AN EVALUATION

OF THE

LESOTHO RURAL HEALTH DEVELOPMENT {LRHD} PROJECT

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EXECUTIVE SUMMARY

The Lesotho Rural Health Development (LRHD) Project has been in operation for about three years. During this period, the Government of Lesotho (GOL), through the Ministry of Health (MOH), has made an impressive start in launching the national primary health care (PHC) program. Their accomplishments include:

- Creation of a new category of PHC workers called nurse clinicians (NC). Legislation formalizing their status is in the final stages of approval.

- Establishing a practical, relevant and high quality problem-oriented training program for the NCs, adapted to the Lesotho situation. The first class of 22 graduates has been deployed to the rural areas; a second class of 19 is now in training.

- Recruiting a nurse tutorial staff to replace the expatriate team training the NCs.

- Developing decentralized management support systems for PHC.

- Producing a management component for the NC curriculum which is practical and relevant.

- Developing training materials for village health workers (VHW) adapted to the Lesotho setting.

- Creating a Health Planning and Statistics Unit (HPSU) in the MOH, which in turn, has designed a system for health planning that is compatible with the decentralized delivery system.

- Recruiting a well-motivated professional staff.

These are impressive achievements by any standard. The MOH, the private health agencies that have collaborated in the LRHD Project and the technical cooperation team from the University of Hawaii should take pride in what has been accomplished.

At the same time, the Project faces some difficult problems. There are important institutional development and operational matters that require immediate attention. There are pivotal policy issues which impact on the future direction and efficiency of health sector programs which must be resolved. There is a need to better harmonize GOL health policy with its use of health resources.

The evaluation team examined the LRHD Project from four perspectives:

- The progress made to date in achieving its objectives and projections of further achievements to be made by the December, 1983 completion date;

- The way in which GOL health policy is articulated and the degree to which it meshes with the use of health resources;

- The soundness of the LRHD Project concept;

- The important planning, institutional development and operational issues which must be resolved to attain the Project objectives.

The team also reviewed a special issue of the relationship between the MOH and the private health sector and the contribution of the latter to

the realization of PHC objectives.

The team's major findings and recommendations are as follows:

- Most of the projected December, 1983 end-of-Project objectives should be achieved. Because of current difficulties in institutionalizing this Project, there is some question whether the GOL will be ready to continue the PHC activities when the Project ends.

- While the GOL's new priority for PHC is well-articulated in the Third Five Year Development Plan, it is not clear where health resources are in fact being spent. This inconsistency causes confusion for the MOH in explaining program priorities both within the government and to donor agencies.

- The design of the PHC system is sound; the team saw no reason to suggest important changes in direction.

- A strategy for achieving the planning objectives of the LRHD Project is needed. Particularly critical is to establish a planning process (i.e., a periodic assessment of alternatives in light of health resources, needs and priorities) which is linked to programming and budgetting, and to begin this by involving the HPSU in LRHD Project implementation.

- The Health Service Area (HSA) concept is practical and potentially workable but long-term success requires management strength in MOH headquarters, adequate financing and vigorous follow-up in the field. The NC management training component is directed to solving practical problems of the LRHD Project in the field. The training materials are first-rate.

• A number of the positions created through the LRHD Project has not been formalized. Particularly serious are the problems in establishing posts and appropriate grade and pay scales for the NC graduates, the NC tutors and the HSA administrators. There are no designated national counterparts for two of the four members of the expatriate technical team. Both of these matters require urgent MOH attention.

• Shifting NC training from the MOH to the new Faculty of Health Sciences (FHS) may produce graduates who are better prepared academically but less ready to serve in the isolated rural areas.

• Retaining trained NC staff in the rural areas is a predictable problem. The MOH and Project team need to systematically analyze and select the mix of incentives needed to hold this trained staff.

• The course design and curriculum content of the NC training program are excellent, having benefitted from workshop adaptation to the Lesotho situation. Professional supervision of NCs by the HSA medical directos is a workable arrangement at the present level of NC development. As the numbers of NCs in the field grows, the capacity of the medical directors to provide adequate supervision will be taxed, and other supervisory modes will have to be investigated.

• Once completed, a problem-oriented curriculum for the training of village health workers (VHW) should upgrade present training efforts. Continuing experimentation with the content and length of training (and retraining) should be encouraged until their appropriateness can be judged. Training and supervision of the VHWs should remain the prime responsibilities

of the NCs, but other members of the PHC health team should assist in both, especially if the numbers of VHWs grow substantially.

• The team feels that the private health sector (represented by PHAL-member institutions) is both a substantial and irreplaceable health asset to Lesotho. However, there are important PHAL institutions which lack the resources necessary to sustain or extend PHC delivery without governmental financial support. MOH should channel its support to these autonomous institutions in ways that make them responsible for delivering an agreed-upon package of health services, and place a minimum supervisory and administrative burden on the MOH.

The team's six principal recommendations are:

• That the MOH should move now to resolve the questions of posts, salaries and grades for the NCs in the field, the NC students in training, the NC tutors and the HSA administrators. These are urgent issues. If they are not satisfactorily resolved, the team fears that the Project may fail.

• That the MOH work vigorously to secure counterparts for two expatriate specialists of the Project team now working without them.

• That the MOH review the proposal to train NCs at the FHS in light of their health services delivery objectives in the rural areas. If the NC program is in fact transferred to the FHS, the MOH will need to find ways to assure that it retains its practical orientation.

• That the MOH consider channelling support to PHAL institutions through grants or contracts tied to the delivery of health services rather

than directly employing the NCs working in PHAL institutions.

• That the planning activities of the HPSU focus on implementing and institutionalizing the management support systems and NC training developed through the LRHD Project. In addition to securing the success of the Project, such actions would also build a foundation for later expanding the scope of planning within the health sector.

• That the MOH start work on a long-term strategy that would relate health sector policy to the allocation of resources and planning to budgetting and programming.

The evaluation team concludes its work with considerable optimism about the rural PHC effort in Lesotho. Provided the policy, planning and management issues cited in this report are satisfactorily resolved and the MOH maintains a high level of commitment to PHC, we believe that the fundamental program objectives will be achieved.

In the more narrow project sense, the issues that concern us most are the establishment of positions and appropriate grades and salaries for the NCs, the NC tutors, and HSA administrators; the capacity of the MOH to find permanent staff for all of the key positions now filled by the technical cooperation team; and that the shift in the site for NC training from the MOH to the FHS will result in a graduate no longer oriented to rural service.

Looking more broadly, the MOH needs to develop a health strategy to harmonize policy and program goals with the use of resources. This would clarify MOH objectives within the GOL and enable them to better direct donor assistance to their priorities.

The success of any project depends greatly upon the quality of the professional staff. The LRHD Project is fortunate to have a number of able and dedicated professionals who are ready to analyze problems and constructively work towards their solution. The willingness of the MOH to face up candidly to the inevitable problems is both refreshing and provides the best chance for realizing a successful Project outcome.

This Project is involved in activities where there are no clear precedents. International PHC experience will be of limited value in solving the many issues which are situation and culture-specific. Setbacks are inevitable and the most, thoughfully-considered decisions will not always turn out to be correct. In circumstances where there are no clear solutions, the Project leaders will have to maintain flexibility in administrative and technical approaches and be ready to try out a range of alternatives on a small scale.

The evaluation team found that the professional quality, flexibility and the degree of commitment of the MOH leadership to the goals of PHC to be a substantial Project strength.

Project Planning Recommendations:

1. The HPSU should develop an implementation strategy for achieving the planning objectives of the LRHD Project. Necessary actions should be identified, prioritized and their level of effort and sequencing calculated. Particularly critical to the prospects of institutionalizing the activities begun in the LRHD Project is to establish a planning process which is linked to programming and budgetting in the MOH. This process should begin by involving the HPSU in planning to completely develop, operate and sustain major activities begun in LRHD Project, i.e., the management support systems and the training of NCs.

2. The use of existing staff time in the HPSU should be improved (e.g., by establishing MOH procedures for dealing with donors more efficiently) and arrangements made for securing the appointments of the two additional staff being trained for the HPSU.

Training, Supervision and Deployment of NCs and VHWs Recommendations:

1. The intensity of the NC training program (e.g., its pace, quantity and range of materials covered) should be carefully monitored and adjusted as necessary to match the learning capabilities of the trainees.

2. A continuing education program for NCs should be developed soon to offer a variety of opportunities for refreshing and expanding their knowledge and skills, and increasing their motivation and enthusiasm for rural PHC work.

3. The MOH should adopt a flexible policy towards setting academic standards for admission to the NC program. If the demand for NCs outstrips the supply of doubly-qualified nurse candidates, consideration must be given to admitting other categories of nurses and adjusting the intensity of the training program accordingly.

4. As the number of NCs in rural areas increases, the capabilities of medical officers to adequately supervise them will be severely taxed; other modes of supervision should therefore be investigated to address this situation.

5. Greater attention should be paid to preparing other health staff to work with the NCs and understand their respective roles and responsibilities in health care delivery.

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Management Support Systems for PHC Delivery Recommendations.

1. The MOH should provide staff leadership, and in turn, develop a strategy to provide ongoing follow-up to HSA Implementation Workshops to maintain momentum in developing the decentralized PHC delivery system. The strategy should be coordinated with the planning and budget-making activities of the MOH, through the HPSU, so that adequate financial and staff resources are available as needed.

2. Opportunities to coordinate implementation of a decentralized financial management system with the planning and budgetting systems scheduled for development in the HPSU should be exploited as much as possible.

3. Immediate attention should be given to finalizing government approval of all MOH district and HSA positions created through the LRHD Project, particularly the HSA administrators, the NCs and NC tutors.

