ECSA-HC

East, Central and Southern Africa Health Community

Khotso Pula Nala

EXPANDING ACCESS TO FAMILY PLANNING SERVICES AT THE COMMUNITY LEVEL:

LESOTHO ASSESSMENT

EAST, CENTRAL AND SOUTHERN AFRICAN HEALTH COMMUNITY

AND

LESOTHO MINISTRY OF HEALTH AND SOCIAL WELFARE

November 2011

ACKNOWLEDGEMENTS

The East, Central and Southern Africa Health Community (ECSA-HC) led this assessment, in collaboration with the Ministry of Health and Social Welfare (MOHSW) of Lesotho. FHI provided technical assistance. Dr. Odongo Odiyo led the ECSA multi-country assessment project, including the assessment in Lesotho. Others on the Lesotho assessment team were: Edward Kataika and Doreen Malanda of ECSA; Florence Mohai, Director of FP, and Motsoanku Mefane, RH Officer, for the MOHSW; and Maureen Kuyoh, a consultant for FHI. Morrisa Malkin and Elena Lebetkin of FHI provided assistance with the desk review. ECSA Director General Dr. Josephine Kibaru-Mbae and Dr. Baker Maggwa of FHI supported and assisted with the overall project. Bill Finger of FHI provided editorial assistance for the report.

ECSA and the MOH express appreciation to all of the respondents who supported the project by providing the valuable information, especially to the community health workers in the selected community units who participated in the group discussions.

This work was made possible by the generous support of the American people through the U.S. Agency for International Development (USAID). The contents of this report are the responsibility of project partners and do not necessarily reflect the views of USAID or the United States Government. Financial assistance was provided by USAID under the terms of GPO-A-00-08-00001-00, Program Research for Strengthening Services (PROGRESS).

TABLE OF CONTENTS

LIST OF ABBREVIATIONS AND ACRONYMS	**3**
EXECUTIVE SUMMARY	**4-5**
1.0 INTRODUCTION	**6-8**
1.1 BACKGROUND	
1.2 OBJECTIVES	
1.3 METHODOLOGY	
2.0 RATIONALE	**9-11**
3.0 FINDINGS: POLICIES, GUIDELINES AND STRATEGIES	**12-16**
3.1 Reproductive Health Policy	
3.2 Structure of Community Health Work in Lesotho	
3.3 Community Engagement and Participation	
4.0 ASSESSMENT SYNTHESIS	**17-20**
4.1 GENERAL BARRIERS TO FAMILY PLANNING	
4.2 OPERATIONAL BARRIERS TO EXPANDING ACCESS TO FP AT THE COMMUNITY LEVEL	
4.3 FACILITATING FACTORS AND OPPORTUNITIES	
5.0 CHWs SPEAK	**21-22**
6.0 RECOMMENDATIONS	**23-24**
Appendix 1. Key Informants and Focus Groups	**25**
Appendix 2. List of Persons Interviewed, Individual and Group Interviews	**26-29**
Endnotes	**30**

LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CBD	Community Based Distribution of Contraceptives
CBFP	Community Based Family Planning
CHAL	Christian Health Association of Lesotho
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
DHS	Demographic Health Survey
DFID	Department for International Development
ECSA-HC	East, Central and Southern Africa Health Community
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
FP	Family Planning
IUCD	Intra-uterine Contraceptive Device
LAPM	Long-acting and Permanent Methods
LPPA	Lesotho Planned Parenthood Federation
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MOHSW	Ministry of Health and Social Welfare
MP	Member of Parliament
PEPFAR	President's Emergency Plan for AIDS Relief
PNC	Postnatal Care
SWAp	Sector Wide Approach
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VHW	Village Health Worker
WHO	World Health Organization

EXECUTIVE SUMMARY

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, universal access to reproductive health, including family planning (FP). Emphasis on community access to FP has emerged as a major goal in sub-Saharan Africa specifically, most recently in the March 2010 meeting among 12 African nations at Kigali. At the Kigali meeting, participating countries reached consensus that community FP should be the priority strategy for expanding access to FP to address unmet need and accelerate progress toward the MDGs. This strategy resonates with earlier calls for action in the region, including the Maputo Plan of Action and the 2009 International Family Planning Conference held in Uganda.

The East, Central, and Southern African Health Community (ECSA-HC) has been working with its member states, including Lesotho, to address issues related to expanding access to family planning. ECSA led this assessment, using a desk review, key informant assessments, and focus group discussions. Similar assessments were conducted in four other ECSA member states (Kenya, Malawi, Uganda, and Zimbabwe).

In Lesotho, the key informant interviews were conducted in April 2011 with eight individuals and six focus groups (see Appendix 1). The interviews were conducted with Ministry of Health and Social Welfare (MOHSW) policy-makers and managers, professional health associations, regulatory boards and councils, community-based FP (CBFP) implementing agencies, donors, Members of Parliament, district level providers, and community health workers.

The Lesotho Reproductive Health policy recognizes community health workers (CHW) as key providers at the community and a link between the community and the health facility. Community participation in the planning, implementation, monitoring and evaluation of reproductive health is also important in the policy. Specific to family planning, the policy recognizes CHWs as providers of information and services to the community but does not spell out what type of services they are allowed to offer. The policy specifically mentions that it will, "Strengthen community-based distribution of family planning commodities."

Section 3 of this report provides more information on policies, guidelines, and strategies about community-based FP services. Section 4 synthesizes findings from the key informants and focus groups. Section 5 contains comments from the community health workers themselves. All of this information combined with the desk review led to the nine recommendations discussed in Section 6 and listed below:

1. Expand Community-based FP using existing CHW Networks.
2. Clarify the guidelines on CHW provision of FP services.
3. Use a simple checklist to rule out pregnancy.
4. Advocate for policy change
5. Harmonize Structure of CHWs.

6. Adopt the supervision model used by EGPAF.
7. Advocate for budget line item in the national health budget for contraceptive commodities.
8. Use a multi-pronged approach to information, education and communication.
9. Develop male involvement programs.

Both key informants and the CHWs themselves expressed concern about the issues listed here and had ideas about addressing them. This assessment shows that CBFP has clear benefits in improving access to family planning information and services. Therefore CBFP is a powerful tool for social transformation towards improved quality of life at the community level, including improvement in the contraceptive prevalence rate and the resulting impact on maternal and child health.

