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ISN = 54602

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Centers for Disease Control

Memorandum

PD-AAX-294

Date · August 17, 1984

From Jack L. Graves, M.P.H., Chief, Program Services Section (PSS), Program Evaluation Branch (PEB), Division of Reproductive Health (DRH), Center for Health Promotion and Education (CHPE)

Subject Foreign Trip Report (AID/RSSA): Lesotho, July 18-31, 1984

To James O. Mason, M.D., Dr.P.H.
Director, Centers for Disease Control
Through: Director, CHPE DDT

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SUMMARY

One purpose of this trip was to prepare a scope of work for the evaluation of family planning service delivery. This is included as Attachment B to this report. Also, as part of this task, preliminary investigations of the provision of technical assistance on logistics and service statistics were conducted. The other purpose was to conduct a needs assessment for training in logistics to be conducted by CDC and the Eastern and Southern Africa Management Institute; the results of the task will be reported separately.

I. PLACES, DATES, AND PURPOSE OF TRAVEL

Maseru and Mafeteng, Lesotho, July 18-31, 1984—There were two purposes for this trip. One purpose was to conduct a needs assessment for training in logistics in cooperation with Dr. James Katorobo of the Eastern and Southern Africa Management Institute (ESAMI) in Arusha, Tanzania; activities on this task are covered in a separate report. The other purpose was to prepare a scope of work for an evaluation of family planning service delivery; this report covers the second activity.

The trip was at the request of USAID/Maseru, AID/ST/POP/CPSD and the AID/Regional Economic Development Services Office/Eastern and Southern Africa (REDSO/ESA) in Nairobi, Kenya. It was in compliance with the Resource Support Services Agreement (RSSA) between AID/ST/POP and CDC/CHPE/DRH.

II. PRINCIPAL CONTACTS

A. USAID/Maseru
1. Edna A. Boorady, Mission Director
2. Thomas Friedkin, Deputy Mission Director
3. Dean Bernius, Program Officer
4. John Nelson, CCCD Project
5. Sandy Tebben-Buffington, Nurse Clinician Training Project

B. World Health Organization (WHO)
1. Dr. Quappe, Team Leader

C. United Nations Fund for Population Activities (UNFPA)
1. Ms. Puleng Luboela, Program Assistant

D. Lesotho Planned Parenthood Association (LPPA)
1. Ms. Azu, IPPF Regional Coordinator
2. Ms. Eunice Makhalemele, Supplies Officer
3. Ms. Limakatso Mokhothu, IEC Program Officer

E. Private Health Association of Lesotho (PHAL)
1. Mr. Thabo Makara, Executive Secretary

F. Kingdom of Lesotho, Ministry of Health (MOH)
1. Ms. R. M. Malibo, MCH/FP Coordinator
2. Mr. Dan Thakisi, Chief Statistician
3. Dr. Deborah Raditapole, Managing Director, Lesotho Dispensary Association/National Drug Stockpile Organization (LDA/NDSO)
4. Ms. M. Bokanyo, Manager, NDSO
5. Mr. Mapetla, Quality Control, LDA

III. FAMILY PLANNING SERVICE DELIVERY EVALUATION

A. Background

In February 1984, Barbara Kennedy and Carolyn Barnes, REDSO/ESA conducted an overview of the Family Planning Program in Lesotho. The results of their visit were reported May 9, 1984, and the summary of that report is attached (see Attachment A). The full report is available in the DRH/PEB/PSS office.

Among the recommendations contained in the Kennedy-Barnes report is that the MCH/FP service program undergo an evaluation. CDC/CHPE/DRH/PEB was contacted by AID/ST/POP/CPSD with a request that a CDC consultant travel to Lesotho to prepare a scope of work for the evaluation.

B. Scope of Work and Proposed Schedule

Upon arrival in Maseru, I met with Dean Bernius to discuss the assigned task. Mr. Bernius gave me a copy of the Kennedy-Barnes report and other documents relative to family planning in Lesotho. He also arranged appointments for me to contact officials of the different agencies that provide family planning

services. After interviewing the officials and reviewing the documentation, I prepared a preliminary report and scope of work for the evaluation (see Attachment B).