4. The adoption of the revised performance evaluation system for MOH personnel (coupled with the necessary delegation of supervisory control over employee incentives) should be considered, as one important means for improving employees' job performance.

5. All feasible options for improving transportation for NCs from health centers should be identified, assessed and pursued as much as possible.

<u>Institutionalizing the LRHD Project Recommendations:</u>

1. The MOH must move urgently to establish the positions for the graduate NCs and the NC class in training, the NC tutors and the HSA administrators. The MOH must make adequate staffing and budget provisions for future NCs and the HSA administrative staff in order to assure the future viability of its PHC program.

2. If responsibility for NC training passes to the FHS, the MOH needs to sustain a strong professional input into (and perhaps a veto over) the proposed changes in the present program. The MOH should be particularly concerned about course design, selection of instructors, and the standards for acceptance into the program and graduation from it.

3. The MOH should systematically examine the determinants of health staff retention in the rural areas, with a specific view to providing an optimal work environment for NCs assigned there.

4. The MOH needs to recruit and assign Basotho counterpart professionals to assume the responsibilities now being carried out by the expatriate management systems specialist and physician trainer.

5. The incumbent management systems specialist should be requested to extend his stay beyond the completion of his present contract (in August 19[illegible]) for a period of up to twelve additional months. Because of the time required to become effective in a new setting, the team questions the utility of recruiting another, long-term expatriate specialist for this position should the incumbent decline to extend.

6. The incumbent physician trainer should be requested to extend his stay beyond the completion of his present contract (in September, 1983) for a period of up to six months (until the second class of NCs complete their three-month preceptorship) provided that the search for a Masotho counterpart continues unrelentingly.

7. The MOH should consider covering in their budget the costs of the modest in-country training program and MOH participation at international PHC conferences that are now supported from Project funds.

I. PROJECT DESCRIPTION

A. Goal, Objectives and Activities

The goal[1] of the five-year LRHD Project is to establish an improved health services delivery system appropriate to the GOL's resources and needs.

To achieve this goal, two objectives are being pursued: (1) the improvement and expansion of health services in the rural areas, and (2) strengthening of preventive and promotive health services.

Activities to achieve these objectives were divided into two phases in the Project[2], viz.:

Phase I: (20 mos) Upgrading the planning, administrative and management competence of the MOH to the level required to develop and maintain a national health services delivery system.

Phase II: (39 mos) Establishing and institutionalizing new health worker cadres required in the rural components of a national health services delivery system.

The phasing of the Project was done to assure that there would be administrative and technical structures and capabilities in the MOH to support and maintain the proposed enlargement of health workers, i.e.,

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[1] LRHD Project Paper (No. 690-0058), January, 1977, as approved September, 1977.

[2] Phase I activities began in February, 1979 and were scheduled to end in September, 1980; Phase II activities will end in December, 1983.

the NCs and VHWs, before these workers were actually trained and deployed. From a sector-wide perspective, the NC and VHW are critical to the MOH's long-range goal to develop an integrated health delivery system to redress the imbalances between the urban and rural populations' access to basic services.

Described elsewhere[3] in greater detail, this proposed delivery system is based on a tiered referral network between each of the ten district hospitals and the health centers/clinics in their catchments or "Health Service Areas" (HSA). The placement of NCs in the rural centers is premised on their ability to provide (and direct others to assist in providing) most of the (first contact) curative, preventive and promotive care needed in the surrounding villages.

The NC is to be supervised, assisted and supported (logistically, technically and psychologically) by a physician-led team of health staff from the HSA hospital. In turn, the NC is supposed to serve in the same roles for the VHWs, in addition to training them.

The activities scheduled to be undertaken during Phase I were the following:

Planning. A planner/administrator from the technical cooperation team would work with counterparts from MOH Offices of Planning and Administration to strengthen MOH planning capabilities, particularly

[3]LRHD Project Paper (No. 690-0058), January, 1977, as approved September, 1977. A Plan for Strengthening and Supporting a PHC System for the Kingdom of Lesotho, 8/31/79.

Reports of Proceedings and Recommendations for Action from the Maseru District HSA Implementation Workshop (October, 1981) and the Mokhotlong District HSA Implementation Workshop (March, 1982).

in the areas of manpower and facilities, for the rural population. Participant training for the head of the planning unit (short-term) and an assistant (long-term) would also be arranged. The planning unit head would proceed to develop and write the health section of the Kingdom of Lesotho's Third Five Year Development Plan (1980-85).

Administration and Management. A management specialist from the technical team would work with the planner/administrator and counterparts to complete and secure the adoption of organizational and operational recommendations for change within the MOH to support an expanded PHC delivery system. This specialist would also assist the MOH to develop and institutionalize decentralized management support and logistical systems, e.g., for drugs, medical supplies, communications, transportation, budgetting and accounting. (Short-term consultants would be called upon as needed to supplement these efforts.) Participant training (long and short-term) would be provided to MOH personnel to improve their management and administrative capabilities.

Health Worker Training. Two other members of the technical team, a physician and nurse clinician trainer, would prepare curricula, organize steering and trainee selection committees, and obtain classroom space for initiating the training program.

The activities scheduled to be undertaken during Phase II were the following:

Health Worker Training. Students would be selected from the early classes for training as NC tutors, to eventually replace the trainers from the technical team. The technical team would work with the MOH to institutionalize the NC training program by the end of the Project.

These NC trainers from the team would also work with the MOH to develop policies relating to the practice of NCs, select adequate deployment sites for them and conduct training programs for other health staff on the role and supervision of NCs. The technical team trainers would also coordinate NC training and deployment with the (ongoing) training of Nurse Assistants in order to prepare for the eventual placement of the latter in rural clinics.

Curriculum would be developed for training VHWs and these training programs would begin.

Planning, Administration and Mangement. Ongoing implementation of the planning, administrative/organizational and management support systems developed in Phase I would occur, with special attention given to their insittutionalization in the MOH by the end of the Project.

An evaluation was conducted approximately one year after the Project began to determine whether Phase I activities had progressed sufficiently to embark upon Phase II. The Report[4] recommended under-

[4] Evaluation of Lesotho Rural Health Development Project, February 5-28, 1980, under the auspices of the American Public Health Association (AID/DSPE-C-0053), page 11.

taking Phase II activities despite finding that the management support systems of the MOH were weak, the problems of personnel retention in the MOH were unresolved and delayed approval and implementation of the MOH reorganization plan was hindering administration of rural health services. Because Phase II activities began before the objectives of Phase I were achieved, the scope of work for Phase II is larger than originally intended and more complex.

B. Targetted Outputs and Projected End-of-Project Status, (December, 1983)[5]

Phase I:

A. Trained Administrative and Management Personnel

B. Organizational/Operational Support Systems Development

C. Ministry of Health Planning Unit

D. Five Year Development Plan

Phase II:

A. Training Program

B. Trained Health Workers

5 Unless denoted by an asterisk(*) in the following tables, statements of goal, objectives, purposes and targetted outputs are taken directly from the LRHD Project Paper, approved 9/26/1977. Asterisk (*) denotes a finer specification of outputs according to the Statement of Work, Phase II of the Contract, 10/1/1980.

EOPS projections are made by the Contract Team, in consultation with the MOH.

B. TARGETTED OUTPUTS AND PROJECTED END-OF-PROJECT STATUS, (December, 1983)

Phase I: Targetted Outputs

A. Trained Administrative and Management Personnel
13 Basotho trained (long or short-term) in health-related administrative and management disciplines and assigned to both the central and district levels of the Ministry (to insure effective implementation and control of MOH program).

B. Organizational/Operational Support Systems Development

MOH adoption of organizational/operational support systems required to establish and maintain the health services delivery system, viz:

• Development and approval of MOH reorganization plans at central and district levels completed during Phase I (including elaboration of operations).*

• Collaboration with PHAL in HSA implementation.*

• Organization/implementation of national and district level management seminars/workshops. Development of a national capability to develop similar seminars/workshops.*

Phase I: End-of-Project Status

A. Trained Administrators and Management Personnel Completed
o 11 Basotho trained (nine months course) in health administration at the Institute of Development Management, by 1981.

o Five working as administrators in HSA hospitals but not in approved posts. Two or three working as administrators in GOL specialty hospitals. Unknown status of remaining two or three.

Projected: 12 additional HSA administrators trained by 1984 and assigned to offically approved positions commensurate in grade/pay scales to their training and responsibilities.

B. Organizational/Operational Support System Development

• Development and approval of reorganization plans for the MOH at central level completed during Phase I.

Projected:
o District level reorganization approved by Cabinet.

• Completion of District Operations Manual by February, 1982 and Health Center Operations Manual by September, 1982.

• Negotiated working agreement on HSA implementation between the GOL and PHAL.

• Two District HSA implementation workshops by March, 1982.

Projected:
o Three additional implementation workshops by December, 1982; 4 additional by December, 1983, for a total of 9 of 10 completed district workshops. (Possibility exists for combining districts in a workshop, allowing total completion.)

• Strengthen MOH management support capabilities, emphasizing requirements for NCs and VHWs,* e.g., in:

-Drug Supplies,
-Financial Management
-General Stores/Supplies
-Communications
-Health Information
-Personnel
-Transportation System
-Maintenance of Health Facilities/Equipment

Management Support Systems

• HSA Drug Supply - Health Center inventory control/ordering systems designed by August, 1981 and operating in all but one (i.e., 15) nurse clinician staffed health centers by 1981. Hospital inventory control/ordering systems introduced in all hospitals in 1981.

• HSA Financial Management - HSA government hospital accounting systems designed by May 1982 and operating in the eight hospitals by end of Project.

• HSA General Stores and Supplies - Inventory control/ordering system for PHC delivery system at district and health center levels designed by May, 1982 and operating in 30 nurse clinician staffed centers and 19 hospitals by 1983.