1.0 INTRODUCTION

1.1 Background

Expanding access to family planning (FP) at the community level is a priority strategy for accelerating progress toward achieving Millennium Development Goals (MDGs), particularly goal 5b, which emphasizes the universal access to reproductive health (RH), including FP services. Most of the populations in sub-Saharan Africa (SSA) live in rural communities, where the demographic determinants including health infrastructure, human resource, and financial support for health are very poor. The achievement of universal access to FP and RH services remains a major challenge. Expanding access of FP to the community has gained recognition as a promising practice for the majority of the populations in SSA, who live in the rural areas.

Expanding access to FP at the community level has been emphasized by resolutions from the East, Central and South African (ECSA) Health Minister's Conference of 2008 and 2009; from the 2010 FP conference in Kigali, Rwanda; the 2009 International FP Conference held in Kampala, Uganda; and the Maputo Plan of Action of 2006. The 12 African nations attending the 2010 Kigali meeting built a consensus to prioritize expanded FP access at the community level as a strategy for addressing the unmet need for FP and accelerating progress toward the MDGs.

Women in rural areas have a particularly high unmet need for FP services, especially during the postpartum period. A review of data from 27 Demographic and Health Surveys (DHS) found that 67 percent of women who gave birth within the previous year had an unmet need for family planning. One way to address this is by strengthening systems that can make FP services more available to the communities. Some approaches have worked successfully to address the critical shortage of medical professionals and to expand access to a range of health services, such as empowering cadres of health workers who have not undergone the regular medical training programmes to provide FP services at the community level. In this concept of skills transfer (known as task sharing or task shifting), which has been endorsed by WHO, providers with less medical or paramedical training can deliver some of the same services with the same quality as providers with more training.

The ECSA-Health Community has addressed issues related to expanding access to FP services at the community level. In 2008, the 46th ECSA Health Ministers Conference (HMC) adopted resolution HMC46/R4, which urged member states to allocate/increase financial resources for FP and to reduce unmet needs by 10% by 2010. The resolution also urged member states to develop and implement policies, guidelines, and training curricula on task shifting among health care providers by 2011 that allow mid-level cadres to carry out specifically identified activities that shift non/less technical duties from mid-level to lower-level cadre staff, such as community based distributors of contraceptives. In the same resolution the ECSA secretariat was directed to support countries to develop and implement policies and guidelines on task shifting among health care providers by 2010.

In 2009, the HMC in ECSA/HMC 48/R5 urged member states by December 2011 to advocate for increased political and financial commitment to FP, ensure the full integration of FP into national development plans and poverty reduction strategies, and develop costed implementation plans for sexual and reproductive health (SRH) services informed by the Maputo Plan of Action. It also called on the member states to develop country-specific policies and guidelines on task shifting by December 2012 for the delivery of SRH and FP services to ensure access to FP services for the poor, marginalized, and underserved communities. The resolution also directed the secretariat to support member states to develop and/or adopt advocacy, costing, and modeling tools; document and disseminate promising and best practices in FP with links to proven effective change practices; and assist member states to implement various international instruments such as the Maputo Plan of Action and the African charter on the rights of the woman. All signature countries to such documents are required to report against the indicators and targets in these documents.

To address these resolutions, ECSA-HC has conducted an assessment on policies, guidelines, and financing of expanding access to FP services at the community level in five member states (Kenya, Lesotho, Malawi, Uganda, and Zimbabwe) to determine the current status of these three areas, and to recommend the best way to implement a strategy to expand services. The assessments took place between November 2010 and April 2011. The Lesotho assessment was conducted in March 2011.

1.2 Objectives

The objectives of the assessment were:

- To describe the degree to which national level policy and service delivery guidelines/standards facilitate the provision of quality FP at the community level.
- To determine the level and modalities of funding of FP services in the region.
- To describe the challenges and opportunities in current community-level FP service delivery systems and how they could be improved to better serve the FP needs of underserved populations.
- To synthesize commonalities with regional application and identify opportunities for improved approaches to FP services at the community level, in order to inform the development of recommendations on country and regional priorities for the improvement of expanded services to FP programs.

1.3 Methodology

The report of each country's assessment includes material from two primary sources:

1) Desk review of related literature, including DHS data, policy documents, national guidelines, research studies, and program reports; and

2) Qualitative input from key informant interviews and focus group discussions. The interviews and focus group discussions followed interview guides.

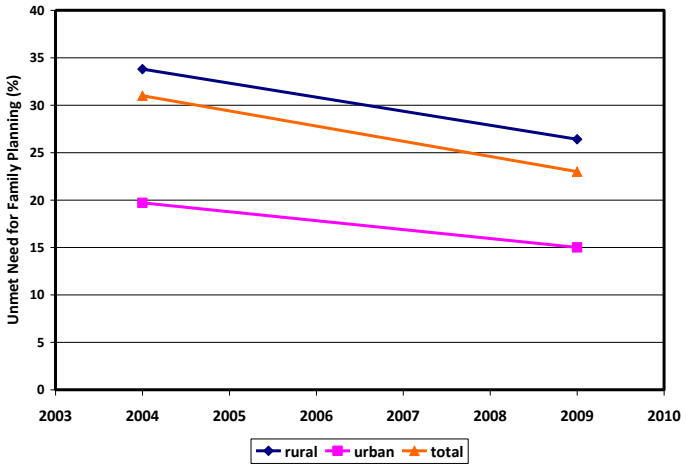
In Lesotho, the interviews and discussions were digitally recorded and notes taken by interviewers. Key informant interviews were conducted in eight interviews, and six focus group discussions were held with professional associations, district informants and implementing partners. The interviews and discussions were conducted with representatives of Ministry of Health and Social Welfare (MOHSW), professional associations, regulatory boards, implementing partners, donors, Members of Parliament (MP), district level providers and community health workers (see Appendices 1 and 2).

2.0 RATIONALE

Why Expand Access to Family Planning at the Community Level

Lesotho has a total population of 1.9 million with about a third under 15 years of age. The unmet need for family planning (FP) is 23.0% in Lesotho, still high but having decreased sharply since 2004 (see Figure 1).[1] Also, the urban rural divide is marked with the rural population reporting a considerably higher unmet need than the urban population.[2] Unintended pregnancy is very high in Lesotho (52%). An unintended pregnancy is a pregnancy reported as either wanted later or not at all.

