades it is sufficient for each staff member to be supervised by one officer. At the higher grades where there is split supervision between administrative and technical/professional aspects of the work, a single appraiser is unrealistic and therefore unjust to the officer. Just as the supervision is split, so must the appraisal be split into the two areas. The supervisors should complete their relevant items in the annual performance appraisal. Making the division between administrative and technical areas work properly requires the understanding and cooperation of the parties involved. This is particularly true for headquarters officials who should resist approaches for involvement in administrative matters from their regional technical counterparts. They should be referred to the RHA.

Finally, the description of the organizational structure and organograms presented in Section 5 further illustrate these distinctions and relationships. The channels of communication are addressed in Section 5 and illustrated in the organograms.



### **3. BACKGROUND**

#### **3.1 Swaziland: Historical Development of Decentralization**

The decentralization thrust in the Swaziland Ministry of Health started with the adoption of a report in July, 1983 which outlined the framework and process for decentralizing the management of health services.

Following, with the assistance of the IHSP Project, the Ministry started implementing the report's recommendations. A developmental strategy was adopted, which included working in each of the four regions for three months. During this period the basic organizational structure was established which called establishment of the Regional Health Management teams and Regional Health Advisory Councils.

Workshops in each of the four regions were conducted to formulate recommendations. The Decentralization task force was also formed and played a significant role in the development of the decentralization plan. Finally, the document, "Guidelines for the Future Operation of Health Services in Swaziland" was prepared and formed the basis for a 'three day working session of the RHMTs and headquarters officials in October, 1985 who approved the blueprint. The Guidelines were then reviewed, edited and approved by the Task Force and the Planning and Policy Committee.

The RHMTs were formed during 1985 and started functioning.

When no plan existed for a health administration cadre, the health manpower plan was revised to include middle, regional and senior management posts. A scheme of service for health administrator was prepared and adopted for one senior health administrator, four regional administrators and four hospital administrators. Personnel were recruited and four hospital administrators were trained at the Botswana Institute of Development Management, while four regional administrators were sponsored for Masters Degrees in the United States.

(Extracts from "End of Tour Status Report", Kess Hottle, Health Management Advisor, Health Planning and Management Project, IHAP, Swaziland, January, 1986. pp. 1, 2, 20, 21).

#### **3.2 Swaziland: Current Status of Decentralization**

Since 1985 the road to decentralization has continued at a steady pace. The Regional Health Management Teams are now all functioning on a regular monthly meeting schedule. Team building workshops have been held for each of the RHMTs, and the members are utilizing a self-assessment questionnaire to assist them in targeting areas to improve meeting performance.

Offices have been established in each of the regional Health Administration. Office furnishings and equipment, vehicles and clerical staff have been provided by the MOH.

The Decentralization Task Force was reconstituted in January 1990 to play a more forceful role in monitoring the decentralization process, and the Regional Health Administrators were made full members. The Task Force continues to provide a useful means for fostering communication between the centre and regions: there are seven members from headquarters and eight from the regions.

Significant steps have been taken in the regionalization of personnel management. The health information system has been decentralized with data management taking places at the regional level. Annual work plans were drafted by all four regions for FY 1990/1. Each work plan contains a section on Regional Management which helps to ensure focus on management – this includes the functioning of the RHMT, planning, budgeting and finance, transport, personnel and training, health information, clinic construction and renovation, and the like.

Each region has organized a Regional Health Advisory Council (with the exception of the Lubombo region which works through a well-established Regional Development Team).

Posts have been established for Regional Public Health Matrons, Regional Health Inspectors and Regional Public Health Physicians. Plans are progressing for posting Health Educators to each of the regions.

Structurally, there are problems in the areas of authority and responsibility, the distinction between administrative and technical supervision, reporting relationships and in communications with headquarters. Also, there is a noticeable lack of coordination between the regional officers (where the work ultimately must get done) and the vertical programs. These weaknesses are recognized and being addressed.

To improve communication, the Principal Secretary has requested monthly reports from each of the regions, and quarterly reviews of the annual workplans. Minutes of the RHMT meetings are dutifully drafted for each meeting and an improved procedure for distributing them to vertical units and headquarters is being installed.

#### **4. HEALTH POLICIES IN SUPPORT OF DECENTRALISATION**

##### **4.1 National Health Policy**

In the National health policy statement of July, 1983, the Ministry of Health outlined a strategy for decentralization and participation as follows:

“Improving the health status of the people requires a partnership between government, acting through the Ministry of Health, and communities, families, and individuals who must participate in the maintenance of their own health. Programmes for which there is community input into planning, implementation, and financing and over which there is a strong measure of local control, stand a better chance of long-term success. The consumers will be more committed to both the establishment and successful implementation of services. In general, intensive grass-roots involvement results in a higher quality of services which reach the people for whom they are intended.

Thus, the Ministry of Health is committed to converting the highly centralized system for the planning and delivery of health services into a system which is decentralized to the district level and which provides for local grass-roots participation in the decision-making process.”

##### **4.2 Three-Year Development Plan**

In the Three-year Development Plan for the period 1990/1 – 1992/3, the Ministry of Health reaffirms its commitment to decentralization, as follows:

“...The Ministry of Health remains committed to decentralizing the system of planning and delivery of health services to the regional level. The concept of decentralization will include coordination of the public and private sectors, encouragement of community and non-government participation, and improvement of the health policy guidance and tighter programme coordination will help community health committees and Regional Health Management Teams to ensure an optimal distribution of appropriate health services, especially in the rural areas.”

The decentralized organizational structure was designed to support these policies. The Regional Health Advisory Councils and Community (or Clinic) Health Committees are intended to provide important community inputs to the determination of need and formulation of health system objectives and priorities. The region has become the pivotal point in this system, bringing decision-making much closer to the people.

## 5. ORGANISATIONAL STRUCTURE

(See addendum – Consultancy Report by Peter Shipp)

## 6. CENTRAL ORGANISATION AND COMMITTEES

(Adapted from original Guidelines, January 1986)

### 6.1 The Central Organization

In support of its national health policy and priorities articulated in 1983, the Ministry has reorganized the way in which it goes about managing its health services. These Guidelines serve to define that way in some detail, providing definitions, terms of reference and job descriptions for the essential elements of the new decentralization approach.