• HSA Communications - Installation of radio units (funded by end of 1982), and an integrated communications system including trained personnel to operate/maintain the equipment (in-kind subsidies from the Mission Aviation Fellowship) in each HSA.

• HSA Health Information - Timely compliance in reporting facility-based morbidity data by 100% of centers and 100% of hospitals.

• HSA Personnel - District, HSA and health center team positions officially established and filled with at least acting appointments in all districts/HSAs. Revised performance evaluation system adopted by MOH and in use in all ten districts, government HSAs and health centers.

• HSA Transportation System - Policies/procedures developed for provision of reliable transport (e.g., sharing vehicles at district levels, maintaining horses) in all district/HSAs.

• HSA Maintenance of Health Facilities/Equipment - Low priority. NCs are being trained to maintain and prevent needs for maintaining important equipment (e.g., refrigerators, radios). District level coordination for building maintenance is encouraged by the MOH.

C. Ministry of Health Planning Unit

A creative and innovative planning unit staffed by two Basotho (trained under the Project); viz:

- Budgetary and health services data systems (including information from special pilot activities) required for health planning and programming and a set of procedures for analyzing and using such data.*
- Operations and procedures for mapping epidemiological information into the MOH planning/programming system.*
- A system for monitoring HSA activities as they relate to planning and programming.*
- Use of data for planning, particularly for manpower and facilities planning.*
- A system for performance budgetting.*

D. Five Year Development Plan

The MOH Planning Unit will be primarily responsible, working with other GOL ministries, for completing the health sector portion of Lesotho's Third Five Year Development Plan.

C. Ministry of Health Planning Unit

Projected:

- Health planning boards formed and beginning to function in ten districts and all HSAs.
- Design and implementation of a system for processing morbidity data submitted by health centers and outpatient departments and producing timely and appropriate informtion for MOH field staff.
- Design and implementation of a system for controlling, monitoring and reporting the expenditures of donor funds and the implementation of projects.
- Establishment of an internal MOH planning process to undertake the following activities:
  - -Development of a health manpower plan;
  - -Periodic review of proposed projects/new services;
  - -Assess the appropriateness of current uses of resources according to disease patterns and the availability of resources;
  - -Identify and prioritize additional needed services and develop programs to meet the needs.

D. Five Year Development Plan

- The MOH Planning Unit was primarily responsible for completing the health sector portion of Lesotho's Third Five Year Development Plan (November, 1981).

Phase II: <u>Targetted Outputs</u>

A. <u>Training Program</u> (Major Project Output)

- A training capacity to produce health personnel appropriate to Lesotho's needs and resources will be institutionalized:

  -a 12-month Nurse Clinician Training program based on modularized, problem-oriented curriculum.

  -a modular, problem-oriented curriculum to train village health workers.

B. <u>Trained Health Workers</u>

- 55 trained nurse clinicians
- 95 trained nurse assistants
- 104 trained village health workers

Phase II: <u>End-of-Project Status</u>

A. <u>Training Program</u>

- Nurse Clinicans:

<u>Projected</u>: Training program to be institutionalized with the Faculty of Health Sciences, National University of Lesotho by December, 1983.

<u>Projected</u>: 7 trained Basotho tutors of NCs, including one in management, by December 1982, and fully in charge of training the third class by January, 1983.

12-month (plus three month preceptorship) training program based on modular, problem-oriented curriculum (including management) by September, 1980.

- Village Health Workers:

<u>Projected</u>: Modular problem-oriented curriculum adapted to Lesotho.

B. <u>Trained Health Workers</u>

- Nurse Clinicians

22 trained by December, 1981 (16 posted to rural areas, 4 trained as tutors).

<u>Projected</u>: 19 trained by December, 1982
20 having completed 12-month training by December, 1983, lacking the three-month preceptorship.

- Village Health Workers

300 (approximately) trained by April, 1982.

<u>Projected</u>: 700 trained.

II. HEALTH POLICY IN THE KINGDOM OF LESOTHO

The goals and objectives of the health sector set forth in Lesotho's Third Five-Year Development Plan (1980/81 - 1984/85) are compatible with those of the LRHD Project. Priority is given to: (1) ameliorating environmental andother preventable causes of disease and illness; (2) health promotion and instilling in people a sense of responsibility for maintaining their own health; and (3) the redistribution of Lesotho's health care resources from urban to rural areas, until the population's accessibility to basic health services is equalized. However, when the stated priorities of the health sector are compared with the budgetary allocations to various programs and activities, a contradiction is apparent. Over the five-year period a greater proportion and more rapidly rising share of the health investment budget is allocated to urban-based curative care than to rural-based PHC care (combining integrated and vertical programs).

Inconsistencies between policy and budgetary allocations appear to reflect a lack of consensus in the GOL about the direction of development and an inadequate appreciation of the recurrent cost implications of major capital investments in the health sector. This failure to come to grips with setting consistent policy and budgetary priorities causes confusion and hesitancy among donors working in the health sector. Actions to resolve this situation should be undertaken, and the resources available to the GOL in the LRHD Project could be drawn on for these purposes.

In the opinion of the team, the MOH must begin to develop a strategy meshing its health policies with its budgetary allocations. At present, the MOH does not appear to have considered the costs, both in terms of finances

and numbers of personnel, and the amount of organization and time it will take to carry out its various programs over the development period. The coordination of planning and programming activities and their linking to budget-making could establish a basis for judging the appropriateness of the size of the incremental increases going to rural PHC expansion as opposed to those going to tertiary care, urban-based health services.

The design of a strategy to inform decision-making in the MOH about the course of health sector development will require MOH commitment of time and resources. Through study and discussion, options must be developed and positions taken on a variety of technical and policy issues, covering all program areas. The team feels efforts so devoted in the present, and particularly given the availability of resources in LRHD Project, will be more than returned by future gains in achieving desired objectives. It should be possible to complete the strategy by the end of the Project.

III. THE SOUNDNESS OF THE LRHD PROJECT CONCEPT

The objectives and purposes of the Project are considered to be sound within the context of Lesotho's major health needs, availability of national resources, its economic situation and prospects, government-wide policies affecting rural areas and the social/cultural and professional milieu.

The stress on prevention and health promotion is appropriate to counter the major causes of illness in the population:

> "...water-borne disease are a severe problem. Also hygienic sewage disposal is available to very few and diseases like typhoid and gastro-enteritis are endemic. The most prevalent diseases are these plus veneral diseases, measles, mumps, whooping cough, and TB. Chronic malnutrition is wide-spread. A special problem is that of migrant workers who suffer diseases and injuries in the mines.
>
> . . . .
>
> The population growth rate remains at 2.3 percent per annum ...family planning...acceptance rate is low.
>
> (Chapter 13, Kingdom of Lesotho, Third Five Year Development Plan)

There is a nation-wide shortage of professional personnel across all categories; the situation is acute in the medical profession. In Lesotho, there are currently 28 practicing Basotho physicians, about 22 of whom are in private practice in the urban area. Basotho are currently in medical schools abroad (there is no national medical school). The current physician: population ration is 1:14773. There is no obligation for physicians to serve in the public sector after graduation, but the issue is currently being reviewed.

GOL health facilities are almost completely staffed by expatriate physicians, working on both totally and partially subsidized government salaries. The rapid turnover of these physicians, coupled with their diverse cultural and professional backgrounds and experiences, has destabilizing effects on the health system and the MOH's attempts to reorganize and reorient it. Given the current and projected Basotho physican shortage in this context, the GOL chose to develop a new health worker cadre, the NC, to replace the bulk of the needs for physician services, particularly in the rural areas where Basotho physicians are reluctant to practice. In general, this choice was a sound one, since potentially there are ample candidates for the NC training program in Lesotho, and nurses are more accustomed than physicians to working in the rural areas.

The focus of the NC training on prevention and health promotion and use of simple health care technologies, sound management principles and cost-consciousness should also allow the rural health care system to operate with much lower unit costs than secondary and tertiary care facilities--an important feature given the MOH's attempt to equalize the population's access to basic health services. The practice of charging fees for services, at both public and private health facilities, contributes to the financial feasibility of the Project and the GOL's ability to sustain the activities after the Project ends. The commitment of GOL leaders (within the MOH and elsewhere) will be as much if not more decisive in the institutionalization of the activities begun under the LRHD Project than the capacity of the GOL to support them financially.

The targetting of Project resources towards the rural areas and the emphasis on decentralizing their control, is compatible with GOL attempts to stem the tide of urbanization and decentralize the provision and management of government services in general. The MOH appears to be one of the first ministries to begin implementing the decentralization policy and is doing so mainly through the LRHD Project. Expectedly, a number of implementation "bottlenecks" experienced in the Project are partly created by this lack of precedent, e.g., approval of the District and HSA health boards. Nonetheless, progress is being made to decentralize the general administration of district level health operations through the HSA structure, particularly financial management and control, ordering and inventory control of drugs, medical supplies and (eventually) general stores (see IV.C for more details).

Rural villagers exposed to NCs appear to be quickly learning to appreciate the value of their skills, while still differentiating NCs' skills from those of physicians (reinforced by the referral system and differences in fees charged for physician and NC services in some private institutions). One physician supervisor of an NC reported an increase in the severity but a decrease in the number of his referrals from the health center after her posting there. Another registered a concern that the NC under his supervision may "burn out" as a result of her large daily patient load. When asked directly about their acceptance by the communities they serve, all NCs responded that they were confronting no major problems.