On July 30, 1984, the scope of work was presented to a meeting at the Ministry of Health (MOH) which was attended by the following:

Mokuba P. Petlane	Chief Health Educator	OH/HEU
R. M. Malibo	MCH/FP Coordinator	MOH/MCH/FP
M. Liphoso	Health Planner	MOH/HPSU
E. N. Makhalemele	Supplies Officer	L.P.P.A. No.
Limakatso Mokhothu	Program Officer	MOH
	Information Education	L.P.P.A. No.
P. Leboela	UNFPA Program Assistant	UNDP/UNFPA
N. T. Borotho	Health Planner	MOH
Dean Bernius	Program Officer	USAID
S. Mohapeloa	Health Planner	MOH/PSU
D. Thakhisi	Statistician	MOH
M. Boikanyo	Manager	NDSO
R. Kuoe	Chief Nursing Officer	MOH
Dr. A. P. Maruping	Director of Health Services	MOH

The participants in the meeting endorsed the scope of work and indicated that they would procede with the evaluation. There was, however, some discussion on timing. It was suggested that technical assistance on logistics and service statistics be initiated before data gathering for the evaluation begins. It was also suggested that the contraceptive prevalence survey proposed by Kennedy and Barnes could procede as an action independent from the evaluation and/or any technical assistance to be provided.

In discussions with USAID officials after the meeting, the following time schedule was proposed:

1. Basotho officials attend the ESAMI workshop on family planning logistics to be conducted at Arusha, Tanzania, scheduled for October 22-November 8, 1984.

2. Technical assistance on logistics and service statistics be provided by two CDC and one ESAMI consultant approximately 3-4 weeks after the ESAMI workshop, subject to the availability of the consultants at that time.

3. Preparations for the evaluation procede immediately, with data collection to take place after January 1985.

4. Timing for the contraceptive prevalence survey be left open until experts in this area could be contacted for assistance. It was recognized that the results of the survey would be helpful to program evaluators.

In addition, USAID/Maseru agreed to provide resources in support of the evaluation.

IV. OTHER ISSUES

During our interviews and document reviews, a number of issues came to light which should help to guide evaluators and/or consultants. Some of these are:

A. Logistics

We observed that the LDA/NDSO organization is very modern and apparently well managed. The site was orderly, records were complete, personnel were well trained, etc. It is indeed a very impressive operation. We were told that their problems center on their inability to get good data on the utilization of drugs that are either manufactured or imported. They, therefore, have a weak statistical base for forecasting future needs. In the opinion of NDSO officials, supply management problems are most severe at midlevel (Health Service Areas) and clinic/hospital level. In addition, there are problems with inadequate transportation capacity in the NDSO fleet.

There are plans to procure a computer for the LDA/NDSO operation, and they expressed interest in the logistics microcomputer programs that CDC has prepared for use in Brazil and Thailand. Lesotho participates in the WHO Action Program on Essential Drugs and Vaccines; they have adopted a formulary and have printed a manual which lists the drugs and supplies available through their system, and includes instructions for the use of all drugs in the formulary. (Although contraceptives are kept in stock at NDSO, no contraceptives are listed in the formulary; a copy is available in the DRH/PEB/PSS office.)

Almost all drugs used by the MOH, PHAL, and LPPA flow through the NDSO; this includes contraceptives which are kept in stock and issued on request. Since the NDSO manages all drugs, the logistics consultancy should include systems for managing total needs; it would be almost impossible to establish a system for managing contraceptives and MCH-related drugs in isolation from the others.

In addition to supplying the drug needs of Lesotho, approximately 60 percent of the LDA manufacturing capacity is exported.

B. Service Statistics

The service statistics system consists of a simple form for reporting monthly attendance data for MCH activities. The family planning report consists of one block for reporting the number of first visits and revisits with a table for method used by the aggregate. A new form is being tested in a few clinics. This form adds a column for "stopped" and requires reporting for all three categories by method. (Copies of both forms are available in the DRH/PEB/PSS office.) In addition to the inadequacy of these forms, we were told that reports are received from about 80 percent of the 116 clinics per month (57 provide family planning services), and a significant number of reports are incomplete. There is also confusion with reports from LPPA and PHAL clinics, particularly LPPA where most clinics are conducted with LPPA staff in MOH sites. It is suspected that some duplication of reporting occurs, but the magnitude is unknown.

C. Other

(a) We were told that a full evaluation of the MCH program in all areas except family planning was conducted by WHO in May-June 1984. The report of this evaluation was not available at the time of my visit.