As described in more detail in Section 2.4 of these Guidelines the central units will continue to have the critical roles of policy formulation, policy guidance, resource allocation, technical supervision and support and monitoring of administrative procedures. Localized planning, allocation of resources and operational management will be delegated to the regions.

The ways and means for carrying out these responsibilities have been established at both central and regional levels. These include the central (headquarters) committees, the Regional Health Management Teams, Community Health Committees, and the establishment of special posts.

Decentralization does not mean that headquarters officials will give up responsibility or power. Rather, they will delegate more and thereby release their time for more appropriate long-range planning, policy-making, monitoring and coordinating the operations of all four regions on a national scale.

Technical heads at the national level will provide technical support to their counterparts in the regions.

### 6.2 Headquarters Committees

The Ministry of Health has established certain Management Committees designed to expedite internal communication, policy development and decision-making. The Senior Health Administrator is a member of each of these committees providing presentation, and a communication link, with the regional administrations.

The original Guidelines of January 1986 specified five Management Committees. Through practice and application this number has been reduced to three. The Principal Secretary's Management Committee is so small that it does not require the formal status of a committee, but rather functions informally as needed. The Headquarters-Regional Joint Management Committee has been absorbed into the Decentralization Task Force.

Following are the terms of reference for three of the committees. The Decentralization Task Force is addressed separately in Section 7 that follows.

### 6.3 Terms of Reference for the Policy and Planning Committee (Senior Staff)

#### Membership

Principal Secretary  
Health Planner  
Undersecretary

Chairperson  
Secretary

Director of Health Services  
Deputy Director of Health Services  
Chief Nursing Officer  
Financial Controller  
Senior Health Administrator  
Principal Personnel Officer  
Senior Health Inspector

#### Functions

- (1) Establishes national policies, goals, priorities, and strategies for national health development; oversees from a national perspective health services functions and activities; negotiates with international and national donors; conduct relations with other ministries.
- (2) Monitors policies, goals, priorities and strategies that have been approved for programmes and regions.
- (3) Reviews and approves donor project proposals; monitors project implementation.
- (4) Receives reports from and takes action on recommendations from the Budget Preparation and Management Committee, Training and Personnel Management Committee, and Decentralization Task Force, including:
  - Review and approval of the Three-Year Development Plan and Capital Budget
  - Review and approval of the Recurrent Budget
  - Review and approval of the Five-Year Manpower Plan and annual Health Personnel establishment
  - Review and approval of the strategies for decentralization, regional priorities and programmes
- (5) Meets regularly to conduct the business specified in items 1 through 4 above, consult on the allocation of resources, coordinate activities, solve problems, and resolve policy and planning issues.

#### 6.4 Terms of Reference for the Training and Personnel Management Committee

##### Membership

Under Secretary	Chairperson
Principal Personnel Officer	Secretary
Deputy Director of Health Services	
Chief Nursing Officer	
Senior Health Inspector	
Senior Health Administrator	
Health Planner	
Principal, Institute of Health Sciences	
Training Officer	

##### By Invitation:

Senior Health Educator  
Principal Tutor, Good Shepherd School of Nursing  
Principal Tutor, Nazarene College of Nursing (RFM)

##### Functions – Personnel

- (1) Reviews, approves and monitors the Five-Year Manpower Plan, and the annual health personnel establishment.

- (2) Receives and acts on recommendations from the Regional Health Management Teams (Regional Personnel and Training Sub-Committees)
- (3) Submits recommendations to the Policy and Planning Committee
- (4) Initiates and/or reviews and approves any recommendations for changes in personnel management practices in the Ministry of Health.
- (5) Monitors recruitment of staff; sets guidelines for the promotion of staff; sets guidelines for the transfer of staff; reviews post requirements; reviews and approves any proposed changes in Scheme Service and Grading before they are forwarded to the Department of Establishments and Training.

#### Functions – Training

- (1) Sets pre-service and in-service training policy.
- (2) Oversees training needs assessments and setting priorities on training needs by the regions.
- (3) Reviews and approves annual training plans.
- (4) Reviews and approves annual reports on training accomplished.
- (5) Determines type of training to be undertaken at health worker training institutes in Swaziland.
- (6) Sets the intake levels for the three health worker training institutes in Swaziland.
- (7) Establishes criteria for trainees to be accepted into in-service training programmes.
- (8) Review all participants for out-of-country in-service training and makes recommendations to sponsoring agencies.

#### 6.5 Terms of Reference for the Budget Preparation and Management Committee

##### Membership

Under Secretary	Chairperson
Principal Accountant	Secretary
Financial Controller	
Deputy Director of Health Sciences	
Health Planner	
Senior Health Administrator	

##### Functions

- (1) Reviews and approves the Three-Year Plan Capital Budget
- (2) Reviews and approves the annual Recurrent Budget (submitted by the Budget Development Team)
- (3) Oversees the budgeting and financial management functions in the Ministry of Health.

- (4) Oversees health sector planning and negotiation for donor contributions (through the Department of Economic Planning and Statistics).
- (5) Oversees enforcement of the finance and audit regulations.
- (6) Receives and acts on recommendations from the Regional Health Management Teams (Regional Planning and Budgeting Sub-Committees).
- (7) Submits recommendations to the Policy and Planning Committee.

## **7. DECENTRALISATION TASK FORCE**

### **7.1 Revision and Update of Terms of Reference**

The terms of reference for the Decentralization Task Force were revised and updated at a Task Force Meeting on 26 January 1990. In taking this action the Task Force combined the functions of the former Headquarters-Region Joint Management Committee with that of the Task Force, thereby eliminating on committee in the Ministry structure which had been inactive and the functions redundant with that of the Task Force.

The revised and updated terms of reference provide for the central management function for the national process of decentralization, and refer to target-setting, supporting implementation, and monitoring follow-up actions and progress in the various regions. Further, the new terms of reference provide for supporting the design implementation of specific management subsystems and for supporting the design and implementation of the decentralization and coordination of vertical programmes.

In the revision the Regional Health Administrators were made full members and a balance struck between headquarters (central) members and regional members designed to facilitate the former Headquarters-Region Committee function of serving as a “forum” for the coordination of the management of health services in Swaziland.