Since NCs are performing well in the field and not directly competing with physicians for patients (and it is unlikely that this situation could

change in the near future), it is understandable that no opposition from the medical community to their use has been raised. Neither do traditional healers appear to be opposed to or threatened by NCs. The practice of traditional medicine in Lesotho had already adapted to modern medicine when the LRHD Project began; the two appear to be complementary for the most part.

IV. PLANNING, OPERATIONAL AND INSTITUTIONAL DEVELOPMENT ISSUES AND RECOMMENDATIONS

A. Project Planning

The objectives articulated in the Third Five Year Development Plan have been translated into a framework for planning in Phase II of the LRHD Project. This framework sets forth an organizational structure through which health planning can occur. This planning structure is designed to be compatible with the decentralized PHC delivery structure, through which HSA hospitals, health centers and VHWs are linked by tiered support and referral networks. Advisory boards/committees are to be attached to each level of care to work with the health staff to solve both individual and community based health problems; the problems which are insolveable by the community at one level are "referred" to the next higher level for solution. In response to the upward flow of information on priority needs, a downward flow of technical guidance and support to address the needs should occur.

The district and HSA health boards are key elements of the health planning structure; their composition and terms of reference have been approved in principle but not officially by Cabinet. Once approved, the board members must be selected, and oriented to their intended functions and operating procedures and means to support them from the MOH established. Likewise, many other elements of the health planning and delivery structure must be developed and set in place before planning can occur as intended. For example, health center and HSA staff positions must be formally established.

staff recruited and organized; development of the management support system, including their staffing, must be completed, funds allotted to their operation and a central monitoring capability established.

While the Director of the HPSU has a general sense of the sequencing of activities needed to make the planning and delivery structures work as intended, no explicit strategy has been developed to achieve this end. Experience with similar planning structures in other countries (including the U.S.) suggests that while they are conceptually simple to understand they are exceedingly difficult to operate due to such factors as the numbers of people involved, organizational requirements and political considerations.

Probably most important to the future viability of health planning in the MOH, which has not yet occurred, is the establishment of a planning process which is linked to programming and budgeting, i.e., a periodic review and assessment of existing programs and alternatives in light of health needs, resources and sector priorities.

The MOH reorganization, which began in Phase I, combined the planning and statistics staff and placed the new HPSU in a strategic position to direct planning information to the key MOH decision-makers: the Director of Health Services and in turn the Permanent Secretary. In fact, the Director of the HPSU has the necessary accessibility to these decision-makers, is qualified to assume a leadership role in planning and has made noticeable accomplishments in the area; e.g., writing the health section of the Third Five Year Development Plan and designing the framework for planning. However, she has little time to develop the analytic, information

and support systems needed for planning, and instead spends much of her time liaising with donors and assisting in all phases of implementing donor-funded health projects.

The involvement of the HPSU Director with donors is not only unavoidable, due to staff shortages in the MOH and her experience and capabilities, but also desirable to a certain extent, since acceptance of foreign assistance commits Lesotho's resources and should therefore be considered within the planning process. However, the amount of time spent with donors is out-of-proportion to the other planning activities she and the HPSU should be involved in.

For example, a critical area of planning which has received little attention by the HPSU, largely due to time constraints, is in manpower. The delay of the MOH in assessing present and future supplies and needs for personnel to serve as staff in the evolving PHC system, and optimally in the entire health sector, has probably contributed to delays in establishing formal positions for the NCs and other personnel categories created through the LRHD Project.

There are several reasons why this situation persists--some of them are not controllable by the MOH alone. First, as mentioned, there is a shortage of qualified staff to whom theHPSU Director could delegate portions of her work. In 1983, a Masotho will have completed a two-year course in Health Planning and Economic Development, funded by the LRHD

Project, presumably to assume duties in the HPSU. Another Masotho may soon begin studies in biostatistics, also in preparation for assuming a full-time position in the HPSU. However, in both cases, it is unclear if the desired placements will in fact occur due to the uncertainties regarding (1) at least one of the trainees eligibility for placement, and (2) the creation of the professional positions which are suited to utilizing the trainees' newly-acquired skills.

Secondly, other organizational problems exist within the MOH which, unless resolved, will hinder the abilities of all professional staff in the HPSU to function properly. That is, the MOH has not established consistent internal procedures for reviewing donor proposals, prioritizing them, negotiating funding and implementation schedules with other GOL units and assigning project monitoring responsibilities. As a result, an excessive amount of scarce staff time is spent on each of these activities. Given this situation, it is to the credit of the MOH that they have been able to increase their portfolio of donor-funded projects over the years which, for the most part, support the development of rural PHC delivery.

Third, the MOH must interact with the Central Planning Office, the Ministry of Finance and Treasury in the course of developing and implementing donor-funded projects. It does not appear that these other GOL units have a smoothly-running system for working with the MOH in these areas.

Given these personnel and organization constraints, the feasibility of accomplishing the planning objectives of the Project can probably only be

judged by working through a plan for their implementation. Such a plan would include the level and sequencing of effort required for each proposed activity (i.e., in staff, time, organization and finances). By going through such an exercise, presumedly some activities now on the planning agenda will drop out, as expectations for their achievement become more realistic.

In the team's judgement, the process of ordering priorities in light of what is both important and feasible to accomplish would focus first on planning to completely develop, operate and sustain activities begun in the LRHD Project, i.e., the management support systems and the training of the NCs for service in the rural areas. The linking of the planning activites in the Project with the management and training activities would involve the HPSU in urgent and tangible problem-solving activities while laying a basis for later expanding its scope of planning within the health sector.

The management specialist is in the final stages of designing the various support systems and is beginning their implementation. Yet there is no national planning of the resources required nor the manner and timing of their deployment for fully implementing and operating all the systems on a sustained basis at the district and central MOH levels. With regard to the NC program, the various options for selecting, training, deploying, compensating and supervising them must be assessed, in light of PHC objectives and available resources, and decided upon. Failure to address either situation threatens the future viability of the LRHD Project and

the PHC program.

Good opportunities exist at this juncture in the LRHD Project for linking the planning activities with the management and NC training activities due to the work being done on establishing decentralized budgetting, financial management and control systems in the MOH (see IV.C. for details). In order to develop these systems, budgets for district level operations will first have to be estimated, accounting norms and procedures established and staff trained to manage and control the funds. District level (i.e., HSA hospital) budgets will ultimately account for most of the current MOH program funds under the decentralized system.

It is important that the HPSU (and other headquarter staff) participate in these activities, for two major reasons. First, to assure that central MOH budgets and information (including accounting) systems become compatible with those at the district level. And second, to begin the process of prioritizing and translating the LRHD Project and PHC program objectives into financial resources.

Project Planning Recommendations:

1. The HPSU should develop an implementation strategy for achieving the planning objectives of the LRHD Project. Necessary actions should be identified, prioritized and their level of effort and sequencing calculated. Particularly critical to the prospects of institutionalizing the activities begun in the LRHD Project is to establish a planning process

which is linked to programming and budgetting in the MOH. This process should begin by involving the HPSU in planning to completely develop, operate and sustain major activities begun in LRHD Project, i.e., the management support systems and the training of [illegible]'s.

2. The use of existing staff time in the HPSU should be improved (e.g., by establishing MOH procedures for dealing with donors more efficiently) and arrangements made for securing the appointments of the two additional staff being trained for the HPSU.

B. Training Supervision and Deployment of Nurse Clinician (NC) and Village Health Workers (VHW)

NC Training. The Lesotho NC training program is fundamentally sound from the standpoint of its conceptual approach, course design, curriculum content, teaching staff, facilities, and current level of financing, and represents an impressive attempt to prepare mid-level health workers for the rural areas of Lesotho.

The curriculum is competency-based, that is, only essential knowledge necessary to understand and perform specific tasks is given to trainees. The pace of learning can be adjusted to suit individual capabilities since the material is in modular form. Students are given ample opportunity to practice skills and apply knowledge that is learned during their training. Sixty percent of the total training time is outside of the classroom--in mountain rural health centers, communities, on hospital wards and in hospital out-patient clinics. Students are periodically evaluated by means of weekly and biweekly written and practical exams so that corrective measures can be quickly taken when needed to improve their knowledge and performance. They are also pre-tested to find out their level of knowledge before starting each teaching module.

The training is expected to prepare NCs to carry out the following broad functions in the field:

- Provide curative medical and surgical services;
- Organize, supervise and help carry out preventive and promotive activities in the community;
- Manage the health center and serve as leader of the health center team;
- Train and supervize VHWs.

The program has a 12-month teaching component followed by a 3-month preceptorship. There are three phases to the overall program: module learning, clinical rotations, and preceptorship, as shown:

	Module Learning	Clinical Rotation	Preceptorship
Length:	7 months	5 months	3 months
Content:	Learning knowledge and skills using competency-based modules	Initiate practice and management experience	Field practice under supervision
Sites:	NC Training Center in Maseru District hospitals	Rural communities Queen Elizabeth II Hospital District hospital wards and outpatient clinics	Rural health centers where NCs will be posted

Initially, instruction was provided by two full-time LRHD Project staff, 33 guest lecturers working in Lesotho and 17 clinical instructors. After the first year full-time instruction was supplemented by a trained Mosotho NC lecturer; 26 guest lecturers and 24 clinical instructors are also participating in the second class.

Guest lecturers consist of physicians and other health specialists in such areas as nutrition, leprosy, tuberculosis, family planning, mental health, management, and dentistry. Clinical instructors are physicians based in district hospitals who subsequently would serve as supervisors of NCs posted in their HSAs.

The classroom where students are taught is part of a prefabricated building located next to the nurse dormitory across from Queen Elizabeth II Hospital in Maseru. It was constructed with Dutch funds from Memisa

and Medicus Mundi. Queen Elizabeth II and eleven district and mission hospitals are also used for the training.