(b) There has been a study of male attitudes toward family planning, and the final report should be available soon. Preliminary results indicate that negative attitudes are primarily caused by ignorance of the benefits of childspacing.

(c) The World Bank has recently completed a program assessment. The report was not available at the time of my visit.

(d) The UNFPA is initiating a project mainly directed towards program managment, but it also includes the provision of orals, condoms, and injectable contraceptives to the program. This project resulted from a needs assessment conducted by UNFPA in April 1984. A draft copy of the report is available in the DRH/PEB/PSS office. The recommendations from this report relative to health and family planning are attached (Attachment C).

Jack L. Graves, M.P.H.

Attachments

ATTACHMENT A
KENNEDY-BARNES REPORT
MAY 9, 1984

I. SUMMARY

At the request of USAID/Lesotho in February 1984, the Regional Population Officer and Social Analyst from REDSO/ESA visited Lesotho to review the status of current population and family planning activities and programs to identify strengths and needs, and to determine the Lesotho Government (GOL) and nongovernment plans and potential interest in strengthening and expanding program efforts. Taking into consideration other donor activities and plans, recommendations were made to USAID/Lesotho on what type of assistance AID could provide, given the wide range and availability of AID central and regional population resources.

The team spent 1 week in February 1984 meeting with key officials in the Ministry of Health, Bureau of Statistics, Lesotho Planned Parenthood Association (LPPA), and Private Health Association of Lesotho (PHAL). The social analyst spent an additional week meeting wih individuals in relevant institutions and reviewing documents. The REDSO/ESA population officer returned to Lesotho April 9-13, 1984, to discuss the draft report and findings with USAID and the GOL in order to finalize the report and seek approval for the recommendations and plan of action.

The Kingdom of Lesotho is a small landlocked country completely surrounded by the Republic of South Africa. The country is dominated by its economic dependence on South Africa, and up to half of its male workforce is employed in the Republic at any given time. The estimated population in 1983 was 1.4 million people with an annual growth rate of about 2.3 percent. Although the growth rate is somewhat lower than other countries in the region, the country is growing too fast in relation to its small size and extremely limited economic resource base. Other population characteristics are not particularly different from other African developing countries characterized by high fertility, high but declining mortality, and low population density. The average completed family size is between 5.7-6.0 children.

The overall health status in Lesotho is better than in many other African countries, due primarily to its high altitude and cool climate that result in the lack of major tropical diseases and less spread of infectious diseases. However, infant and maternal mortality are high (106-130 per 1,000 births and 3.7 per 1,000 live births, respectively), and malnutrition and diarrheal diseases are common among young children. Health problems could be dealt with more effectively through improved preventive health measures.

The Bureau of Statistics is the organization responsible for collecting all statistics on behalf of the Government. The Bureau is preparing for the 1986 National Population Census and intends to expand its capacity so it can undertake a national household survey program. One problem at the Bureau, due to inadequate equipment, has been long delays in data processing. New equipment is expected soon which will help to alleviate this problem. The Institute of Southern African Studies at the National University of Lesotho and the Lesotho Distance Teaching Center are other groups that have undertaken surveys on fertility-related topics including family planning.

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A major survey conducted in 1977 was the Lesotho Fertility Survey (LFS). The data from the LFS, along with other smaller surveys, indicate little variation in fertility levels except among women with a secondary education or higher. The proportion of urban residents who use contraceptives, however, seems to be higher than for rural residents. The majority of adult men and women are aware of family planning, yet only 7 percent use any method. There seems to be a very high dropout rate, since some 20 percent have used contraceptives at some point in time. Access to oral contraceptives is legally restricted, whereas other contraceptives can be sold without prescription but apparently are not.

For a number of years the Kingdom of Lesotho has been concerned with the imbalance between population growth and scarce limited resources. Lesotho has a written population policy statement developed during National Population Conferences held in 1974 and 1979. In 1980, the Cabinet approved the resolutions adopted during the 1979 Conference which serve as policy guidelines for the development and implementation of programs. The resolutions encourage decreased population growth, promote family planning, advise the development of family life programs, and support the role of women in development activities. Both the Second (1975-1980) and Third (1980-1985) 5-Year Plans include statements on the need to decrease population growth and support family planning programs. However, little has beeen done to followup these resolutions and statements and to translate them into specific strategies and actions.