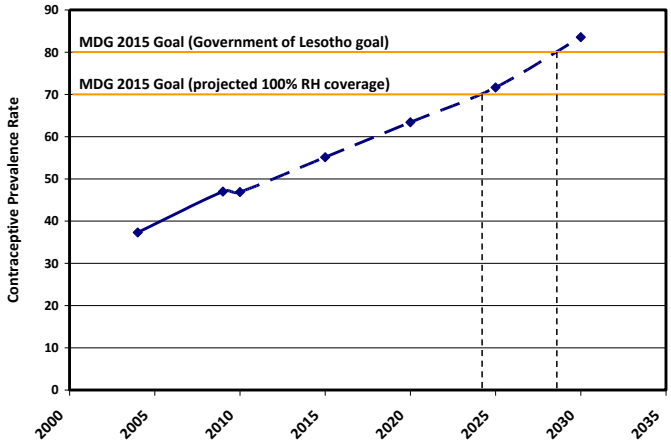
Figure 1: Trends in Unmet Need for Family Planning



If women who desired to space or limit births had access to FP, 25 to 35% of maternal deaths could be avoided, including abortion-related mortality. Lesotho's maternal mortality rate (MMR) has increased in recent years. The current rate is 530 deaths per 100,000 live births.[3] Increasing access to family planning services is a highly effective means of meeting the unmet need for family planning and thereby protecting the health and well-being of women and children.

The current contraceptive prevalence rate (CPR) for married women is by all women in Lesotho is 46%.[4] The use of contraceptive methods has increased substantially since 2004 and is predicted to continue increasing (see Figure 2).

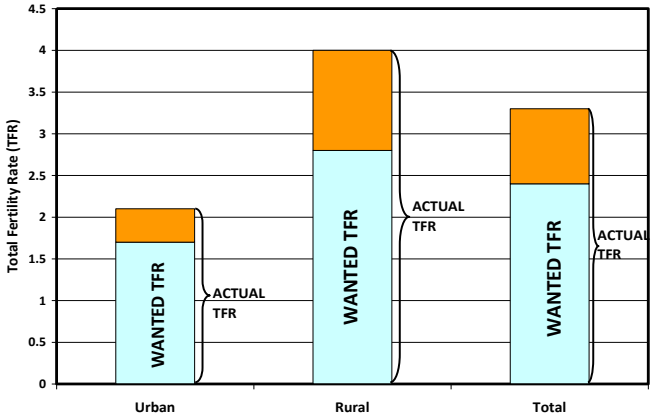
Figure 2: Trends in Contraceptive Prevalence Rate (Married Women, All Methods)



To achieve the Millennium Development Goal (MDG) for family planning by 2015, Lesotho's CPR needs to rise to about 70% (see Figure 2). The CPR would have to continue to rise (as in recent years) to reach the MDG target, even by 2025, which is 10 years after the target year. The data through 2009 come from the DHS; the dotted line for subsequent years comes from a recent modeling study.[5]

The total fertility rate (TFR) has decreased between the 1976 census (5.4) and 2009 (3.3), at the last DHS. The divide between the urban TFR (2.1) and the rural TFR (4.0) is large and demonstrates the geographic inequities of access to services. Additionally, the divide between wanted and actual TFR is higher in rural areas (1.2 rural vs. 0.4 urban) (see Figure 3).[6]

Figure 3: Total Fertility Rate, Wanted versus Actual, Lesotho 2009



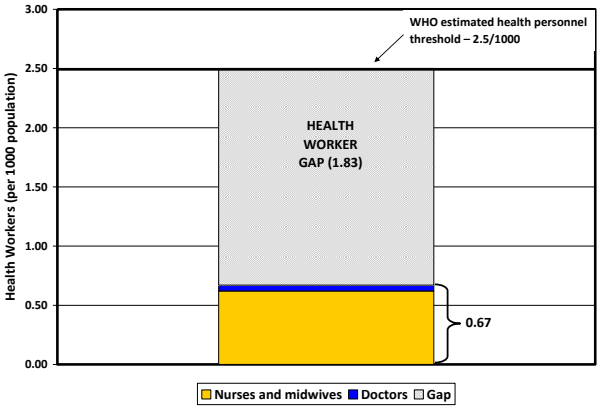
Nearly three fourths (73%) of women in Lesotho report at least one problem accessing health care with the most commonly reported reason being concern the drug would be unavailable (58%) and the second most commonly reported reason being getting money for treatment (33%). Having to take transport (32%) and the distance to a health facility (31%) were also reported as significant barriers to accessing care. Not surprisingly, rural

women are more likely to report problems in accessing health care especially citing concern the drug would be unavailable, the distance to a facility, having to take transport, and getting money for treatment as key issues.[7]

Most women in Lesotho access family planning from a public source (63%). Approximately two thirds of people (69%) access family planning from hospitals, health centers, or clinics while 11% of people access family planning from a pharmacy or shop. Only 1% of women access services from community based distributors or community health workers.[8]

The WHO recommends that the health workforce (doctors, nurses, and midwives) ratio be at least 2.5 health workers per 1000 population to make progress on global health goals like the MDGs. The ratio is Lesotho is 0.67 health workers per 1000 population, according to the latest data, well below the 2.5/1000 threshold (see Figure 4).

Figure 4: Lesotho Heath Work Force



The total health expenditure in Lesotho for 2007 (latest data available) is 97.9 million US dollars, amounting to US $47 per capita expenditures on health.[9] Notably, this is above the WHO Commission on Macroeconomics and Health recommendation of US $34 per capita.[10] The Government of Lesotho abolished user fees for basic health care services in 2008, leaving a very small portion of the health budget comes from user fees (3%).[11] The majority of health funding comes from donor support through a sector-wide approach (SWAp).[12]

Lesotho needs to build on its recent momentum in rising contraceptive prevalence rate and utilize its relatively high health expenditures to achieve higher contraceptive prevalence rates. This can help women achieve their own pregnancy goals and to help the country meet its MDG goals.