The LRHD Project provides all the funds for staff salaries, and some funds for equipment, transportation and salaries for PHAL NC trainees (the MOH assumes the total costs of these salaries for the third class). The MOH provides salaries and per diem for public sector NC trainees and some funds for transportation.

The intensity of the NC training program is a potential concern. Students cover 30 modules in a year, ranging from diagnosis and treatment, subspecialty training, and maternal child care to community health, working with support systems and health center management (see Appendix A). This wide range of topics, combined with the high frequency of exams, the large time requirements and the overall rapid pace of the training schedule rivals the intensity of some medical school programs.

In its monitoring of the progress of the training program and the students, it is important that the MOH be conscious of its high intensity. For example, students may require emotional support and more time to complete their studies satisfactorally. It might also be helpful to consider selectively trimming back the content of certain modules and reassessing the material that is covered based on evaluation and feedback from students, NC graduates and faculty.

Continuing education is particularly important in this context. Maintaining the professional growth and high level of performance of NCs in the field

may require a combination of approaches. For example, NCs could be brought together periodically from the field for refresher courses; they would also benefit from the opportunities to discuss their experiences and share information among themselves. Supervisory visits should also include training; some is occurring but more could be encouraged. The existing NC newsletter is also a valuable means for communication among NCs and between NCs and the faculty which should be continued.

By program regulation, students are selected from among nurse candidates who are doubly-qualified with three years of training as registered nurses and one year as midwives and experienced in working in a rural health center. For the first class, 22 were selected from 27 applicants; for the second class, 19 were accepted from 30 applicants. The size of this pool of qualified nurse-midwife candidates in unknown, but it is suspected that it will be depleted quickly at present training levels (differences between the first and second classes are already noticeable).

There are other categories of nurses experienced in working in rural areas and potentially capable of successfully completing the NC training program, i.e., the registered and enrolled nurses. The former have higher academic qualifications for admission to training and are trained longer than the latter. In addition, registered nurses take the Professional Nursing Qualifying Examination of Botswana, Lesotho and Swaziland prior to practicing. The only enrolled nurses training program (conducted by a PHAL institution, Morija Hospital) is ending, but a large (and unknown) number of enrolled nurses work in the rural areas.

Recognizing that there are differences in professional opinion on this matter, a change in admission policies to the NC training program may be needed if the demand for NCs continues as it has. The training course is designed to be competency-based and therefore able to be paced to suit the student's ability to aquire new knowledge and skills. The extensive rural work experience of many enrolled and registered nurses could well substitute for their deficiencies in academic preparation relative to the doubly-qualified nurses.

NC Supervision. At present, the District Medical Officer who is in charge of supervision, visits each nurse clinician no more than once a month. This visit is often limited to delivering drugs and supplies and attending to referrals from the NC. Perforce, supervisory and support functions, such as providing continuing education, sharing information about district-wide health activities, and general boosting morale are given lower priority.

The quality of NC supervision is greatly affected by the individual medical officer's personal interest in and commitment to promoting the NC as the pivotal community-level health practitioner. But as the number of NCs increases, the quality of supervision will deteriorate if left solely the responsibility of even the best-intentioned medical officer. The skills and background of other members of the district level health team could well be applied to assisting in NC supervision. Furthermore, if the training of NCs continues, the more experienced ones could eventually assume major supervision responsibilities over the others, particu-

larly if NCs were posted (intermittently or permanently) in HSA hospital outpatient clinics (as discussed in the following section).

NC Deployment. Nineteen NCs are presently working in health centers in rural areas (two were selected to be NC tutors and one as the Principal Nursing Officer and lecturer of the program). Twelve of these NCs are working for the MOH and the others for PHAL institutions. NC postings were decided on the bases of communities' needs for their services and their places of employment prior to entering NC training (most graduate NCs returned to their prior places of employment).

An important aspect of NC deployment which does not seem to be receiving adequate attention, is preparing other health staff to work with the NCs and understand their respective roles and responsibilities in health care delivery. (Apparently some misunderstanding on this matter was created at the HSA Implementation Workshops.) Health care personnel in the field as well as students in various professional training programs[6] could be introduced to and instructed in these areas as a means to accelerate implementation of the PHC program.

The use of NCs in HSA hospital outpatient clinics as well as in health centers is becoming an issue, especially since hospitals began to make inquiries to the MOH about this possibility. These outpatient clinics handle

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6 The Nurse Assistant training program was to have been modified to equip these personnel to work with NCs in the rural health centers. The LRHD Project training them, in turn, was to have coordinated NC training with the modified Nurse Assistant program. (See C.Collins, 3/26/80, memo to the files after the LRHD Project Evaluation, Phase I.) However, no progress in either area was found to have occurred.

a patient mix similar to that of rural health centers and are normally very busy; two arguments favoring the posting of NCs at the hospitals. Another, is to use the NCs posted at the hospital outpatient clinics to supervise NCs posted in rural health centers of the HSA.

The major arguments against posting NCs in hospitals are first, that in the short run, it decreases the number available for posting in the rural centers and thus inhibits development of the PHC delivery system as conceived by the MOH; and second, that it risks drawing the NC back into focusing on curative, facility-based care.

VHW Training and Supervision. Current world-wide interest in the VHW concept stems, in part, from the important role that village-based personnel can play in providing primary health care services to rural communities. VHWs in Lesotho are expected to bring simple preventive and curative services to villages through health education and motivation, treatment of minor health problems and first aid.

Lesotho has had the benefit of about 11 VHW training programs during the past five years that have trained approximately 300 of these workers. All but one program was carried out at a PHAL-member facility. It is suspected that these programs vary in quality, length of training, trainee selection, curriculum content, supplies and medications, supervision and continuing education. But, there has been no attempt to determine the number of VHWs who are still working, their performance in their villages, nor their role vis a vis traditional practitioners.

Under the LRHD Project, NCs are being taught techniques for introducing VHWs into the PHC delivery system. NCs learn how to:

- Set up a VHW training program;
- Train VHWs;
- Offer supervision and continuing education;
- Motivate a community;
- Help a community in preparing to choose a VHW.

Serious work on the development of modular materials and illustrations for training VHWs began in May 1981 when a consultant for the LRHD Project visited PHAL institutions that had ongoing VHW training programs. In August 1981, a workshop of representatives from PHAL institutions and other interested parties was held and VHW materials were completed and reviewed. This workshop was the first coordinated attempt in Lesotho to develop a VHW curriculum and training manual on a national basis. These materials have been refined, reviewed andsubmitted to the MOH for its input and reaction. Final modules and materials in Sesotho, including illustrations, should be field-tested and ready for use and distribution in August or September 1982 (see Appendix A).

Meanwhile, a few of the NCs currently in the field are organizing villagers, encouraging them to select VHW candidates, and initiating training using the draft VHW materials. In an effort to share knowledge and promote the use of these teaching materials, the VHW modules will be made freely-available to PHAL institutions and other interested parties who are carrying out training activities.

Under the LRHD Project, the NC will have chief responsibility for all training and supervision of VHWs. Because of the magnitude of these and the other activities of the NCs, it will be important that other professional health workers assist in the activities, especially as the numbers of VHWs grow . Sources of help might include the public health nurse, health assistant, nursing officer, health inspector and members of the Communicty Health Education Unit. However, it is impor-ant that the role of the NC be preserved as the person with these primary training and supervising responsibilities. These roles for the NC should be reinforced by the LRHD Project team and the MOH.

Under current plans VHWs will not receive regular compensation from the MOH for their services, but they will be offered free medical treatment along with their families. It is unclear whether VHWs can be expected to serve for any period of time without compensation; the issue of volunteerism as it relates to VHWs should be looked at to see what evolves in Lesotho. The MOH should be prepared to discuss alternatives to volunteer services by VHWs through such mechanisms as modest payments by villagers or individuals or a self-imposed community tax.

Evaluation of NCs and VHWs. All aspects of the NC and VHW programs, the selection of candidates, their training, supervision, continuing education and deployment, affect their performance in the field and the ultimate impact they have upon the health of the communities they serve. It is important to distinguish between evaluating (for example) the effectiveness and efficiency of NCs and VHWs in providing certain vital services to the rural population and evaluating the impact of these workers on the

population's health status. The former type of evaluation, as previously noted, is important in order to make timely corrections in current activities and should be started as soon as possible. The latter type of evaluation cannot yield valid information except over a very long-term and only in a tightly controlled (experimental) setting. Experience from the Project confirms the general soundness of the NC and VHW programs and the usefulness of these workers in the underserved rural areas of Lesotho. In the near term, the MOH should not be concerned about evaluating the impact of NCs and VHWs on health status, but rather on evaluating the processes of the programs that select, train, place, support and sustain NCs and VHWs in the rural areas and ways to improve those processes.

Training, Supervision and Deployment of NCs and VHWs Recommendations:

1. The intensity of the NC training program (e.g., its pace, quantity and range of materials covered) should be carefully monitored and adjusted as necessary to match the learning capabilities of the trainees.

2. A continuing education program for NCs should be developed soon to offer a variety of opportunities for refreshing and expanding their knowledge and skills, and increasing their motivation and enthusiasm for rural PHC work.

3. The MOH should adopt a flexible policy towards setting academic standards for admission to the NC program. If the demand for NCs outstrips the supply of doubly-qualified nurse candidates, consideration must be given to admitting other categories of nurses and adjusting the intensity of the training program accordingly.

4. As the number of NCs in rural areas increases, the capabilities of medical officers to adequately supervise them will be severely taxed; other modes of supervision should therefore be investigated to address this situation.

5. Greater attention should be paid to preparing other health staff to work with the NCs and understand their respective roles and responsibilities in health care delivery.