Lesotho has been providing family planning services for over 10 years. The Ministry of Health (MOH) provides roughly 50 percent of the services while nongovernment groups, such as the Private Health Association of Lesotho (PHAL) and the Lesotho Planned Parenthood Association (LPPA), provide the remaining 50 percent. LPPA is the largest single nongovernment group which supports family planning in the country. The Association has 65 paid staff and operates 10 clinics and 17 outstations served by mobile units. The program consists of clinical services, motivational work, training of paramedical workers, family life education and women's projects. LPPA is currently experiencing severe management problems, as reported by a recent management audit of their program. It is hoped that these problems will soon be resolved, since the Association plays a major role in providing family planning information and services in Lesotho.

The Catholic Church provides a substantial portion of the health care in the private sector. There is interest from Catholic hospitals and clinics in offering natural family planning services. The Lesotho Catholic Secretariat has conducted some training in natural family planning but, to date, the number of couples practicing any of these methods is small. For example, the MOH recorded only 12 users for the entire country in 1982.

The total number of reported users for all methods of contraception for 1982 was 19,603, or about 7 percent of the at risk couples. While the numbers are not totally reliable, a review of statistics from the past few years reveals that the percentage of users has not increased much since 1977 and that contraceptive prevalence remains at about 7 percent. Very high dropout rates

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are recorded especially among pill users and, from statistics, it appears that the program has predominantly attracted younger rather than the older women of childbearing age. Both MOH and LPPA have experienced frequent shortages of certain contraceptives over the past 5 years. Supply problems center around poor coordination among the various groups providing services and lack of a standardized system for forecasting, ordering, and distributing supplies, and for collecting information on usage.

The World Bank and UNFPA are in the process of conducting health and population assessments, which will most likely result in the development of projects to provide increased support to these sectors. Due to UNFPA's more comprehensive definition of population, support may also be identified for other sectors as well. Nonetheless, it is clear from this review that, given the size of the country and its limited human and financial resource base, there exists a real potential for donor activity overload. Care should be taken to coordinate activities, focus on priority problems identified by the Government, and phase efforts to assure that key Basotho have the time to take an active role in implementing program activities.

The recommendations of this review focus on three key problem areas. These areas were identified by analyzing problems cited in a number of reports, reviewing research findings, and confirmed by the people with whom we talked. They are: commodity assistance and support, evaluation of the MCH/FP program, and support to increase the policy dialog among Lesotho leaders to encourage a stronger strategy, and plan to implement the country's current population policy.

It is proposed that over the next 12 months, AID provide limited but directed assistance in these areas (see recommendations on pages 21-22 and 32-34) using the following ST/POP resources:

1. contraceptive logistics management/statistics assistance from Centers for Disease Control;
2. contraceptive supplies from either FPIA or AFR/RA Family Health Initiatives project;
3. Centers for Disease Control family planning consultant to assist in the evaluation of the MCH/FP service program;
4. the Futures Group to assist in the development of a RAPID presentation;
5. technical assistance and support from the Family Planning and Demographic Surveys Project to conduct an MCH/FP contraceptive prevalence survey; and
6. a natural family planning consultant to determine natural family planning needs and possible AID support.

Once these activities are under way, it is further recommended that AID and the Government of Lesotho review progress and determine the need for increased AID assistance in population and family planning.

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ATTACHMENT B
Maternal and Child Health/Family Planning Evaluation,
Scope of Work and ESAMI Logistics Workshop

1. Background

It is generally recognized that infant and maternal mortality increase as the time between pregnancies decreases. One of the objectives of family planning programs is to ensure that enough time elapses between pregnancies to allow the mother to recover from the delivery and to allow her time to ensure that the new baby thrives. In Lesotho, infant mortality is estimated to be 106-130 per 1,000 births, and maternal mortality is estimated to be 3.7 per 1,000 live births. Both of these rates are considered to be high and could be reduced if the interval between pregnancies could be increased.

That the population growth rate in Lesotho is too high to be consistent with economic development is well documented and has been recognized for at least 10 years by high Government officials, including the prime minister, who said (at the opening of the National Population Symposium in 1974): "...the population of this country cannot, and should not, be permitted to increase indefinitely...the time to take corrective measures is now...". Since that time, other conferences have addressed this problem, resolutions have been made, and these resolutions have been endorsed by the Government. Action has been taken in some areas while others await decisions and/or resources for implementation.