### **7.2 Terms of Reference for the Decentralization Task Force (Combining the Former Headquarters-Region Joint Management Committee)**

#### **Task Force Membership**

Under Secretary Senior Health Administrator Director of Health services Chief Nursing Officer Health Planner Principal Personnel Officer Financial Controller RHA from each region (4) One additional member from each region who is to be a senior technical officer (selected by the RHMT and approved by the Under Secretary) [4]	Chairperson Secretary
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Total number of members: 15  
(Headquarters – 7, Regions – 8)

### Task Force Meetings

Regular quarterly meetings are to be held by the Decentralization Task Force. The date, time and place shall be determined by the Chairperson. As possible, the meeting venue will be rotated among the regions and headquarters locations. Special meetings may be called by the Chairperson at any time.

### Purpose of the Task Force

The purpose of the Decentralization Task Force is to promote, support and facilitate the decentralization of health services management in Swaziland.

### Functions of the Task Force

1. Plan, set targets and time schedules for the design and implementation of the decentralization process at both the headquarters and regional levels. Monitor and evaluate progress against these targets and time schedules.
2. Support the design and implementation of the decentralization of specific management sub-systems of the health system at both the headquarters and regional levels, i.e. (a) personnel and training, (b) health information, (c) planning, (d) budgeting, (e) financial management, (f) transport, (g) communication, and (h) supply.
3. Support the design and implementation of the decentralization and coordination of vertical programmes at both the headquarters and regional levels, i.e. (a) health education, (b) health inspectorate, (c) mental health, (d) laboratory services, (e) central medical stores, (f) malaria control, (g) bilharzia control, (h) tuberculosis control, (i) AIDS control, (j) family planning, (k) expanded programme for immunization, (l) control of diarrheal diseases, (m) acute respiratory infections, (n) growth monitoring and nutrition, and (o) Rural Health Motivators
4. Serve as a forum for the coordination of the management of health services in Swaziland to review and resolve problems and obstacles to decentralization and to improve communication among the regions and between the regions and headquarters on matters of decentralization.

## **8. NATIONAL HEALTH ADVISORY COUNCIL (NHCA) COMPOSITION AND TERMS OF REFERENCE (From original Guidelines, January 1986)**

### **8.1 NHAC Role**

The strategy for socio-economic development of the nation requires participants outside of the Ministry of Health. It calls for assistance and cooperation from all sectors and from the communities for mobilization of "Health for All" and "All for Health". As noted in the Swaziland National Health Policy (July 1983) and reiterated in the latest 3-year Development Plan (January, 1990), the concept of decentralization calls for the coordination of the public and private sectors and encouragement of community and non-government participation (see page 10 of these Guidelines). Thus the formation and active functioning of councils and committees at the three levels – national, regional and community – become instrumental in carrying out this national strategy.

### **8.2 NHAC Membership**

The composition of the Council as outlined in the original Guidelines consists of the following:

Parliamentarian	Chairperson	(1)
Ministry of Health (Minister, PS, DHS, CNO, HP, SHA) Health Planner, Secretary		(6)
Ministry of Agriculture (PS/US, Head of Home Economics)		(2)
Ministry of Education (PS or representative)		(1)

Ministry of Interior (PS or US)	(1)
Ministry of Finance (PS or US)	(1)
Dept. of establishment and Training	(1)
Ministry of Natural Resources	(1)
Sebenta (Adult Education)	(1)
Dept. of Economic Planning & Statistics	(1)
Regional Health Advisory Councils representatives	(4)
Swaziland National Council	(1)
Traditional Healers Society	(1)
LUTSANGO	(1)
Non-Governmental Organizations	(1)
Tinkhundla (PS or representative)	(1)
Rural Water Supply Board	(1)
Water and Sewage Board	(1)
Public Works Department	(1)

### 8.3 NHAC Functions

- (1) Inform itself about health care needs in the country.
- (2) Advise on allocation of resources within the health sector and on additional resources necessary.
- (3) Advise on technical cooperation and coordination with other Ministries and Countries, advice to include the creation of a practical and comprehensive infrastructure for the implementation, monitoring, and evaluation of health care programmes.
- (4) Receive and recommend action on recommendations made by the Task Force on Decentralization.
- (5) Make recommendations on national health policy to the Ministry of Health.

### 8.4 NHAC Meetings

The council would meet at least once a year between July and August. Two-thirds of the membership would constitute a quorum. Extra meetings can be arranged when necessary.

Services of a Parliamentarian from the Parliamentarian Committee would be requested to guide the meetings as Chairman. The Health Planner would serve as Secretary.

## 9. **REGIONAL HEALTH ADVISORY COUNCIL (RHAC)** **COMPOSITION AND TERMS OF REFERENCE** (From original Guidelines, January 1986)

### 9.1 RHAC Role

It is clear that if the health status of the people is to be improved through the provision of primary health care, a high level of inter-sectoral cooperation will be required at all levels. It is expected that the health advisory councils and community health committees will meet this need to a good extent.

With the Regional Secretary acting as Chairperson of the RHAC, it supports his other responsibilities for coordinating regional services and for referring identified community service needs. He can also assist with communicating health issues to the Regional Council (Tinkhundla). The Regional Health Administrator services as Secretary of the RHAC. In this way, s/he can assist with planning and scheduling meetings and can assure that the RHAC is an active part of the health system.



In order to ensure liaison and involvement with MOH Headquarters, the RHA should always request participation at the Council meetings. Normally the Deputy Director of Health Services or a member of the Health Planning Unit fulfills this responsibility.

## 9.2 RHAC Membership

The composition of the Council may vary according to the manpower resources in the region. Members can be added with the advice of the Regional Health Management Team, giving consideration to geographic areas of the region. Members generally include the following:

Regional Administrator/Secretary	Chairperson
Regional Health Administrator	Secretary
Non-Governmental Organization	
Representative from the Region	
Industry Representative	
Regional Representative from:	
Ministry of Agriculture	
Ministry of Education (DEO)	
Home Economics	
Water and Sewage Board	
Rural Water Supply Board	
Natural Resources	
Town Council/Town Board	
Public Works	
Labour	
Regional Council (Tinkhundla)	
Sebenta (Adult education)	
Traditional Healers Society	
Chieftainship	

## 9.3 RHAC Functions

- (1) Identify and prioritize health needs and problems throughout the region
- (2) Mobilize regional resources which might assist with meeting health needs of the region.
- (3) Advise the Regional Health Management Team on development and evaluation of health programmes.
- (4) Promote inter-sectoral cooperation on meeting health needs
- (5) Review recommendations from Community Health Advisory Committees and submit recommendations on health policy to the National Advisory Council.