3.0 FINDINGS: POLICIES, STRATEGIES AND GUIDELINES

The main policy document that was available to the assessment team was the National Reproductive Health Policy (2009). The reproductive health guidelines are in the final stages of being drafted and should be launched soon. According to the respondents, the policies are developed by MOHSW in close collaboration and consultation with implementing and development partners. The process is usually funded by development partners.

3.1 Reproductive Health Policy

The RH policy recognizes community health workers (CHW) as key providers at the community and a link between the community and the health facility. Community participation in the planning, implementation, monitoring and evaluation of reproductive health is also important in the policy. Specific to family planning, the policy recognizes CHWs as providers of information and services to the community but does not spell out what type of services they are allowed to offer. The policy specifically mentions that it will, "Strengthen Community-Based Distribution of family planning commodities."

Currently, the practice is that CHWs can resupply clients with oral contraceptives and condoms but they cannot initiate the use of oral contraceptives. A woman has to go to a facility to start the use of the method and then get her resupplies from the community health worker. There was a feeling among some respondents that the available policies need to be reviewed to include clear guidelines on criteria for selection of CHWs and their roles and responsibilities. Some respondents also felt that there is need to standardize the incentives given to CHWs regardless of who supports or trains them.

An Adolescent Health Policy acknowledges peer educators as an important strategy to reach youth with information. The MOHSW has established youth corners at 24 health facilities; this is assisting in providing services to the youth seeking services at these facilities including FP services. This is a good strategy but is yet to be expanded to majority of facilities in the country. (There are 22 hospitals and 170 health centers in the country.) Unfortunately, only 18 of these youth corners are active as some have been converted into ART centers with the scaling up of HIV and AIDS treatment and care. For the rest of the country, it was reported that reproductive health services to adolescents are limited to promotion of abstinence but in reality many young people are having sex before marriage and having adverse events of unprotected sex including unintended pregnancies and sexually transmitted infections. Teenage pregnancy was reported to be at about 40%. Peer educators provide information and in some instances condoms to their peers. Other than the adolescent health policy, there are no written guidelines for the provision of reproductive health services to young people and providers are therefore left to follow their own discretion in providing RH services to youth.

Since the inception of free health service policy in 2008 at the community and health centre levels, CHWs no longer charge for the commodities they provide to community members. Previously, they had charged clients for the commodities and would retain a

portion of the proceeds. As a result of this change in policy, the MOHSW has started paying village health workers (VHW) Maluti 300 (about US$ 42) per month to motivate them to continue to work. However, this payment has not taken effect across the country as reported by VHWs in Butha-Bothe District and some of the respondent at the central level. In areas where payment has commenced, it is usually delayed for several months. Most respondents were concern that this arrangement may not be sustainable in the long run, given the large number of VHWs and CHWs as a whole. The MOHSW's intention is to pay all CHWs regardless of who has trained them or who they are working with. They are therefore in the process of compiling a directory of all the trained CHWs to be able to include them on the incentive list.

3.2 Structure of Community Health Work in Lesotho

Lesotho started using CHWs in the early 1960s through Christian Health Association of Lesotho (CHAL) as lay people to provide anti-TB drugs and collecting sputum from TB patients for testing in hard to reach communities using horses. In the 1970s, at Sakhulu health centre in one of the districts, a service provider realized that many women were coming to the health facility for ANC and yet very few delivered at the facility. The service provider then decided to use community members to trace and encourage women to go to the facility to deliver. In 1984, UNICEF through CHAL found that the VHWs were the same as TBAs and decided to change the term to CHWs.

VHWs are volunteers selected by the community after several mobilization meetings with community members conducted by the public health nurse from the nearest health facility. There is no specific strategy on community health work in Lesotho. The main cadre of CHWs in Lesotho involved in provision of information and services on family planning are VHWs and CBD agents (in some villages this is one and the same person). Other cadres include youth peer educators, care facilitators and health surveillance assistants. These cadres do not provide FP information or services but some provide condoms for HIV infection prevention.

Village Health Workers. Currently, Lesotho has a network of about 6000 village health workers (VHW) spread all over the 10 districts in the country. Some VHWs double up as CBD agents and provide FP services. However, the CBD agents under Lesotho Planned Parenthood Association (LPPA) are limited to providing FP services only. The VHWs mainly work in the rural areas and are attached to the nearest health centre. To be a VHW in Lesotho one has to meet the following criteria:

- Aged between 25-60 years
- A resident of the village and not planning to move out
- Available to be a CHW
- Physically fit (some of villages are very mountainous)
- A non-alcoholic
- Able to read and write
- Married

The VHWs provide various services to the community including:

- Home visits
- Encourage women to go for ANC and PNC services
- Encourage community members to seek health services including FP
- Growth monitoring for children under five years
- Encouraging good sanitation in the village
- Health education
- Some provide adherence counseling and defaulter tracking
- Undertakes nutrition counseling
- Counsels and refers potential clients to the facility for initiation of FP services
- Some provide immunization services to children but most encourage mothers to take children for immunization
- Some resupply oral contraceptives and condoms
- Keep records and submit monthly reports to the health facility

Some VHWs are also trained as CBD agents with the responsibility of educating the community on family planning issues; send potential clients to the facility to be examined and given their method of choice; and give resupply of oral contraceptives and condoms. They use a checklist to ascertain if the woman is doing well on the oral contraceptives before resupplying.

Community-Based Distributors. The CBD agents in Lesotho are also volunteers under LPPA or Christian Health Association of Lesotho (CHAL). A CBD agent goes door-to-door providing services to clients. They are expected to distribute contraceptives and provide FP education and counseling. The distribution of contraceptives is limited to resupply of pills and condoms. The criteria for and process of selection of a CBD agent is the same as that for a VHW.

The roles and responsibilities of a CBD agent include:

- Home visits
- Provision of FP information to community members
- Counseling on FP and referral of potential clients to the health facility for further counseling and initiation of methods
- Resupply of pills and condoms
- Referral of FP clients to health facilities for methods they cannot provide
- Creating awareness at public gatherings on FP
- Record keeping and reporting on monthly activities to the nearest health facility

The CBD agent's area of operation is a village with number of households ranging from 20 in the highlands to 200 in the lowlands. The number of VHWs or CBDs per village depends on the size of the village but ranges from 1-3 per village. MOHSW wants to train more VHWs to be CBD agents but this process has been slowed down by lack of funds.