Although family planning services have been provided through formal programs and projects since 1972, the services have not been used by a significant number of couples. The Lesotho Fertility Survey, 1977, found that approximately 7 percent of fertile couples were using some method of contraception. Experts, including family planning program leaders, estimate that this percentage has remained fairly constant since that time.

Since family planning practice seems to have reached a plateau, some Government officials have become concerned and frustrated by the apparent lack of progress. A number of studies and other assessments have been conducted which indicate that the reasons for this lack of progress are varied and complex. The Ministry of Health (MOH) has, therefore, proposed that family planning practice in Lesotho be evaluated by conducting evaluations of current programs to determine the efficiency and effectiveness of (a) family planning service delivery, including both the delivery of health and family planning services, and (b) the provision of information, education, communication, and motivation services to fertile couples and the general population. In addition, a contraceptive prevalence survey has been proposed to determine the extent of contraceptive use and the barriers to family planning acceptability among the population.

Interviews with key officials within the family planning service delivery network have been conducted during this mission, and the consensus of opinion seems to be that a statistical baseline for the status of family planning in Lesotho is needed so that future evaluations can be measured against it. Basically the questions are: (a) Where are we with respect to family planning? (b) Where do we need to be? (c) How do we get from where we are to where we need to be with the resources available to us?

These questions have both service delivery and acceptability implications. Indeed, they imply an examination of all facets of the problem including: (a) any legal and cultural barriers to family planning, (b) the Government's plan to deal with the problem, (c) the implementation of the plan, and (d) the effect of these efforts. The program evaluation should deal with the first three of these areas and the contraceptive prevalence survey, the last one. The results of these evaluations should indicate what actions will be necessary to improve service delivery and acceptability of family planning services so that the rate of population growth can be reduced and the health of mothers and babies improved. The purpose of this mission is to propose a scope of work for the program evaluation; the contraceptive prevalence survey will be considered at a later date.

2. Scope of Work for the Evaluation

2.1 National Level

The evaluation must include all levels of the program, and we must, therefore, define what we mean by "the program." In Lesotho, family planning services are delivered by several agencies, the largest ones being the MOH, the Lesotho Planned Parenthood Association (LPPA), and the Private Health Assocation of Lesotho (PHAL). Although these are separate agencies, their operations are in many ways integrated so that it will be difficult to separate them into separate activities. Examples are: (a) the LPPA provides clinical services at locations in all 10 districts of the country by conducting clinics in MOH and/or PHAL locations; (b) while the PHAL is an organization of private hospitals (primarily church associated), many of the activities of their clinics are influenced, if not governed, by Government regulations; and (c) the MOH, through its National Drug Stockpile Organization (NDSO) manages most of the drugs and other supplies used by all three agencies. We, therefore, propose that a very important phase of the evaluation should be to examine the relationships between these organizations. We have been told that cooperation between these agencies is excellent; perhaps, however, some improvement could be made in coordination so that family planning services could be made more widely available throughout the country.

In addition, the evaluators should determine the extent to which other agencies, both private and public, participate in or might be persuaded to participate in, the provision of family planning services or assisting with educational efforts.

2.1.1 Information, Education, Communication, and Motivation

One of the activities of the program is to try to educate the public so that the implications (health, demographic, economic, sociological, etc.) of family planning practice are well understood. As we understand it, national policy is that family planning services are to be made available to all citizens who might benefit from these services, and it is the prerogative of each couple, in cooperation with their clinicians, to decide which method, if any, they will use. There is no Government coercion to limit family size or to choose any particular method. The program, therefore, attempts to provide accurate information to individuals and the general public so that informed decisions can be made; this is done in respect to cultural sensitivities. The evaluators should assess the materials used and the methods employed for disseminating family planning information to determine their effectiveness in informing the public.

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2.1.2 Training

As with any program, effectiveness depends on adequate numbers of trained staff to be posted throughout the country. The evaluation should include a review of training opportunities for family planning program staff, including domestic and international. The investigations should include the adequacy of training courses to meet the needs of the program, the frequency of training courses, the numbers of staff trained, and the proportion of trained staff who continue to work in the project.

2.1.3 Research

Extensive research has been, and continues to be conducted on subjects important to the conduct of the program. This research covers the fields of sociology, education, demography, and others. The evaluation should include a study of the appropriateness of research that has been, and is being conducted. It should also determine how the results of research have been used to improve the program and what additional research is needed.