## 9.4 RHAC Meetings

The Council would meet at least quarterly (or at the discretion of Chairman) to advise on health problems and priorities and to mobilize inter-sectoral support for meeting primary health care needs.

The Regional Administrator (or delegated to the Regional Secretary) would normally serve as Chairman. Members of the Regional Health Management Team would attend meetings as technical resource people. The Chairman of the RHMT would serve as secretary to the council.

## 10. THE REGIONAL TEAM (RHMT)

Worldwide, in the evolution of the primary health care approach, the concept of the team was a natural follow-on as the need for communication and coordination became apparent. The team made it possible to bring together the various key actors at the regional (district) level for sharing, managerial functions could be added, such as planning, budgeting, monitoring and evaluation. A number of countries have applied the team concept.

### 10.1 The Team Concept

The Regional Team is located at a critical level in the system - midway between the top and the bottom. "It can thus be seen as a key cross-over point within the health system, where national strategies are converted into action; local demands are aggregated and incorporated into action plans; and where horizontal relationships are established with other agencies and other sectors covering the same geographical area." (Guidelines for Strengthening Primary Health Care in Districts," Draft. Author unidentified. Attributed to WHO, Geneva, June, 1986)

In Swaziland, the RHMT is responsible for planning, budgeting, monitoring and supervising all health facilities and services within the region, for both government and missions. The RHMT is headed by a specially-trained Regional Health Administrator, who supervises the Assistant Health Administrators (Hospital Administrators) in the region. The members each have authority over their respective areas of responsibility – hospital administration, medical services, nursing services, public health, health education, health inspectorate, etc.

The RHMT participates in a collective decision-making process. It draws on the experience and capabilities of its members. Sub-committees are established by the RHMTs to carry out some of the more important team responsibilities. These are: (1) Planning and Budgeting, (2) Personnel and Training, and (3) Health Information. Typically, the RHA serves as chairperson of these sub-committees.

In his/her leadership role, the RHA serves as Secretary of the Regional Health Advisory Council, and is a member of the Decentralization Task Force. The RHA is also the warrant holder for the region's clinics.

### 10.2 RHMT Membership

The following are core members of the RHMT:

- Regional Health Administrator, Chairperson
- Senior Medical Officer from each government and mission facility in the region
- Senior Matron from each government and mission facility in the region
- Administrator from each government and mission facility in the region
- Regional Health Inspector
- Regional Public Health Matron
- Regional Health Educator

Other department heads may be added as appropriate, including those from the Town Council, Mental Health and School Health. Clinic Supervisors may participate. Membership should be limited in order to optimize the efficiency and effectiveness of team functioning. Generally a top limit of 12 is recommended.

### 10.3 RHMT Terms of Reference

(Revised and updated, August 1990)

NB: These Terms of Reference are integrated with the revised and updated job descriptions for the Senior Health Administrator and Regional health Administrator.

Major activities of the regional Health Management Team include the following:

- (1) Develops and supervises integrated health services for the region, with a reasonable balance of preventive, Promotive, curative and rehabilitative services at all levels, covering government, mission and private services.
- (2) Meets regularly (at least once per month) to consult on the allocation of resources and responsibilities; coordinate activities; solve problems; prepare work schedules; and to plan, monitor, and evaluate programmes, services and special events and activities.
- (3) (In consultation with the Senior Health Administrator, Deputy Director of Health Services, Health Planner, Statistics Officer, and relevant vertical programme managers) develops an annual work plan for the region including priorities for action, programme objectives, and specific activities with assigned responsibilities.
- (4) Maintains regular liaison with (vertical) programme officers for the purpose of joint planning, budgeting, implementing and evaluating special programmes, and effectively integrating them into regional operations.
- (5) Arranges for management support services for subordinate units and health workers within the region including assistance with financial management, personnel, training, drug and general supplies, health and management information, transport, communication, records and reports, supervision, clinic operations, mobile clinics and the support of Rural Health Motivators.
- (6) Provides staff support for the work of the Regional Health Advisory Council and technical and logistical support to clinic nurses in their work with the Community Health Committees.
- (7) Prepare a capital budget for the region annually as input to the Three-Year Development Plan (updated annually).
- (8) Prepares the annual Recurrent Budget for the region; prepares requests for re-allocation of resources with the region.
- (9) Plans staffing needs and deployment of staff in the region; prepares a regional Manpower Plan each year as input to the Five Year Manpower Plan (updated annually).
- (10) Submits staffing needs to the Principal Personnel Officer for the annual regional staffing requirement in line with the Five Year Manpower Plan.
- (11) Carries out personnel management functions for the region as specified in the operating procedures for Regional Personnel Management.
- (12) Identifies training needs of health workers within the region (including the training needs for vertical programmes), plans in-service and continuing education programmes within the region, and submits requests for longer term training to MOH headquarters. Prepares an Annual Training Plan for the region to be integrated into the National Training Plan, and plans, selects candidates for, and conducts training activities for the region in the region.
- (13) Prepares and reviews monthly health information status reports; oversees the regional computerized Health Information Systems for outpatient and inpatient data.

- (14) Through the Chairperson (RHA), communicates regularly with the other regional officials, the MOH Senior Health Administrator and Deputy Director of Health Services on regional health service needs and developments.
- (15) Maintains communication with other organizations concerned with health and related services.
- (16) Oversees the preparation of annual reports for each health service unit in the region.
- (17) Oversees the conduct of an annual Needs Assessment of all health services in the region as a basis for the annual preparation of plans and budgets.
- (18) Prepares and submits quarterly reports to Ministry of Health Headquarters; submits minutes of RHMT meetings and other pertinent documents to Ministry of Health Headquarters.

(It should be noted that the RHMT is not to assume the responsibilities and roles of its individual members who have clearly-defined responsibilities and authority in their respective technical areas. The RHMT can offer guidance to these officers who may wish to obtain collective judgment and support from their colleagues.)