6. Together with promoting the use of the VHW curriculum developed in the Project, continuing experimentation with the content and length of this training should be encouraged so that they are appropriately adapted to local conditions.

7. The primary role of the NC in training and supervising VHWs should be maintained, but other members of the PHC team should be encouraged to assist in both areas and particularly if the numbers of VHWs increase substantially.

8. The MOH should begin to design a framework and a means to evaluate the NC and VHW programs (i.e., establish evaluation criteria and indicators and a staff capability to monitor activities and collect, process, and analyze the data). A primary purpose of evaluation should be to improve the processes of the NC and VHW programs that select, train, place, support and sustain these workers in the rural areas.

C. Management Support Systems for PHC Delivery

Since the inception of the LRHD Project, the MOH has been undergoing both a reorganization and decentralization of its service delivery structure. The reorganization began and was approved for the central level in Phase I; approval for district level reorganization is pending Cabinet approval. Efforts have been ongoing at all levels of the MOH in Phase II to make the reorganization functional, despite the fact that several new positions still have not been officially approved by Cabinet Personnel (see Appendices B and C for a description of the Health Program Delivery System and the MOH Organizational Chart).

All position descriptions for the new MOH organization have been written, but many are not filled. One particular vacancy, Deputy Director of the HSA Hospital Services, is important to fill in order to maintain forward momentum in implementing the decentralized PHC delivery system. It appears that a qualified candidate has been identified, but there is a question regarding her ability to fill this post due to procedural matters.

Centrally, management training curriculum has been developed for the NCs and is being taught by the Management Specialist and a counterpart during the classroom portion of the training. Management skills are tested through on-the-job exercises in the pre-deployment period. This component of the training program is extremely impressive in that it seeks to impart practical information to NCs on how to manage PHC delivery at the community level, given prevailing conditions in rural Lesotho.

The bulk of the management efforts in Phase II have been focused on making the HSAs operational, i.e., organizing and conducting HSA workshops, designing and beginning to implement the management support systems and writing district and health center operations manuals (the first such manuals to describe how the MOH operates).

Workshops have been used frequently in the LRHD Project for achieving a variety of implementation milestones, e.g., adaption of training curricula for the NCs and VHWs. In the planning and management areas, an ambitious schedule of district level HSA Implementation Workshops is being followed, with plans to conduct one in each of nine of the ten districts by the end of the Project (and perhaps combining two so that all ten can be completed by December, 1983). "Results" from the two which have been held are mixed--one was much more positive than the other. But in both cases, the results of the workshops appear to be more a reflection of the pre-existing situation in the respective districts than a consequence of the workshop activities, _per se_. The use of workshops in the planning and management areas appears to be more effective to introduce, discuss and/or gain consensus on strategies and objectives as opposed to implementing planning and management systems.

Implementation is an ongoing process, not a one-time event. There is serious concern that the MOH begins now to formulate a strategy to follow-up the workshops' recommendations with the technical assistance, information and support required to convince district and community-level people of its commitment to the reorganization. Coordination of

this strategy with the planning and budget-making activities of the MOH, through the HPSU, would assure an adequate commitment of financial and staff resources to complete and maintain development of the support systems.

More involvement of Basotho staff in completing the scheduled HSA Workshops would begin to build a staff capability for carrying on with HSA implementation. The specific need to develop a "national capability to arrange similar workshops"[7] after AID-funding ends is not as important as addressing the more general need to follow-up the workshops through any variety of appropriate measures.

Development and implementation of the management support systems needed to make the HSA concept operational, and specifically to support the NCs in their new roles in the rural health centers, have met with mixed success, as summarized below.

- <u>Drugs and Medical Supplies</u>. The Lesotho National Drug Stockpile Organization (LNDSO) has cooperated exceedingly well with the LRHD Project management specialist to assist and instruct hospitals and health centers in the organization and maintenance of a drug inventory and order system. Health centers with NCs are given priority over others, but approximately 50% of all centers have received assistance to date.(The LNDSO supports these activities:

[7] Management Specialist Scope of Work, Task 5, Phase II Contract with the University of Hawaii, 10/1/1980.

the LRHD Project provides instruction to NCs on drug supply systems management and control.)

Financial Management. A LRHD Project-funded financial consultant is working with the MOH to design a decentralized system for book-keeping and financial accounting and reporting while this evaluation is occuring. Preliminary impressions are positive that he will recommend policies and procedures for decentralizing budgeting and financial management in the MOH, linking health planning to budgetting and training Basotho in financial management. Presumably, the decentralized budget and financial system to be designed will interface with the planning and budgetting system to be established in the HPSU.

The scheduling of this consultant was proposed early in Phase II but was inexplicably delayed. Fortuitously, the timing of the consultancy now coincides with the issuance of new GOL-wide policy that ministries decentralize fiscal decision-making to districts. While Permanent Secretaries retain responsibility for the overall flow of funds, for the first time they can make explicit allocations to their district operations so that these units know the size of their annual operating budgets and can better control their expenditures. Introducing such fiscal discipline on district level operations in health, i.e., to hospitals and perhaps eventually to health centers, is an extremely bold and positive step for the GOL to take. The onus on ministries to equip district level opera-

tions to account for their fiscal actions will be less heavy on the MOH than elsewhere due to the LRHD Project-supported activities in this area. Nonetheless, this undertaking will be a major and very important one for the MOH, and care must be taken to anticipate and plan for the types and amount of resources needed to develop and operate a financial system.

Communications. Installation of an integrated radio system in all HSAs is being sought. A UN agency has offered to purchase the equipment, once a complete system is designed to install, maintain, and operate it properly. Together with the Mission Aviation Fellowship, the LRHD Project has plans to hire a trainer to train Basotho technicians to install and in turn train hospital and health center staff to use and maintain the radios. A training facility and the trainees have been chosen. The organizational slot for communications under the Deputy Permanent Secretary for Administration is not filled, but in order to expedite installation of the communications system, the proposed trainer will fill the slot for eight months and provide the field support required.

Personnel. There is one over-riding personnel issue to the future viability of the HSA concept (discussed more fully in part D, Institutionalization of the LRHD Project): official approval of all district and HSA positions created through the LRHD Project, particularly the Nurse Clinicians and HSA Administrators, but also the District Medical and Nurse Officers.

Two other important but far less urgent personnel issues are the decentralization of recruitment and disciplinary action authority and adoption of a revised performance evaluation system in the MOH. These issues are complementary, since the latter presumes that supervisors have the latitude to effect employee behavior by changing incentives. The NCs have been trained in the performance evaluation system and its instruction GOL-wide is conducted by Lesotho Institute of Public Administration. To the extent that supervisors' interactions with employees can be a motivating force for improving job performance, such opportunities are being lost by delaying use of the new system.

General Stores and Supplies. Management of central operations and links to health centers are weak. Shortly after this evaluation, a LRHD Project-funded consultant in supplies management will be in Lesotho to develop guidelines for reorganizing these services under the new PHC system and recommend inventory control and ordering procedures for the MOH at central, district and health center levels.

Health Information Systems. Development of this system has been assigned to the planning advisor. Hospitals and clinics are asked to report data on disease frequencies, laboratory activities, personnel and institutions regularly to the HPSU (but reporting is far from complete). NCs are taught to use both health and non-health data (e.g., literacy rates, occupations, size of family) to develop community programs, but it is suspected that little activity of this sort is actually occuring.

The HPSU Director has spearheaded a proposal to the MOH to improve the processing of reported data on disease frequencies and shorten their transmittal time back to the field, thereby encouraging their use for planning and management. The usefulness of these data are circumscribed by the fact that they are facility rather than population-based (the latter are needed for planning preventive and promotive services). Neither has there been an attempt made by the HPSU to assess the attitudes of the staff of health centers and out-patient departments about the usefulness of the data being collected or its proposed formatting (the reporting forms have been frequently revised by consultants). Notwithstanding these criticisms, the acquisition of a small computer as a part of the proposal appears to have merits on the general grounds of improving the capacity of the HPSU to develop other information systems for planning and budgetting.

Transportation. A problem cited by MOH staff at every level of operations is the lack of reliable transport. There is a general shortage of vehicles in the system; adequate operating funds and maintenance are ongoing problems. NCs are instructed not to expect or rely upon vehicular transport. (In many areas served by NCs there is no road network.) One hope for improving the situation in the short-run is to coordinate sharing of transport among various ministries at the district level. In the long-run, few options appear to be available; one suggestion being studied is for the MOH to devise a reliable system of horse transport and maintenance from the health centers.

HSA Maintenance of Health Facilities and Equipment. While included in the Six Month Report (8/31/1979) to the MOH from the LRHD Project staff as an important management support system for PHC, these functions never officially became MOH responsibilities. Since maintenance was a problem raised at the HSA workshops, the Project team has considered ways to address it, for example, by training equipment repair technicians and by encouraging district level coordination with the Ministry of Works (responsible for facilities maintenance). NCs are trained to do their own simple repairs of refrigerators and radios and to practice preventive maintenance of both equipment and facilities.

Management Support Systems for PHC Delivery Recommendations.

1. The MOH should provide staff leadership, and in turn, develop a strategy to provide ongoing follow-up to HSA Implementation Workshops to maintain momentum in developing the decentralized PHC delivery system. The strategy should be coordinated with the planning and budget-making activities of the MOH, through the HPSU, so that adequate financial and staff resources are available as needed.

2. Opportunities to coordinate implementation of a decentralized financial management system with the planning and budgetting systems scheduled for development in the HPSU should be exploited as much as possible.

3. Immediate attention should be given to finalizing government approval of all MOH district and HSA positions created through the LRHD Project, particularly the HSA administrators, the NCs and NC tutors.

4. The adoption of the revised performance evaluation system for MOH personnel (coupled with the necessary delegation of supervisory control over employee incentives) should be considered, as one important means for improving employees' job performance.