Training and Supervision. VHWs are trained for two weeks at their reporting health centre by nurses and/or members of the district health management team (DHMT) at the facility. They are trained on PHC activities including how to counsel and refer for FP services, recording keeping and reporting, and how to create awareness and educate community on various PHC issues. Respondents felt that there is quite a bit of fragmentation of VHWs as each partner works with and gives incentives as they please. There is no regulation of incentives and how to work with VHWs. This sometimes leads to high attrition rates as VHWs looks for a better rewarding partner to work with.

They report to a nurse at the nearest health facility to submit reports and get resupply of commodities. According to most respondents, the supervision process is inadequate because the nurses are unable to visit the VHWs at their work locations but rely on the reports the VHW provides. It is therefore difficult to ascertain and guide the VHW based on practical performance and consequently quality of services provided may be affected. Updates for VHWs and CBDs are also hampered due to inadequate financial resources.

EGPAF works with MOHSW trained VHWs and give them extra training in line with the activities they want them to undertake at the community level. EGPAF then appoints one of the trained VHWs to be a focal person who has the added responsibility of linking the VHWs in his/her catchment area with the district community coordinator. A catchment area is composed of the villages around a health facility. A district community coordinator working with EGPAF trains and updates the VHWs on the job and supports their operation on the ground. Since the coordinator has a motorcycle, he/she is able to meet with the VHWs individually or as a group within a catchment area on a monthly basis and support them. This is a more effective supervision arrangement than the general MOHSW one. EGPAF pays their VHWs an extra monthly stipend regardless of the MOHSW's monthly allowance to them. This makes it quite lucrative to work for EGPAF as a VHW.

3.3 Community Engagement and Participation

There seemed to be little involvement of the community in health generally. Respondents felt that communities can be involved in health activities in their communities in various ways including:

- Advocacy for FP at the community level especially among mothers-in-laws and husbands who are the key gate keepers and decision makers on FP use among women
- Being members of the community council where health issues are discussed
- Supporting the work of CBDs and/or VHWs in their community
- Supporting outreach services through provision of unavailable equipment and supplies e.g. couches for medical examination,
- Providing transport to the outreach team so they can make frequent and regular outreach visits to their communities.

Respondents said that communities need to be empowered to demand for services so that they are not passive recipients of whatever services they are given. Community education is of paramount importance especially in the rural areas where media exposure is low.

The MOHSW has started a process of decentralization of the health system and is empowering communities to take responsibility for their own health through participating in the decision-making process in their community and nearest health center. The parliamentarians interviewed felt that as community members they need to be equipped to be able to educate their constituents on the importance of FP.

With the support from the German Technical Cooperation (GTZ), MOHSW has started a new project on health system decentralization to empower local councils to manage health matters at their level instead of relying on the center to make decisions and implement on their behalf. One of the first areas to be decentralized is primary health care under which CHWs operate. The process will also result in the establishment and/or strengthening of District Health Management Teams (DHMT) to be fully responsible for health matters at the district level. Some DHMTs have already been formed.

4.0 ASSESSMENT SYNTHESIS FINDINGS

This section synthesizes information obtained during the key informant interviews and focus group discussions. The material is grouped according to general barriers to family planning that arose, barriers specific to CBFP programs, and facilitating factors and opportunities.

4.1 General Barriers to Family Planning

Poor Road Infrastructure. Lesotho is generally a mountainous country with a scanty road network. Accessibility to several rural areas is therefore curtailed especially during winter and rainy seasons. All respondents agreed that this makes it difficult for women to access FP services when they need to.

Decentralization Process. This sometimes acts as a barrier to FP as partners may not know who to contact for specific issues. The decentralization process is at its initial stages and sometimes causes confusion and delay in implementation of activities both at the central and district level.

Training and Updating of Service providers including CHWs. Due to lack of funding, training and updates for service providers are also hampered thus some facilities have providers who can only provide a limited range of contraceptive methods even though the facility infrastructure enables the provision of more methods. Grossly affected are long-acting and permanent (LAPM) methods especially IUCDs and implants which are mainly provided by nurses.

Policy. CHWs are not allowed to initiate a client of oral contraceptives but experience from other countries show that they can safely initiate and effectively support clients on oral contraceptives and injectables without any higher risk of adverse events than those clients served by clinic based providers.

Flow of Information among partners, associations and regulators. Some respondents were not aware that CHW provide oral contraceptives and condoms at the community level. They thought they only provide information and refer to facilities for services. Most of the respondents were not aware that some implementing partners have already trained CHWs to provide immunization services at the community level and such there is experience in the country with injections at the community level.

Myths and rumors. Respondents mentioned that there were myths and rumors that affect negatively the use of FP among community members. Some of the rumors included: women who use contraceptives become promiscuous;

Contraceptive Method Mix. The method mix is skewed toward short-acting methods with the most popular method being the injectables, pills and condoms. The use of implants in increasing steadily but is still very low. The main reasons given for the low level of use of long acting and permanent methods (LAPM) included inadequate skills

among service providers; lack of essential equipment and supplies for provision of LAPMs; and high work load at health facilities and outreach services. Due to the high HIV infection rates there is a push towards the use of condoms for dual protection especially among the youth. This has led to the high percentage of use of this method in the method mix. The use of vasectomy in the population is practically non-existent. Men would not allow themselves to undergo vasectomy but very few can allow their wives to undergo tubal ligation.

Contraceptive Security. All contraceptive commodities are procured through bilateral and multi-lateral support. There is need to undertake advocacy activities among members of the Parliamentarian Social Cluster Portfolio Committee to lobby for funds allocation for reproductive health commodities in the national budget. They would in turn put pressure on the Ministry of Finance and budget officers to allocate funds for this purpose in the health budget.

Socio-cultural Issues. Men and mothers in-law were cited as the gate-keepers to health interventions affecting women at the community level. Most respondents felt that men especially husbands were generally left out of reproductive health services both on the program and the client side. They suggested greater involvement of men in delivery of services and as users. They also felt that CHWs and a strengthen mass media can assist in educating this category of community members on the importance birth spacing for the health of mother and child and adolescent reproductive health. This would also mitigate myths and rumors about FP in the communities.

Some respondents felt that traditionally the Basotho would like to have many children especially among the men and mothers in-law. Closely linked to this is the search for sons which greatly impedes the use of FP methods.