2.1.4 Logistics

No program can succeed without an effective logistics system. Logistics is concerned with ensuring that needed supplies and equipment for all program activities can be efficiently delivered to the places of need in a timely fashion; this includes not only drugs and contraceptives, but also educational materials, office suplies, transportation, and other items. The evaluation should include an investigation of logistics systems to determine what deficiencies exist so that recommendations can be made for improving the systems, thus ensuring continuing availability of needed items.

2.1.5 Service Statistics

Service statistics are collected at the clinic level of the program, summarized in monthly reports, and submitted to the headquarters of the parent agency. The evaluation should include an examination of statistics, the systems through which they flow, how the statistics are summarized and analyzed, and what use is made of the systems for management purposes. Included in this investigation should be judgements as to the quality of the data (accuracy, completeness, proper analysis).

2.1.6 Administration

The evaluation should include an assessment of how the programs of each agency are organized and how administrative procedures could be improved to increase the effectiveness of the program. As mentioned before, the relationships among the agencies should be studied to be sure that the program takes maximum use of the strengths peculiar to the individual agencies involved in family planning service delivery.

The decision has already been made by the MOH to fully integrate family planning services with other MCH services. The procedures for this integration should be examined to see how this effort affects the program.

3. Intermediate Levels

In Lesotho, the family planning program exists on three program levels, i.e., central, intermediate, and clinic. The intermediate level is the Health Service Area (HSA). The HSA is essentially a coordinating body that provides technical supervision and program support (such as supply management) to its area of responsibility. The evaluation should include an examination of the functions of the HSA's to see how supervision and the flow of information and commodities up and down the organizations can be made more effective.

4. Clinic Level

Since the clinic level is the level at which program personnel interface with clients (or patients), the scope of work is given in more detail. We have attempted to cover all areas of clinic operations; however, the evaluation team may feel that additional areas should be evaluated. If modifications in the following outline are desired, the team should feel free to do so. Since this is to be an evaluation of service delivery, the importance of an accurate evaluation at this level cannot be overemphasized; the clinic is the focus of the evaluation.

4.1 Evaluation of Clinical Services/Profile of Family Planning Users/Nonusers

Method: Review a representative sample of medical charts/user records.

Data to collect:

4.1.1 Social, economic, demographic characteristics of each client chosen in the sample (age, education, marital status, number of live births, stillbirths, occupation of client/spouse, distance of residence from clinic, geographic characteristics of residence (urban, suburban, rural remote, etc.) and other data as appropriate).

4.1.2 History of contraceptive use/pregnancy/reproductive health since entry into program. (Evaluators may choose to limit this to the last 3 to 5 years.)

4.1.3 Quality of medical services. (Make checklist from MOH medical standards or from internationally recognized standards.)

Thoroughness of services

Presence or absence of contraindications to family planning method prescribed.

4.2 Evaluation of Service Statistics

4.2.1 Consistency of reports (percent months reports submitted)
4.2.2 Completeness of reports (percent with missing elements)
4.2.3 Accuracy of reports (as appropriate)
4.2.4 Evaluation of reporting system

4.2.4.1. What important elements are not contained in the report form?

4.2.4.2. Would the data be helpful for program management or planning if it were consistent, complete, and accurate?

4.2.4.3. Are instructions for completing the report clear? Have staff been trained to complete the report?

4.2.5 Analyze data form reports to the extent possible or practical (from sample of reporting clinics).

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4.3 Logistics

4.3.1 Number of line items maintained in stock; family planning methods available, number on MOH formulary/not on formulary.

4.3.2 Mean monthly consumption of all contraceptives and selected sample of other items.

4.3.3 Stock on hand. Is it appropriate according to use levels, lead time, resupply frequency?

4.3.4 Proportion of line items ordered that were received. Are any quantities reduced by supplier? If so, why?

4.3.5 Number of stockouts for last 12 months for all contraceptives and other selected items.

4.3.6 Determine lead time for last six requisitions.

4.3.7 Check stock records against monthly reports for accuracy.

4.3.8 Is max-min inventory control system in operation? If not, how is order point determined? Is it appropriate?

4.3.9 Is storage facility adequate? What deficiencies exist? (size, orderliness, cleanliness, light, security, etc.)

4.3.10 Quantity of contraceptives provided to new/continuing clients.

4.4 Site

4.4.1 Size and arrangement of physical facility. Floor plan with types of rooms indicated. Is the space adequate relative to staff working and number of patients? What are the deficiencies?