#### 10.4 RHMT Sub-Committee

The RHMTs may appoint sub-committees from time to time. Some are ad hoc, designed to carry out a specific project or activity, or to investigate a given problem. These are short-term and dissolved once the work is completed and a final report submitted to the parent RHMT. Other sub-committees are standing and function on a continuous basis. There are at present three standing sub-committees appointed and functioning for each of the RHMT. These are: (1) Planning and Budgeting, (2) Personnel and Training, and (3) Information. Terms of reference for each of these sub-committees follow:

##### 10.4.1 Planning and Budgeting Sub-Committee – Terms of Reference

###### General Responsibilities of the Planning and Budgeting Sub-Committee

The Planning and Budgeting Sub-Committee of the RHMT is responsible for all activities in the region concerning Planning and Budgeting. Specifically it is responsible for developing the regional component of the 3-year Development Plan and Capital Budget, Annual Recurrent Budget and Annual Regional Work Plan. (the 5-year Manpower Plan, Annual Manpower Requirements and Annual Training Plan are the responsibility of the Personnel and Training Sub-Committee).

As a sub-committee of the RHMT it is responsible for all its actions and is required to submit regular reports to the RHMT. Draft plans and budgets prepared by the Sub-Committee must be submitted to the RHMT for review and approval.

All Sub-Committee communications to and from the region shall be through the Chairperson. The Sub-Committee shall maintain records as appropriate and prepare minutes of meetings. These records shall be kept on file in the Regional Health Administration Office. The Sub-Committee shall meet at such times and at such locations as the Chairperson may determine.

###### Membership of the Planning and Budgeting Sub-Committee

There shall be from three to five members of the Sub-Committee. They are to be appointed by the Regional Health Administrator with the consent of the RHMT. The membership can be rotated among RHMT members.

The RHA shall serve as chairperson.

Other members may be seconded as required, particularly warrant holders in the region.

The Health Planner and Financial Controller provide technical support for the Sub-Committee.

#### Functions of the Planning and Budgeting Sub-Committee

- (1) Working according to the guidelines issued by the Health Planning Unit and the MOH Budget Preparation and Management Committee, draft the regional component of the 3-year Development Plan, including proposed capital expenditure projects (equipment and facilities) for the region. Prepare a complete justification for each, and establish priority among them.

Attend all workshops and working sessions with the Health Planning Unit and other officials to draft the Plan.

Conduct an adequate needs assessment to determine capital budget requirements for the region, for both government and mission services and facilities.

Present the draft 3-year plan (the third year of the plan which is developed annually) to the RHMT, review and make adjustments according to RHMT decisions.

Submit the draft 3-year plan to the Planning Unit and the MOH Budget Preparation and Management Committee, review, negotiate and defend all proposals.

- (2) Working according to the guidelines issued by the Financial Controller and the MOH Budget Preparation and Management Committee, prepare the recurrent budget estimates for the region each year.

Attend all workshops and working sessions with the Financial Controller and Committee to draft the budget.

Conduct an adequate needs assessment to determine recurrent budget requirements for the region, for both government and mission services and facilities.

Present the draft recurrent budget to the RHMT, review and make adjustments according to the RHMT decisions.

Submit the draft recurrent budget to the Financial Controller and MOH Budget Preparation and Management Committee, review, negotiate and defend all items.

- (3) Working in collaboration with the Senior Health Administrator, deputy Director of Health Services, Health Planner and Statistics Officer, prepare the Regional Annual Work Plan.

Consult with and involve all relevant department or unit head in the region, in preparing the Work Plan.

Consult with and involve all relevant vertical programme managers in preparing the Work Plan.

Liaise with the Personnel and Training Sub-Committee to obtain necessary inputs on training needs and activities which should be a component of the Work Plan.

Conduct an evaluation of the previous year's Work Plan to provide inputs for the subsequent year.

Conduct an adequate needs assessment to determine the most effective interventions for the plan year to improve the health status of the region.

Plan, organize and conduct appropriate consultations, working sessions and workshops as may be required to draw up the work plan.

Present the draft Work Plan to the RHMT, review and make adjustments according to RHMT decisions.

Finalize the Work Plan, prepare copies and circulate to the RHMT members, other regional health officers, other regional officials, headquarters officials and vertical programme managers.

(The monitoring and follow-up of the Regional Work Plan is the responsibility of the Regional Health Administrator. See job description).

- (4) Consult with the RHMT on planning and budgeting matters, and carry out special assignments concerning Planning and Budgeting at the request of the RHMT.

#### 10.4.2 Personnel and Training Sub-Committee – Terms of Reference

(NB: these terms of reference are taken directly from the Regional Personnel Management Policies and Procedures Manual. They require some updating).

#### General Responsibilities of the Personnel and Training Sub-Committee

Each Regional Health Team shall form a Personnel Sub-Committee responsible for overseeing personnel management in the region.

#### Membership of the Personnel and Training Sub-Committee

The Personnel Sub-Committee shall have three members. The Regional Health Administrator shall serve as permanent member and chairman. The two other members shall be elected annually by the Regional Management Team and shall be subject to recall by the RHMT. All Sub-Committee members must be Government Employees as the Sub-Committee shall deal with employment, discipline, grievance, etc. of Government employees only.

The elected members of the Sub-Committee shall be chosen at the first regular meeting of the RHMT in each calendar year. They shall serve on the Sub-Committee until the first regular meeting of the RHMT in the following year. In the event that the Regional Health Administrator is not a Government employee, the Regional Health Management Team will elect all three members of the Sub-Committee annually.

The Sub-Committee functions under delegated authority from the RHMT, and reports to the RHMT all actions taken. The quorum for meetings of the Sub-Committee shall be all three members. Questions shall be decided by a simple majority vote. Members temporarily unavailable (for example, on leave) may be replaced by the RHMT.

The Sub-Committee may co-opt any person for the purpose of aiding its deliberations, and said co-opted persons shall have no vote. The Sub-Committee may invite the Chairman of the Hospital Management Committee or heads of departments to accord them the opportunity of making recommendations.