4.2 Operational Barriers to Expanding Access to Family Planning at the Community Level

Limited CHW coverage for FP. There is a large network of CHWs in Lesotho that are not being utilized to provide information and services on FP. Only a few VHWs and the limited number of CBD agents provide FP information and services to communities. This is in spite of inaccessible rural villages and facilities, few health facilities and high provider workload at the facilities.

Policy-level Barriers. The unwritten policy is that CHWs can only provide condoms and resupply pills. This curtails accessibility to women who would like to use pills but cannot access a health facility to initiate use of the method for various reasons already mentioned previously.

Resistance to Provision of some FP methods by CHWs. Some professional associations and regulatory bodies emphatically opposed the initiation of pills and provision of injectables by CHWs. The main reasons cited included not being able to regulate the service provision at the community level; inadequate training of CHWs; and

CHWs not being health professionals. Some respondents felt that instead of strengthening the skills of CHWs to provide FP services at the community level MOHSW should train nursing assistants to provide these services and supervise CHWs. However, when asked how the nursing assistants would access hard to reach communities they were not able to give any suggestions. Some felt strongly that CHWs should not even give pill resupplies let alone provide injectables with the suggestion that may be this will be realized after a decade of lobbying as the country is not yet ready for such a move. A number of the respondents who took this stand knew that evidence from other countries show CHWs can provide these methods at the community level safely and effectively.

Inadequate training and supervision. CHWs receive an initial two week training that may be inadequate for initiation and provision of methods like oral contraceptives and provision of injectables. There is need for more training and real-life experience under the supervision of trainers before CHWs are released into the community to provide services on their own. There are also no funds to conduct update training and supervise CHWs at the community level. This may affect the quality of services offered to women at the facility level.

Retention of CHWs. There is a high turnover CHWs. The main reasons given for the high turnover include: lack or low level of incentives; search for greener pastures and competition of payments of CHWs by various implementing partners over and above the monthly stipend from the MOHSW.

4.3 Facilitating Factors and Opportunities for Community-based Family Planning

Wide Network of CHW and Availability of Checklist to Rule out Pregnancy. Lesotho is a small country with a wide network of various cadres of CHWs. If all the VHWs, peer educators, health surveillance assistants and care facilitators are trained to provide FP information and pills and condoms, access will be greatly increased. In addition, VHWs and CBDs who are already resupplying clients with oral contraceptives and condoms can be trained further with the use of a simple checklist to rule out pregnancy so that they are able to initiate pill use at the community level. The checklist is available internationally and can be introduced in the country for use at the clinic and community levels.

Retrain Lower Cadre of Nurses - Nursing Assistants. Conduct in-service training for nursing assistants to provide FP services and supervise CHWs at the community level. This is a certificate level nurse who assists the nurses in the work at the health centre level. A health centre staffing is composed of a nurse clinician (degree level), nursing sister (diploma level) and a nursing assistant (certificate level). It was felt by some the professional associations that nursing assistants are less busy at the facility and can take on an extra role of providing FP services and supervising CHWs.

Poor Road Network. The rough terrain and poor road network necessitates that the country strengthen community based distribution of services if they want to make steps toward meeting their MDG goal of increasing CPR to 70% by 2015. This strategy is more

economically viable than training and deploying more nurses to facilities for outreach and clinic based services given the high brain-drain of nurses the country is experiencing.

HIV Programs Want to Integrate FP into their Activities. Implementing partners like EGPAF who have primarily concentrated on HIV/AIDS activities now appreciate the importance of integrating FP in their activities. This is a great opportunity for the MOHSW to train the large number of VHWs working under EGPAF to provide FP information and services to their clients and/or patients. EGPAF is the main PEPFAR partner in the country undertaking HIV clinical and community services.

Some VHWs are Already Providing Immunization Services at the Community Level. The provision of injectables by CHWs will not be a totally new intervention as some CHWs already provide immunization services for children at the community level. Learning from the experience of those already providing injection services through immunization in the community will facilitate the introduction of provision of injectables by CHWs.

5.0 In Their Own Words: CHWs Speak

As part of the assessment, 21 (one male and 20 women) VHWs in Botha-Buthe District participated in a group discussion. All the VHWs also doubled up as CBDAs but they were not actively distributing FP commodities. Though they provide information and refer clients for services. In addition, one CBDA (male) was interviewed briefly during the LPPA interview. The team interacted with only two male CHWs during this assessment. The summary below is as close to their words as possible, given the fact that these responses were translated from Basuthu, and that the remarks by individuals have been merged into one response for each question.

How do you view your role as Community Health Workers?

We provide first aid to sick or injured community members before taking them to the health facility for further care and treatment. We are the door way to the community on health matters and it is through us that the community accepts sensitive health services such as HIV testing. This is because we create awareness in the community on these issues. We also support chronically ill patients in the village e.g. TB and HIV/AIDS patients.

Community members appreciate the work we do because they come to seek services even at night from us. They consult us on health matters that they are not clear to them after coming from the health facility e.g. how to take the prescribed drugs. We are given opportunity to address public gatherings on health issues. When our drug kit is replenished they bring their children in large numbers to us for growth monitoring

What motivates you to be a Community Health Worker?

We like being CHWs because the community accesses health services through us and it is the community that chose us to serve them – it is honoring. We are motivated to continue serving as CHWs because we received a special training; we love to serve our community; we see positive behavior change in community health status and health seeking behavior; and we know that we are trusted and respected by the villagers. They share with us intimate medical issues such as HIV status.

How do you think the community can be more involved in delivering health services to women, men, and families?

Communities should not hide any health issues that emerge or exist in the village but openly come out and have their issues addressed. Men should be more involved in supporting the services especially accompanying their partners to facilities for reproductive health services.

What do you think about the training and supervision you received?

We received adequate training in primary health care including FP but we need more frequent training updates to stay informed. However, we lack skills on how to respond during emergency deliveries and how to handle adolescent reproductive health. We are currently not given any FP commodities yet villagers need them. We have to refer for all clients for FP commodities to the facilities.

We appreciate when we are supervised as it provides an opportunity to know if we are doing the right thing and also learn new things but currently we do not receive any supervision. (The DHMT was in the process of organizing monthly supervisions visits to all VHWs in the district).

What are some of the challenges of being a community health worker?