4.4.2 Location relative to residences of service population.

4.4.3 Transportation available to clients. Public transportation, frequency.

4.4.4 Appearance of building. Clean, well-lighted, adequacy of waiting area, etc.

4.4.5 Periods of greatest/least activities at the site.

4.4.6 What days/hours are family planning services provided?

4.5 Staff

4.5.1 Number and type of staff. Is it adequate relative to services provided?

4.5.2 Training and experience of staff. What training is needed? Is training available?

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4.5.3 Are there competing responsibilities/tasks that may prevent staff from providing family planning services?

4.5.5 Is the staff properly supervised? Frequency and type of supervision received.

4.5.5 Are there needs that staff cannot meet because of lack of staff, lack of training, supplies, equipment, etc.? What are they?

4.5.6 Are services well organized for efficient client flow?

4.6 Clients (Interview selected sample; family planning users/nonusers; female/male.)

4.6.1 What are deficiencies of the clinic from client's point of view?

4.6.2 What is the client's perception of waiting time to receive services? (If possible, check waiting time for selected sample by noting arrival/departure times.)

4.6.3 Attitudes toward family planning.

4.6.4 Present/former user of family planning services, plans for future, characteristics (see 4.1 above). If previous user, why did she discontinue? If not present user, why not?

5. Other Areas

During our interviews, it was suggested that the evaluation include the feasibility of alternate service delivery methods such as community-based distribution, social marketing, etc.

6. Preparing for the Evaluation

The first activity should be to choose the Basotho members of the evaluation team. The team should examine this report and agree on the work areas outlined or modify them as they see fit. As a part of this activity, they should identify other evaluations that have been conducted, are being conducted, or are planned to be sure that parts of this evaluation are not unnecessary duplications. They should then decide what, if any, assistance from outside the country will be needed, make their request to USAID, and start the process for locating international team members. At the same time, a tentative date for the evaluation should be set. (CDC could participate in the evaluations and could provide experts in reproductive medicine, demography, program analysis, statistical analysis and/or program management, and logistics).

The team should then begin to design data collecting instruments for the evaluation, including questionnaires and statistical sheets. In addition, documents describing family planning related research, needs evaluations, MCH program evaluations, statistical reports, technical assistance reports, and any other documentation that would be useful to the evaluation team should be collected and assembled. The bibliography appended to the Kennedy-Barnes report of May 9, 1984, is a good start for this activity.

When the completed evaluation team assembles, a chairman should be designated and specific work areas for individual team members assigned. International team members should be given time to review documentation relative to their areas of responsibility before fieldwork begins. During this time, a representative sample of clinics to be evaluated should be chosen and travel plans made. The team will then go to the field to conduct their investigations and collect data.

The team would then reassemble in Maseru for data analysis and deliberations before preparing their preliminary report. The findings would then be presented to top officials of the agencies involved. If more extensive data analyses are required, they should be completed as soon as possible, and final reports should be submitted. Depending on the size and composition of the evaluation team, we estimate that the evaluation can be completed in 3 to 4 weeks.

Managing officials would then decide what action to take and make plans for implementation of any program changes adopted as a result of the evaluation.

7. Technical Assistance Requested

During this mission, two areas were identified where problems are known to exist; these are logistics and service statistics. There was not universal agreement as to whether the evaluation should be scheduled without regard to these problems or to wait until corrective action can be taken in these areas before conducting the evaluation.

The implications of this are that evaluators might have to work with data that are known to be deficient, and that service delivery has been hindered by periodic shortages of supplies. On the other hand, it will take some time, perhaps 6 months or more, to correct these problems.

In addition, the East and Southern Africa Management Institute (ESAMI) will conduct a workshop on logistics management in Arusha, Tanzania, in October; several officials from Lesotho will be invited to attend. Those to be invited are:

(a) MCH/FP Coordinator
(b) NDSO Manager
(c) NDSO/LPA Managing Director
(e) Chief Statistician
(f) Senior Public Health Nurse
(g) Executive Director, PHAL
(h) Executive Director, LPPA
(i) Supplies Manager, LPPA
(j) Project Coordinator, UNFPA Project

This workshop is being sponsored by AID, and CDC will cooperate with ESAMI in its conduct. The workshop is the first activity in a 3-year program designed to improve the capabilities of ESAMI in providing training and technical assistance (including resident experts and in-country training courses, as needed). In addition to Lesotho, officials from Zambia, Zimbabwe, and Uganda will participate in the workshop.