All Sub-Committee communications to and from the region shall be through the Chairman. The Sub-Committee shall keep accurate and complete records of its deliberations and actions taken. The original records shall be held in the custody of the Chairman. All such records are confidential. The Sub-Committee shall meet at such times and at such locations as the Chairman shall determine.

#### Functions of the Personnel Sub-Committee

The Personnel Sub-Committee of the Regional Health Management Team shall:

- (1) Coordinate the development and annual revision of the Regional Manpower Plan;
- (2) Review the recruitment and selection procedure for Permanent and Non-Pensionable staff and appoint Permanent and Non-Pensionable staff;
- (3) Declare to the Principal Personnel Officer vacancies in Permanent and Pensionable posts in the Region and liaise with the headquarters Personnel Unit on the filling of declared vacancies.
- (4) Keep responsibility centres in the Region adequately supplied with all personnel forms referred to in the Regional personnel Manual, e.g. Transfer request, Application for Training, Leave Report form, Leave cards, etc.;
- (5) Recommend on the extension or renewal of contracts for Contract staff;
- (6) Post personnel to duty stations in the Region;
- (7) Request creation of supernumerary posts when required;
- (8) Organize an employee orientation programme and ensure that all new Regional employees are properly oriented.
- (9) Ensure that probationary officers are regularly supervised and that the probationary period is used effectively for selecting only suitable officers for permanent employment in the Public Service;
- (10) Transfer employees within the Region;
- (11) Recommend on the transfer of employees out of or into the Region;
- (12) Promote Permanent and Non Pensionable staff;
- (13) Circularize announcements of promotional vacancies in Permanent and Pensionable posts and encourage well qualified officers in the Region to apply for such vacancies.
- (14) Maintain a complete set of up to date job descriptions for all posts in the region; ensure that each employee has a copy of his job description; ensure that supervisors are instructed in the use of job description;
- (15) Recommend amendments to job descriptions
- (16) Ensure that the annual staff performance appraisal reports are completed on time and in the prescribed manner.
- (17) Identify in-service training needs; develop in-service training plans; recommend personnel for training within the region; circularize announcements of training courses and scholarship opportunities; recommend candidates for training outside the region.
- (18) Ensure that supervisors properly apply policies and procedures for administration of leave.

- (19) Meet with employees who are not responding to direction from their supervisor and head cadre.
- (20) Recommend to MOH headquarters disciplinary actions beyond verbal and written warnings;
- (21) Respond to properly channeled employee grievances which are not resolved at the first step of the grievance process;
- (22) Maintain and keep up-to-date personnel reference documents as specified in Section 2.3 of the Regional Personnel Manual and train Regional personnel in the application of personnel policies and procedures;
- (23) Recommend amendments as necessary to the Regional Personnel Management Policies and Procedures manual.
- (24) Ensure that all Regional responsibility centres submit Monthly Staff Reports to the MOH Personnel Unit by the required date;
- (25) Check the accuracy of the quarterly Establishment/Staff Register printouts and distribute the printouts to responsibility centres.
- (26) Ensure that proper personal files are kept on all employees in the Region.

#### 10.4.3 Information Sub-Committee – Terms of Reference

##### General Responsibilities of the Information Sub-Committee

The Information Sub-Committee of the RHMT is responsible for health and management information that is developed, processed and utilized in the region, and submitted to MOH headquarters. Specifically, it is responsible for the inpatient and outpatient data systems and for analyzing data, presenting it to the RHMT, and submitting recommendations for programme and service changes based on the information.

As a sub-committee of the RHMT it is responsible for all its actions and is required to submit regular reports to the RHMT.

All sub-committee communications to and from the region shall be through the Chairperson. The Sub-Committee shall maintain records as appropriate and prepare minutes of meetings. These records shall be kept on file in the Regional Health Administration office. The Sub-Committee shall meet at such times and at such locations as the Chairperson may determine.

##### Membership of the Information Sub-Committee

There shall be from three to five members of the sub-committee. They are to be appointed by the Regional Health Administrator with the consent of the RHMT. The membership can be rotated among RHMT members.

The RHA may or may not be a member, and may or may not be Chairperson.

It is generally recommended to include in the membership a Senior Medical Officer from the region and a Clinic Supervisor who is familiar with health information problems on first-hand basis.

Other members may be seconded as required.

The statistician from MOH headquarters provides technical support for the Sub-Committee.



### Functions of the Information Sub-Committee

- (1) With the support of the MOH Statistician, oversee the operation of regional data systems, including:
  - Outpatient data
  - Inpatient data
  - Management data
  - Special programme and service data
- (2) Monitor the operation of these systems:
  - Ensure that reporting units submit complete, accurate and timely reports (by working through the appropriate supervisors – Hospital Administrators, Public Health Sisters and Clinic Supervisors).
  - Ensure that the data processing system functions correctly, that data are entered correctly and on time, and that reports are printed out in a timely fashion (by working through the RHA)
- (3) Select indicators which will serve to monitor priority health problems, programmes and services of the region and track these on a regular basis.
- (4) Analyze data returns and present a summary report with findings and recommendations to the RHMT on a regular basis (monthly or quarterly)
- (5) See that regional data sets are submitted to the Central Statistics Unit promptly on a monthly or quarterly basis as directed by the MOH statistician, and that appropriate reports are fed back to the clinics, OPDs, hospitals and other reporting units.
- (6) With technical support from the Statistics Officer, design and carry out special surveys and studies as may be required in the region.
- (7) Organize regional support for national surveys and studies as required and as are approved by the RHMT.
- (8) Submit an annual “Needs Assessment Report” based on regional data trends and implications to the RHMT and Planning and Budgeting Sub-Committee for use in planning and budgeting.
- (9) Consult with the RHMT on health and management information matters, and carry out special assignments concerning health and management information at the request of the RHMT.

### **11. VERTICAL PROGRAMMES**

(See addendum – Consultancy Report by Peter Shipp)

### **12. COMMUNICATION**

Communication is an important element in making an organization function efficiently and effectively. This is particularly true in the decentralization process.

#### **12.1 Communication in the Ministry of Health**

In the Ministry of Health we are concerned with communication:

- Between Ministry of Health Headquarters and the regions and the reverse
- Between vertical programmes and the regions
- Among RHMT members

- Between the Ministry of Health and other ministries
- Between Government and the mission and private sectors

## 12.2 Vertical and Lateral Communication

Communication within the organization can be classified as (1) vertical and (2) Lateral.