We sometimes experience drug stock-outs in the drug kits and this can be de-motivating patients coming to seek services from us. We also lack basic supplies such as gloves to provide services to the sick.

Male involvement is inadequate in both service delivery and as users of health services especially with regard to use of reproductive health services. If men were more involved as service providers they would talk to fellow men to convince them to support FP as they are traditionally opposed to the use of FP. The local administration support and involvement in reproductive health issues is also lacking.

The level of poverty in the village is high and sometimes we have to provide financial support to transport patients to the health facility. We are few VHWs and the work load is high, all the villagers come to us for services; sometimes we do not sleep as we are consulted at any time and we have to accompany patients, especially pregnant women who are about to deliver to the health facility at night. We are usually called upon to be birth attendants even though we are not trained.

We are not allowed to be involved in work-for-pay because we are VHWs and we are therefore forced to rely on our partners and/or older children for financial support. We do not receive any compensation for our work. We are not able to address youth RH issues because we are older and we should have younger people recruited as VHWs to reach fellow youth with services.

6.0 RECOMMENDATIONS

6.1 ***Expand Community-based FP using existing CHW Networks.*** The MOHSW can enlist the support of LPPA and CHAL who have a long history working with CHWs in FP to train CHWs who have not yet been trained in provision of FP information and/or services. This will increase access to women who find it difficult to access services at the facility level especially in winter and rainy seasons. This will also increase knowledge of FP and reduce unmet need of FP among women. It may also reduce opposition of FP use FP use by mothers-in-law and husbands.

6.2 ***Clarify the guidelines on CHW provision of FP services.*** The level of services CHWs are allowed to provide with regard to FP need to be spelt out clearly. It is not clear currently if this has been addressed in the RH service delivery guidelines that have been drafted and awaiting final approval. If the services CHWs are supposed to offer are spelt out clearly and disseminated to everybody in the health care system, doubts as to what is allowed and not allowed will be erased.

6.3 ***Use a simple checklist to rule out pregnancy.*** Simple checklists have been used successfully in other countries in the region to reasonably rule out pregnancy in non-menstruating women who want a method of contraception. Without a checklist a large proportion of women are denied methods of their choice because they are not menstruating. This affects both CHWs and clinic-based FP clients. This can be eliminated by introducing a simple checklist to rule out pregnancy for both clinic- and community based providers. It would also enable VHWs and CBDs to initiate pill use among their clients.

6.4 ***Advocate for policy change*** to allow lower cadre FP providers especially at the community level to offer services that available evidence show can be offered effectively and without any risk to clients. This will ease the burden at the facilities and give providers more time to provide other contraceptive methods and other services that only they can provide. The services that can be provided by CHWs include initiation of oral contraceptives and provision of injectables.

6.5 ***Harmonize Structure of CHWs.*** MOHSW needs to develop/review and disseminate guidelines spelling out clearly what services CHWs can offer. This will leave no doubt within the MOHSW and partners about the type of services CHWs can offer and address the confusion currently reigning on what services CHWs are allowed to offer.

There is also need to harmonize the incentives given so that CHWs do not seek to work with the most lucratively paying partners within the same village or look for better paying jobs. This will increase the retention rate of CHWs. It is great that the MOHSW has undertaken to pay VHWs registered with them regardless of who has trained and is working with them. This should be extended to other CHWs categories such as youth peer educators.

6.6 ***Adopt the supervision model used by EGPAF.*** MOHSW can solicit technical assistance from EGPAF and other partners to adopt the supervision and on-the-job training model used by EGPAF from the district to the community level. It can be modified to suit the large number of VHWs MOHSW manages. This will ensure the services provided by VHWs are of quality and VHWs are paid their stipend in good time.

6.7 ***Advocate for budget line item in the national health budget for contraceptive commodities.*** The parliamentary structure in the country facilitates lobbying for inclusion of reproductive health commodities in the national health budget. There is an existing Social Cluster Portfolio Committee that has the mandate of working with the MOHSW to ensure activities budgeted for are implemented. They requested to be educated on the importance of FP in the country's economic development and for the health of women and children. This will enable them to lobby for inclusion of a line item on RH commodity procurement in the national health budget. Additionally, they will be able to educate their constituents on the importance of birth spacing for the well being of mother and child.

6.8 ***Use a multi-pronged approach to information, education and communication.*** The knowledge of contraception for both men and women continues to be higher than the use level. This gap can be narrowed with continued and intense IEC activities both in urban and rural areas utilizing multi-pronged channels of communication. This could also mitigate rumors and myths on FP especially in rural areas and may be change the attitudes of husbands and mothers in-law towards FP. Specific messages targeted at changing the attitudes of mothers in-law, men and cultural leaders should be developed.

6.9 ***Develop male involvement programs.*** Men are the main decision makers in Basotho land. If the unmet need for FP is to be reduced, they need to be involved in programs both on the supply and demand side of reproductive health services. More men need to be involved as CHWs and encouraged to use reproductive health services. MOHSW and partners need to develop strategies of reaching men especially in the rural areas to participate in FP.

Appendix 1

Key Informant Interviews

Group Type	Data Collection Method	Number conducted
Ministry of Health & Social Welfare	Interview	1
Donors/Implementing Partners	Interview	4
Professional Associations	Interview	2
Regulatory Board	Interview	1
Total		**8**

Focus Group Discussions

Group Type	Data Collection Method	Number conducted
Ministry of Health & Social Welfare	Group discussion	1
Implementing Partners	Group discussion	2
Community Health Workers, Butha-Bothe District Hospital	Group discussion	1
Parliamentarians	Group discussion	1
DHMT, Butha-Bothe	Group discussion	1
Total		**6**

Appendix 2

List of Persons Interviewed, Individual and Group Interviews

	Organisation	Names	
	Ministry of Health and Social Welfare		
1		Dr. L. Budiaki Director, Primary Health Care	
2		Dr. M.C. Pherson Director, Curative services & Chairperson Lesotho Medical Association	
3		Mansebo Moji Chief Nursing Officer	
4		Khasiane Kabi Disease control officer	
5		Mangose Sithole Family Planning Officer	
6		Maleshoane Monthu-Seiisho Principal Nursing Officer Queen Elizabeth II Hospital & President ECSACON	
7		Machaka 'Mabahoko Kikine MCH officer Queen Elizabeth II Hospital	
8		Cecilia Khachane Community Based Programme Officer	
9		Konosoang Nkuatsana Adolescent Health Programme Officer	
10		Florence Mohai Director, Family Health	Assessment Team member
11		Motsoanku Mefane Reproductive Health Officer	Assessment Team member
	WHO - Lesotho		
12		Dr. Jacob Mufunda Country Representative	mufundaj@ls.afro.who.int
13		Mrs. Montsane Bolepo Family Health Advisor	
	Lesotho Nursing Council		
14		Mrs. Flavia Moetsana –	