Consideration should be given to providing technical assistance in logistics after the Lesotho officials have received the training to be provided at ESAMI. It has been proposed that this technical assistance begin in late November. The initial work should require approximately 3 weeks to complete.

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ATTACHMENT C

RECOMMENDATIONS ON HEALTH AND FAMILY PLANNING
FROM THE UNFPA NEEDS ASSESSMENT
APRIL 1984

A. Health and Family Planning (see Chapter VIII)

1. The Mission considers that the extension of physical health facilities should be matched by a commensurate increase in the output and employment of trained manpower to ensure adequate staffing.

2. Terms of service should be enhanced and those qualified promoted. The recruitment of trained staff on a casual basis and the retention of personnel in the same salary bracket beyond 3 years leads to low morale and to indifferent performance.

3. Attractive terms of service would prevent Lesotho's trained manpower being enticed to other countries.

4. The training of health manpower needs to be strengthened through the provision of trainers, training materials, and by expanding training facilities.

5. The basic training curricula of health workers (nurses and doctors, particularly) should be designed to ensure that trainers become competent counselors and providers of family planning as an integral part of MCH services. Those already employed should be given special in-service courses to broaden their attitude, knowledge, and skills.

6. The existence of a Primary Health Care (PHC) system is to be commended. The selection of Village Health Workers (VHW's) should be related to existing and projected physical health facilities as these provide support, referral points and supervision for the VHW's.

7. Traditional Birth Attendants (TBA's) who assist a considerable number of births should be identified and trained to improve their supervision of pregnant mothers prenatally, perinatally and post partum as well as advising on the care of babies. TBA's can also become promoters of environmental health, nutrition, immunization, and family planning.

8. To achieve a multisectoral approach, PHC workers of other ministries, such as agricultural extension workers and community development workers, should be trained in PH techniques effectively to relate their respective responsibilities to family health and population.

9. Family planning services now provided on certain days of the week in selected locations within health facilities should be integrated with the Maternal and Child Heath (MCH) services so that clients can be served, as well as women seeking antenatal or postnatal care, and mothers who have brought their children to the under 5 clinics. The current arrangement, which distinguishes family planning clients from others, is unsatisfactory.

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10. Contraceptives available to the Ministry of Health (MOH), the Private Health Association of Lesotho (PHAL), and LPPA should be identical to enable users to have access to the same supplies.

11. To avoid shortages, and based on anticipated consumption rates, the contraceptive needs of the MOH, PHAL, and LPPA should be grouped. Contraceptive donors such as the International Planned Parenthood Federation (IPPF), USAID, the Swedish International Development Authority (SIDA), the Danish International Development Agency (DANIDA), and Family Planning International Assistance (FPIA) should be approached to meet such demands.

12. The importation of high progesterone and oestrogen oral contraceptives should be avoided. Low dose hormone pills should be preferred.

13. The importation of progesterone oral contraceptives and injectables appropriate for breast-feeding mothers should also be considered.

14. The Community-Based Distribution (CBD) of nonclinical contraceptives (condoms and foaming tablets) by village health workers and trained extension workers and women's groups should be encouraged. This method delivers contraceptives directly to the consumer, ensures privacy, and reduces the distance to be traveled to reach a clinic.

15. Natural family planning should be promoted as an alternative means of fertility regulation, and prolonged breast-feeding should be sustained.

16. The formats of reports on contraceptive users should be made uniform throughout the country to facilitate data collection and analysis.

17. MOH should promote and integrate population/family life into their training and outreach programs.

18. Family life education should be provided for young people in or out of school. Collaboration should be established between MOH, the Ministry of Education, and PHAL to prepare youth for responsible parenthood.

19. The promotion of family life education, already undertaken by LPPA, should also be the responsibility of community leaders in churches, pitso (village meeting), schools, and vocational training institutions.

20. A contraceptive prevalence survey should be carried out to provide baseline data to assess future trends. The resultant information could also be used to plan future strategies and estimate contraceptive supply needs.

21. A study to determine what TBA's know, how they perform their duties and evaluate their own responsibilities should precede their training in order to meet self-identified needs.

22. The Mission endorses Project LES/82/P02 "Assistance to National MCH/FP Program" and recommends its implementation without further delay.

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