5. All feasible options for improving transportation for NCs from health centers should be identified, assessed and pursued as much as possible.

D. Institutionalization of the LRHD Project

There are six issues associated with the institutionalization of the LRHD Project activities. These are:

1. NC Training. While Nurse Clinician (NC) training is well ad-advanced, the institutionalization of their status in law and in the Lesotho civil service has not yet been resolved. The legislation that would establish their professional status is still pending but is expected to clear Cabinet this session. But the NCs who graduated in December, 1981 are serving in the field at the same pay scales as before they commenced training. Cabinet Personnel, in consultation with the MOH, is in the process of deciding on an appropriate NC grade and pay level and the total number of new positions needed to cover the NCs working in the field, in training and those yet to be trained for the public sector.

The effort to establish the NC status has been underway for more than two years, substantially before the present class entered training. It is apparent that any further extended delay in resolving these issues will clearly damage the training effort. The morale of the present field staff will certainly fall, the prospects dim for retaining them after their bonding period and for recruiting the most attractive candidates for future NC training programs.

It is essential to the future of NCs in the GOL health sector that the MOH, Ministry of Finance and Cabinet Personnel agree to integrate certain numbers of future NC graduates into the civil

service at the appropriate grade and pay level. If the Ministry of Finance and Cabinet Personnel cannot provide the funds and positions for the expected numbers of new NCs, then changes need be made in the planned training schedule and/or the terms under which NC candidates are recruited.

The situation of the NC with respect to their civil service grade and pay levels applies almost equally to the NC tutors and the HSA administrators. In the case of the latter, there is no legislative issue. However, five administrators trained at the Institute of Development Management in Botswana are now working in HSA posts at pre-training salary scales and there are plans to train and deploy 12 more (i.e., for a total of 17).

It is of great importance that the senior management of the MOH work persistently with the other concerned ministries to resolve these issues. Failure to do so will, in the evaluation team's judgement, scuttle the new rural health system.

2. Training of Nurse Clinicians at the New Faculty of Health Sciences. The MOH is collaborating with the National University of Lesotho to establish a Faculty of Health Sciences (FHS) where NCs and other health care personnel will be trained. The FHS intends to initially train a range of health support personnel including pharmacy assistants, medical laboratory technicians, dental assistants and environmental health officers. Graduates from the NC program will

receive diplomas; the others will receive certificates.

FHS hopes to improve the quality of these training programs through upgrading the teaching staff. FHS is also concerned with health manpower planning, and would like to assure that the number and categories of personnel being trained at the Faculty will both meet Lesotho's priority health care needs and be absorbed into the public and/or private sector system when their programs are completed.

The long-term goal of the FHS is to establish a rurally-oriented medical school in Lesotho to increase the numbers of Basotho physicians (there are 28 now in Lesotho) to diminish the GOL's present reliance on expatriate medical personnel.

There seems to be general agreement that incorporating NC training into the University curricula would be a substantial step forward in institutionalizing it in Lesotho. At the same time, experience in both developed and developing countries suggests that moving this training to an academic (university) from an operational (ministry) base and raising professional credentials can erode the practical nature of the program.

The team felt it would be quite unfortunate if the institutionalization of NC training at the University (a) detached this training from its present very practical and operational goals, (b) refused applicants with successful field experience but without some formal

credentials, and (d) produced a graduate with a perspective that was not committed to serving the health care needs in the rural areas.

3. Retention of Field Staff. The success of the LRHD Project will depend heavily upon the capacity of the health care system to hold at a high state of technical preparation and morale the key staff that serves the rural areas. In Lesotho, the key staff person that must be retained is the NC. The training program should produce a health care professional that is technically and psychologically prepared to undertake this rural PHC work. The NC employer, either the government or a private institution, is responsible for creating a work environment that will retain that trained staff.

The factors that determine staff retention are a combination of incentives, such as compensation, management and professional staff support and personal encouragement. There must be an attractive economic package of pay and allowances that are specifically available for service in remote and isolated rural areas (and are lost if the individual leaves). Adequate management support includes, for example, maintaining sufficient drug and medical supplies, reliable transport and communications, all factors that permit the NCs to carry out their functions as they have been trained and with minimum frustration.

This field worker also needs a regular source of construction supervision, opportunities to exchange perspectives with colleagues and contin-

uing education to upgrade and expand skills. On the more personal side, the NC needs reasonably attractive housing, regular maintenance and supplies of fuel for cooking and heating. Where possible, the NCs should have a voice in determining the location of their assignments. Beyond these, the NC needs the psychological support, personal satisfaction and espirit that is derived from knowing that the work performed is both important and recognized. The depth of this satisfaction could carry the individual through the inevitable personal crises, job frustrations and breakdowns in the support systems.

The LRHD Project is already addressing many of the economic and management support issues associated with the retention of the NCs. However, the Project does not seem to have addressed all of the personal and psychological factors that relate to holding these trained staff in the field. Since holding field staff is both crucial to the success of the Project and a problem that can be confidently anticipated, an in-depth examination of the retention issues, especially in the isolated rural areas, merits priority consideration by the MOH.

4. Assignment of National Counterparts for LRHD Project Expatriate Personnel. Institutionalizing the LRHD Project will require assigning and training Basotho professionals to replace the following expatriate personnel:

- o Health planner
- o Management systems specialist
- o NC trainer
- o Physician trainer

There are very satisfactory counterpart relationships for two of these personnel: the health planner and NC trainer. However, there is no counterpart for either the physician trainer or the management systems specialist. In the latter case, a qualified candidate now concluding participant training in administration in the U.S. may be available for this assignment when she returns to Lesotho in May, 1982. However, no candidate for the physician trainer post has been identified.

Both the physician trainer and the management systems specialist perform functions that are vital to the successful operation of the LRHD Project and the rural health system. Yet both are working in the MOH without permanently designated counterparts. As matters now stand, the management systems specialist will leave in August, 1982 and the physician trainer in September, 1983. It is urgent that Basotho counterparts be found for both of these two expatriate specialists.

5. Participant Training. Despite a rather late start in planning for the use of participant training funds, the project has now programmed $290,438 for training of Ministry of Health personnel

through the end of the Project. $119,850 of this total is committed for training that is already underway and for training for which firm commitments have already been made. The remaining $170,588 is programmed for training which will commence later in 1982 or early in 1983.

Earlier problems with identifying appropriate candidates for training have been reduced by selecting candidates already employed at the MOH rather than recruiting recent university graduates and others from outside it. Also, this approach should better assure that personnel returning from Project-sponsored training will be placed in appropriate positions within the MOH.

The exception to this solution is training of HSA administrators. Because of the relatively large number of trainees required for this position, and because no such position, or even similar position currently exists, it has been difficult to identify appropriate candidates. Preliminary attempts to recruit from clerical levels yielded underqualified personnel who experienced difficulties both during training and in the field. Nurses have proved successful during training and also in the field, but the MOH is rightly quite hesitant to deplete the current supply of nurses to fill administrative positions.

A previously-advocated solution to the problem is to add HSA administrator posts for each of the HSAs in the establishment list, at a grade and pay level which accurately reflects the con-

siderable responsibilities in finance, purchasing, supervision, community organizations, planning, and intersectoral liaison which these individuals are expected to assume. In so doing, candidates could be recruited from outside the MOH and assured positions after their training.

Since successful implementation of HSA structures and decentralization objectives depend so heavily upon the availability of these administrators in the field, it is of the utmost importance that the MOH work to add these posts to the establishment list at the earliest possible date.

In summary, the participant training plan includes the following:

1. o Long-term (degree) training (31% of funds):

   Health planning and economic development (2 year Masters)**
   Biostatistics and planning (2 year Masters)***
   Nursing education (2 year Baccalaureate)***

   o Short-term (non-degree) training (61% of funds):

   Tutor training for PHC (six students for three months)**
   HSA administration (eight students for nine months)***
   Planning and management systems (three students for six weeks)***
   Development planning (one student for one month)***
   Nursing administration (four students for nine months)***
   Fundamentals of statistics (two students for eleven days)***
   Management (12 students for nine months)**

   o Workshops (8 % of funds):

   Financial management at the HSA level***
   Orientation of newly-arrived physicians to the HSA system***
   Preventive maintenance of vehicles***
   HSA implementation workshops in ten districts **

** In progress
*** Not yet begun

6. Donor Project Financing. The Project has supported modest amounts of in-country and overseas training and MOH participation in international development conferences on PHC. Some in-country and overseas training will continue to be required when the present Project is completed. The total amount of funds required for this training is not large but it is in line item categories that are difficult to secure (e.g., international travel and per diem). While international assistance can reasonably be expected to support some of the overseas training, funding for in-country orientation and training conferences will be short unless adequate provision is made for them in future health budgets.

Institutionalizing the LRHD Project Recommendations:

1. The MOH must move urgently to establish the positions for the graduate NCs and the NC class in training, the NC tutors and the HSA administrators. The MOH must make adequate staffing and budget provisions for future NCs and the HSA administrative staff in order to assure the future viability of its PHC program.

2. If responsibility for NC training passes to the FHS, the MOH needs to sustain a strong professional input into (and perhaps a veto over) the proposed changes in the present program. The MOH should be particularly concerned about course design, selection of instructors, and the standards for acceptance into the program and graduation from it.

3. The MOH should systematically examine the determinants of health staff retention in the rural areas, with a specific view to providing an optimal work environment for NCs assigned there.

4. The MOH needs to recruit and assign Basotho counterpart professionals to assume the responsibilities now being carried out by the expatriate management systems specialist and physician trainer.