Vertical communication goes up and down the chain-of-command. A typical weakness of vertical communication is that it is usually not fully two-way; that is, communication from the top (boss to subordinates) is much stronger than communication upward from the bottom. There is normally inadequate feedback from below. This appears to be the situation with the Swaziland health system where there is inadequate communication upwards from the regions.

Lateral communication cuts across the vertical lines of authority in the organization, crossing from one department to another. Lateral communication channels are strengthened through the circulation of files and inter-office memoranda, through staff meetings, project teams, and training sessions. The use of project teams or task forces is a common organizational device to improve lateral communication.

Clearly, lateral communication is essential for the functioning of a decentralized system. The RHMT is a good example of lateral communication bringing together department heads and others who contribute technical expertise from their respective areas. These differing skills, knowledge and positions of authority contribute to improved decision-making and in carrying out the decisions.

## 12.3 Communication Problems in the Ministry of Health

Miscommunication (or lack of communication) has been cited a number of times (in RHMT meetings and in the meetings held with the RHMTs by the Decentralization Task Force) as the cause of problems which arise within the health organization.

However, most of the mechanisms are in place to facilitate communication within the Ministry of Health, both vertically laterally. These include specified roles of officers, the regional teams, advisory councils, community health committees, regional sub-committees, and the Decentralization Task Force. The challenge at hand is to make them all work better.

Areas of weakness in communication affecting decentralization include:

- (1) Lack of written communication of RHMT needs and of decisions taken at meetings.
- (2) Lack of joint planning and programming between headquarters and the regions by both technical and administrative departments (particularly vertical programmes)
- (3) Inadequate technical direction and support from HQ to the regions
- (4) Inadequate and too infrequent feedback from the regions to HQ
- (5) Cancellation and postponement of RHMT meetings
- (6) Inactivity and lack of reporting by some RHMT sub-committees
- (7) Inactive Regional Health Advisory Councils
- (8) Non-existent and inactive Community Health Committees

- (9) Inactivity of the decentralization Task Force

#### 12.4 Guidelines for Communication to Support Decentralization

##### Headquarters-Region and Region-Headquarters

- (1) Department heads should formulate annual programme guidelines and communicate them to regional staff
- (2) The SHA and DDHS should attend RHMT meetings on a frequent basis
- (3) Other department heads and vertical programme heads should attend RHMT meetings from time-to-time to present, review and discuss programmes, resolve problems, etc.
- (4) RHMTs should draft and submit written requests, recommendations and major decisions taken at meetings to the P.S and relevant department heads.
- (5) Technical and administrative programme heads should conduct seminars with regional counterparts to discuss issues and problems, formulate solutions and determine improved means for managing the system.
- (6) RHMT meeting minutes should be circulated to HQ officials.
- (7) Established HQ committees should meet on a regular basis and invite and involve regional staff as appropriate.
- (8) The SHA should hold regular staff meetings with the RHAs and AHAs.
- (9) HQ officers should conform to accepted channels of communication (i.e. not permit regional staff to bypass the regional officers or relevant HQ officers when making requests)

##### Region-to-Region and Within Regions

- (1) Draft annual Plans by and for regions with inputs from (a) the vertical programmes, and (b) the community level through the Community Health Committees, clinic staff, and RHMs.
- (2) Exchange RHMT meeting minutes among regions.
- (3) Arrange for the exchange of RHMT programme innovations among regions and of “consultants” from one region to another (for example, health information, personnel management)
- (4) Arrange inter-regional “study tours”
- (5) Activate, train and develop Community Health Committees and the Regional Health Advisory Councils.
- (6) RHMTs should meet on a regular basis (at least once per month). RHMTs should actively monitor their annual work plans.
- (7) RHMT sub-committees should meet, work and report to the RHMT on a regular basis (combine and eliminate redundant or unnecessary sub-committees, as some tasks delegated to sub-committees should be more appropriately undertaken by the responsible department in the region)

- (8) Staff that work together should be trained together. Training workshops for budgeting, health information, community leaders, community health committees, intersectoral collaboration, etc. on the regional level all foster better communication and understanding.
- (9) Regional staff should participate on Regional Development teams, and liaise with the regional administration
- (10) Regional staff should work with other sectors on mutual projects (for example, Rural Water, Community Development, Agriculture, Education)
- (11) The regions should involve private physicians and industry in all plans and programmes, and open channels of communication through circulation of papers, meetings and conferences, and by inviting the private sector to participate in training activities.

### **13. JOB DESCRIPTION**

#### **13.1 SENIOR HEALTH ADMINISTRATOR** Job No. 008 – A

NB: In order to adequately support and advance the regional administration of health services, the job description of the Senior Health Administrator has been revised to enable him/her to devote 100% of his/her time to this effort. This description is integrated with the revised and updated terms of reference for the RHMT and job description for the Regional Health Administrator.

#### **GENERAL DESCRIPTION OF DUTIES:**

Serves as senior Ministry of Health Advisor on all matters related to health services administration; is responsible for overall coordination of all health activities in the regions including the programme activities at the regional level with the technical support of the Deputy Director of Health Services; is responsible for developing, supporting and monitoring the decentralization process; design and implements management support systems for the regions; supervises the Regional Health Administrators, both technically and administratively; provides technical assistance to regional health officials; assists with planning and budgeting of regional health services.

#### **SUPERVISORY AND COLLABORATIVE RELATIONSHIPS:**

1. Reports directly to the Under Secretary
2. Supervises the Regional Health Administrators
3. Communicates regularly with heads of other MOH administrative units and the Deputy Director of Health Services; provides administrative and technical support to the Regional Health Management Teams.

#### **EXAMPLES OF PRINCIPAL DUTIES**

1. Introduces redesigns and maintains regional level organizational structure, management systems and practices.
2. Ensures that health administration staffing needs are adequately identified, posts established and filled; recruits, selects, orients and trains new health administration staff as needed.