		Poka Registrar	
15		Mrs. Emelina Raseleso Chairperson	
16		Mrs. Doreen Mapetda	
	Elizabeth Glaser Pediatric AIDS Foundation		
17		Dr. Leo Buhendwa Country Director	lbuhendwa@pedaids.org
18		A. Isavwa Performance Improvement & Health Systems Strengthening Director	tisavwa@pedaids.org
19		M. Nyabela Nutrition Advisor	mnyabela@pedaids.org
20		M. Khang M & E officer	mkhang@pedaids.org
21		M. Nei Family & Community Outreach Advisor	mnei@pedaids.org
22		M.Foso MNCH Programme Officer	mfoso@pedaids.org
23		P. Tsokeli M & E Advisor	ptsokeli@pedaids.org
24		Allan Ahimbisibwe PMTCT,Care & Treatment Advisor	aallan@pedaids.org
	Lesotho Nursing Association		
25		Makholu Lebaka President	nlebaka@yahoo.co.uk
26		Mammnuku Mokebisa Member, LNA	nukokamwe@yahoo.com
	Christian Health Association of Lesotho		
27		Anna M. Ntholi Executive Secretary	
28		Agnes Lephoto HIV/AIDS Coordinator	
	German Development Cooperation (GTZ)		
29		Martin Mayer Programme Coordinator	Martin.mayer@giz.de
30		Lifuo Molapo Sector Decentralization Advisor	lifuo.molapo@giz.de
	Lesotho Planned Parenthood Association		
31		Mrs. Makatleho Mphana Program Director	mmphana@lppayrc.org.ls

32		Malereko Mokuoane YCR Manager	ntha@lppayrc.org.ls
	Parliamentarians - Social Cluster Portfolio Committee		
33		Hon. Mabetha T. Chairman of the committee	Mohale's Hoek
34		Hon. P. Leteetee Member	Qhalasi constituency
35		Hon. K. Diholo Member	'Maletsunyane constituency
36		Hon.N.Selepe Member	Matalile constituency
37		Hon. S. Demane Member	Ketane Constituency
38		Hon. L. Mokhanoi Member	Litoteng constituency
39		Hon. M. Chaule Member	Maseru central constituency
40		Hon. T. Kholoane Member	Thaba constituency
41		Mrs. M. L Lehonla SCPC Coordinator	
	UNFPA -Lesotho		
42		Dr. L. D Marutle Country representative	marutle@unfpa.org
43		Dr. Thabelo Ramatlapeng RH Advisor	ramatlapeng@unfpa.org
44		Ms. Mamorao Khabana HIV Prevention and Gender Advisor	khaelana@unfpa.org
45		Nestor Owomuhangi International Programme Specialist	owomuhangi@unfpa.org
	UNICEF - Lesotho		
46		Dr. Victor Ankrah Chief, Child Survival & Development	vankrah@unicef.org
47		Blandinah Motaung PMTCT Health Officer	bmotaung@unicef.org
	Village Health Workers, Botha-Bothe District		
48		Mats'oenyane Lerole	
49		Mathoma Mngomegulu	
50		Malephoi Maduma	
51		Momokoena Mathlane	
52		Mantale Phooko	
53		Masephara Marobe	

54		Mathithiboea Mochabelele	
55		Malibuseng Tsilonyane	
56		Mammohli Tsilonyane	
57		Mahalieo Sequala	
58		Mamoruti Mohlorumo	
59		Mathabo Chabalala	
60		Manchakha Tsosane	
61		Mentatutli Masiu	
62		Matheakoema Lehlabophi	
63		Mameflalepuka Sehlala	
64		Mathaha Constane Lesela	
65		Mamabusane Letsolo	
66		Mamosinoa Letata	
67		Ma'makiso Machenene	
68		Mapusetso Morobele	
	Botha- Bothe District - Health Management Team		
69		Dr. Anthony Chuyuna Acting, District Medical Officer	
70		Tse'po Selebalo District Public Health Nurse	
71		Likabelo Moketeu MCH Nurse in-charge	
72		Mamapolesa Qoliso District Pharmacist	
73		Paballo Mahumo MCH/FP nurse	
74		Nthabiseng Kopo Senior Nurse Officer	

Endnotes

[1] Lesotho DHS 2009
[2] Lesotho DHS 2004, 2009
[3] WHO, UNICEF, UNFPA, The World Bank. *Trends in Maternal Mortality: 1990-2008*. (Geneva, Switzerland 2010). Available: *http://whqlibdoc.who.int/publications/2010/9789241500265_eng.pdf*
[4] Lesotho DHS 2009
[5] DHS data and Moreland S, Smith E, Sharma S. *World Population Prospects and Unmet Need for Family Planning*. April 2010. Futures Group, Washington, D.C. Available from: http://www.futuresgroup.com/wp-content/uploads/2010/04/World-Population-Prospects-and-Unmet-Need-for-Family-Planning.pdf
[6] Lesotho DHS 2009
[7] Lesotho DHS 2009
[8] Lesotho DHS 2009
[9] http://data.worldbank.org/indicator/
[10] http://www.who.int/macrohealth/events/en/cmh_rprt_overview_afro.pdf
[11] Witter S. Mapping user fees for health care in high-mortality countries: evidence from a recent survey. Sept. 2010. HLSP Insititue. Available from: http://www.hlsp.org/LinkClick.aspx?fileticket=BmlwPoRonho%3D&tabid=1570
[12] http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2010/07/14/000333037_20100714003218/Rendered/PDF/ICR14270Box0341FICIAL0USE0ONLY01091.pdf

USAID
FROM THE AMERICAN PEOPLE

fhi360
THE SCIENCE OF IMPROVING LIVES

PROGRESS
IN FAMILY PLANNING