3. Provides technical assistance to all regional health and hospital administrators, both government and mission; provides administrative advice to medical and nursing personnel at facilities where there is limited or no administrative expertise.
4. Identifies health management problems and needs and arranges for outside technical assistance and consulting services as necessary.
5. With the relevant administrative heads, designs and implements management support system in the regions including Planning, budgeting, finance, health and management information, Personnel, Training, Transport, Communication and Supply; develops, maintains and sees to the utilization of operating manuals for these systems.
6. Under general direction of the Under Secretary assists with preparation of the Recurrent Budgets and Three-year Development Plans (including the Capital Budget) in cooperation with the Health Planner, Financial Controller and Principal Personnel Officer.
7. Serves as the Secretary of the Decentralization Task Force, and as a member of the MOH Policy and Planning Committee (Senior Staff), Training and Personnel Management Committee, and the Budget Preparation and Management Committee.
8. Identifies health administration and management training needs and advises the MOH on issues relating to training programmes; plans, organizes and conducts management training workshops and seminars.
9. Assists regional Health Management Teams with preparation of their annual workplans in cooperation with the Deputy Director of Health Services and the Health Planner.
10. Maintains liaison with all headquarters management and technical support units for resolving logistical support problems for the regions; maintains communication with all non-government health administration officials for coordination of management support functions within the health system.
11. Serves as the communication link among the regions, headquarters and programme units; ensures that written reports on regional activities are submitted on time to headquarters; serves to bring problems and issues constraining regional activities to the attention of the appropriate headquarters personnel. All communication between headquarters and the regions is channeled through the SHA.
12. Routinely attends Regional Health Management Team meetings to provide management support assistance, to provide information on national health policies, programmes and priorities, and to convey problems and requests back to headquarters.
13. Perform other duties as necessary.

#### QUALIFICATIONS

Post graduate training in health administration and a minimum of two years high level management experience after post graduate training, equivalent experience and training (such as a bachelor's degree in administration plus four years experience as a Regional Health Administrator); Swaziland Driver's license with Government Operating Permit.

13.2 REGIONAL HEALTH ADMINISTRATOR  
Job No. 122-A

NB: This job description has been redrafted to update it according to the prevailing state of decentralization and regional health management. It is integrated with the revised and updated terms of reference for the RHMT and job description for the Senior Health Administrator.

GENERAL DESCRIPTION OF DUTIES

Provides general supervision of all health management activities within the region (not requiring professional supervision), including that for rural health motivators, clinics, health centres, public health units, and hospitals. The RHA is responsible for planning, budgeting, monitoring and supervising all health facilities and services within the region, for both government and mission services. As Chairperson of the Regional Health Management Team, communicates regularly with the Senior Health Administrator, Deputy Director of Health Services, proprietors of non-government health facilities, regional officials, Regional Secretary, Chiefs, community leaders and community organizations, and the Regional Health Advisory Council. Assures equitable distribution of preventive and curative services to the population. Is the Warrant Holder for regional clinics. Does other related work as required.

SUPERVISORY AND COLLABORATIVE RELATIONSHIPS:

1. Reports directly to the Senior Health Administrator
2. Supervises the Assistant Health Administrators (Hospital Administrators), both administratively and technically.
3. Supervises the Regional Public Health Matron, Regional Health Inspector and Regional Health Educator, with technical support provided by their respective senior technical heads.
4. Provides administrative support to the Senior Medical Officer (hospitals) and Regional Medical Officer for Public Health.
5. With the cognizance of the Senior Health Administrator, works with central administrative heads in carrying out regional operations including the Financial Controller, Principal Personnel Officer, Health Planner and Statistics Officer.
6. Works with Mission Officials in carrying out management support activities for all health services in the region.
7. Receives recommendations from the Regional Health Management Team on programme services and operations in the region.

EXAMPLES OF PRINCIPAL DUTIES

1. As Chairman of the Regional Health Management Team is responsible for carrying out the functions of the RHMT as specified in the RHMT role description, including:
  - Developing the annual regional work plan
  - Arranging for management support services for all units and health workers in the region
  - Preparing capital and recurrent budgets
  - Planning staffing needs
  - Planning and implementing training

- Carrying out personnel management functions
  - Managing the health information system
  - Overseeing an annual Needs Assessment
2. Convenes meeting of the RHMT; prepares agendas, conduct the meetings, and is responsible for preparing and distributing the minutes; follows up on decisions taken.
  3. Serves as Secretary of the Regional Health Advisory Council and assists with its work; otherwise attends Advisory Council meetings as a technical advisor; encourages the development of Community Health Committees and maintains liaison with these committees; serves as a member of the Regional Development Team of the Regional Administrator; serves as a member of the Decentralization Task Force.
  4. Develops integrated health services for the region; with the Senior Health Administrator, introduces redesigns and maintains regional level organizational structure, management system and practices.
  5. With the Senior Health Administrator and the relevant administrative heads, designs and implements management support systems in the region including Planning, Budgeting, Finance, Health and Management Information, Personnel, Training, Transport, Communication and Supply; develops, maintains and sees to the utilization of operating manuals for these systems.
  6. Monitors and follows –up implementation of the Annual Regional Work Plan
  7. Communicates regularly with the MOH Senior Health Administrator and Deputy Director of Health Services on regional health needs and developments.
  8. Liaises with and presents the MOH with the offices of the Regional Administrator, other sector officials, chiefs and community leaders.
  9. Collaborates with other organizations, agencies and community leaders in the development of health services.
  10. In the absence of Assistant Health Administrators (Hospital Administrators) oversees hospital, health centre and clinic management activities.
  11. Ensures revenue collection procedures for hospitals, health centres and clinics, and provides for proper accounting and security of funds and regular deposits; advices staff on collection and security of monies.
  12. Serves as the Warrant Holder for the region’s clinics.
  13. Is responsible for all transport for the region, including the allocation of vehicles. In the absence of Assistant Health Administrators supervises senior drivers and ensures servicing and maintenance of vehicles.
  14. Assists the RHMT members in developing improved procedures for technical support and supervision of health personnel, including the Rural Health Motivators.
  15. Prepares necessary records and reports, including quarterly status reports to MOH headquarters, and is responsible for all units in the region.

QUALIFICATIONS:

Masters degree in health administration and prior middle management experience, or equivalent experience and training. (Equivalent experience and training might be a bachelor's degree in administration and four years related health management experience).