5. The incumbent management systems specialist should be requested to extend his stay beyond the completion of his present contract (in August 1982) for a period of up to twelve additional months. Because of the time required to become effective in a new setting, the team questions the utility of recruiting another long-term expatriate specialist for this position should the incumbent decline to extend.

6. The incumbent physician trainer should be requested to extend his stay beyond the completion of his present contract (in September, 1983) for a period of up to six months (until the second class of NCs complete their three-month preceptorship) provided that the search for a Masotho counterpart continues unrelentingly.

7. The MOH should consider covering in their budget the costs of the modest in-country training program and MOH participation at international PHC conferences that are now supported from Project funds.

V. SPECIAL ISSUES:

RELATIONSHIPS WITH THE PRIVATE HEALTH ASSOCIATION OF LESOTHO (PHAL)

PHAL was formed in 1974 to represent the interests of private voluntary groups involved in health care programs in Lesotho to the GOL. The organizations affiliated with PHAL are diverse; mostly sponsored by churches (charter members were the Anglican, Evangelical, Seventh-Day Adventist and Roman Catholic Churches) or religious congregations, but also include private voluntary agencies, such as CARE. External assistance from donors, patient fees and charges are also important sources of support for covering the operating costs of these organizations.

A large amount of health services in Lesotho are delivered by PHAL members. Nine of the 20 hospitals are owned and operated by PHAL members and about three-quarters of the health clinics and centers.[8] Two of the three doubly-qualified nurse training programs are in PHAL insitutions; 39% of nurses and 49 % of physicians work for PHAL-member institutions.[9]

The evaluation team was not able to assess the overall quality of health care delivery in PHAL institutions as compared to GOL institutions. The impression is that it varies both within the public and private sectors. Nonetheless private health centers and hospitals play an important role in providing health care in Lesotho, especially in the rural areas and their cooperation is needed to implement Lesotho's PHC delivery system.[10]

8,9,10 PHAL member institutions represent 65 of 91 health centers (71%); 8 of the 17 HSA hospitals (47%), which account for 76% of all outpatient visits; and employ 134 of 343 nurses (39%) and 43 of 88 physicians (49%). HPSU/MOH data 1981.

In general, PHAL member institutions are enthusiastic both about employing NCs and the HSA concept of rural health delivery introduced by the LRHD Project. Some private institutions began to implement the HSA structure as soon as initial guidelines were issued by the MOH; a true test of the practicality of HSAs in Lesotho. (A concept similar to the HSA was being tried on a pilot basis in a private institution prior to the LRHD Project.) However, there are several areas of disagreement between the MOH and PHAL institutions regarding their respective roles and responsibilities in the evolving PHC system. The most important issue concerns the terms of employment and compensation of the NCs in private institutions.

In order to control NC placement and retention, the MOH favors employing all NCs in the government at a uniform level of pay and grade, regardless of whether they work in a public or private health facility. PHAL, on behalf of its members, is opposed to this arrangement on these same grounds, i.e., it would loose control over NC selection and retention. (In addition, the proposed government salary level is out of line with the wage and salary structures of private facilities and thus seen as a source of potential friction between the NC and other staff.)

PHAL agrees with the MOH that compensation levels between the public and private sectors ought to be comparable for NCs but that its institutions cannot afford to pay the proposed government salaries for NCs. PHAL favors a (lump sum) subsidy from the MOH to facilities employing NCs (or optimally, to all its member institutions). The private facilities feel confident that they could use these funds to offer the NCs a sufficient level of compensation

to attract them to their employ. (Several NCs interviewed confirmed the importance of both monetary and non-monetary compensation to their job satisfaction.) In addition, PHAL is sensitive to the fact that their fee schedule is as much as twice the level of MOH fees, and in their opinion, as high as most rural people can afford without foregoing necessary service use. PHAL members would thus use a MOH subsidy to hold down cost increases which might otherwise raise fees.

The MOH recognizes the need for subsidizing the private sector's delivery of services, in order to avoid either a further widening of their fee schedule or a reduction or elimination of services. A MOH request for a budgetary allocation to support private sector health delivery appears to have been granted for the 1982/83 fiscal year, but whether this subsidy will be used to pay NC salaries or for more general support has not yet been decided.

PHAL and the MOH have reached agreement on the basic features of PHC delivery, i.e., the integration of their activities within the HSA organization and delivery of a common mix of health services to the rural population at affordable prices. Given these common objectives and the private facilities' fine general track record for operating efficiently, it makes more sense to link the MOH subsidy to the delivery of a set of services, or "outputs", rather than specifically to the NC, an "input". PHAL and the MOH could agree on minimum quality standards for services, NC placement and employment rights and other issues through contractual agreements. This arrangement would be easier for the MOH to administer than the alternative.

Over the longer run, the team feels it is important for the MOH and PHAL to continue to develop their working relationships in planning and implementing the PHC delivery system. For example, many PHAL institutions have developed effective budgetting and financial management systems; the MOH should be sure that the systems they develop, both centrally and at the district level, interface with the PHAL systems to the extent possible. The private sector could also directly assist MOH planning and budgetting activities by sharing information on their costs of delivering services.

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CURRICULUM MODULES FOR NURSE CLINICIANS

Assessment Skills and Core Material

1. Primary Health Care
2. Anatomy and Physiology
3. Medical History
4. Physical Examination
5. Causes of Diseases
6. Formulary Use

General Clinical Training

7. Common Skin Problems
8. Ear, Nose and Throat Problems
9. Respiratory System and Heart
10. Gastro-Intestinal Problems
11. Genito-Urinary Problems
12. Common Medical Conditions
13. Common Communicable Diseases
14. Mental Health
15. Dental Problems

Trauma and Emergency Care

16. Trauma and Emergency

Maternal and Child Care

17. Child Care
18. Family Planning
19. Diseases of Infants and Children
20. Prenatal and Postnatal Care
21. Labor and Delivery
22. Problems of Women

Community Health

23. Community Environmental Health
24. Community Family Planning
25. Community Nutrition

Management

26. Working with the Health Team
27. Working with the Support Systems

Reference Materials

28. Lesotho National Formulary
29. Clinical Reference Manual Containing Patient Management and Diagnostic Protocols
30. Administrative and Overall Management Protocols

CURRICULUM: MODULES FOR VILLAGE HEALTH WORKERS

31. Health and the Village Health Worker
32. Child Care and Nutrition
33. Prevention and Care of Diarrhea
34. Clean Water and Clean Village
35. Safe Pregnancy, Normal Delivery, and Child Spacing
36. First Aid and Common Illnesses
37. Tuberculosis, Leprosy, Mental Health and Venereal Disease

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DESCRIPTION OF HEALTH PROGRAMME DELIVERY SYSTEM

A. MOH Organizational Structure

Much concern and effort has gone into developing an organizational structure which will promote the development of an integrated primary health care system designed to serve all the citizens of Lesotho. This is the result of several years of organizational development carried out by key public and private officials. These people had an interest not only for meeting the WHO objectives (of "Health for all by the year 2000") but of strengthening the systems serving the rural communities of the country.

Note that on the organizational chart which follows, all district health services are co-ordinated under the leadership of a Director of Health Services (DHS). This official reports directly to the Permanent Secretary for Health and Social Welfare. The DHS has responsibility for the national co-ordination of all district health services, including implementation of the plans for primary health care systems involving the Health Service Area hospitals, the Lesotho Flying Doctor Service, and their health centres.

B. Primary Health Care

A Primary Health Care Programme is the Government commitment to provide essential health services fairly to all people by the active participation of the people in the planning and delivery of these services. Primary Health Care Programme includes promotive, preventive and essential curative services with easy access to all the people through several levels of personnel, for example, through Doctors, Nurse Clinicians and Village Health Workers, and initially the family itself.

Primary Health Care has been defined as the maintenance of health, prevention of illness, and the treatment of illness when it does occur. Such care is provided at all levels but is primarily given by the person who first provides health care for the client or is responsible for the well-being of another person.

For Lesotho, the framework for Primary Health Care programmes can be diagrammed as follows:

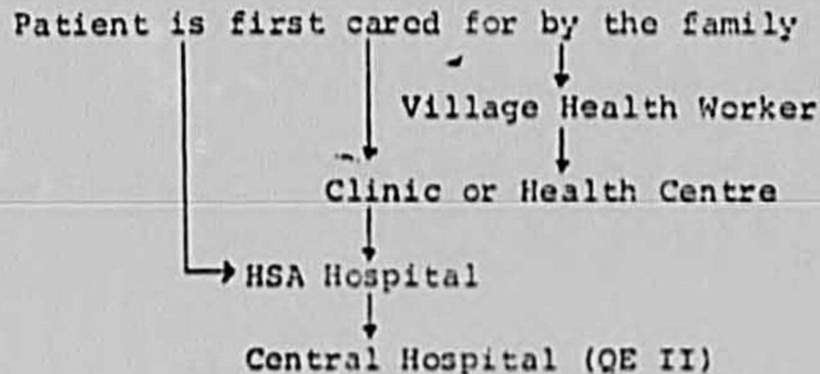
1. Family - the family is the first unit within which the first level of care is provided.

2. VHW - the provider of PHC at the village level and who provides the link between the village and the health care system.

3. (Rural) Health Centre (unit) - Government or private.

4. HSA Hospital (Government or private).

5. Central Referral Hospital (Queen Elizabeth II).



C. <u>District Health Team</u> (also see Appendix a)

The key members of the District Health Team are the District Health Officer, the District Nursing Officer, the District Public Health Nurse, the District Health Inspector and the administrative staff. They are responsible for planning, co-ordinating and evaluating the health programmes and operations of all services within the district. The District Medical Officer of Health will report directly to the MCH Director of Health Services. The Nursing Officer, Public Health Nurse and Health Inspector will be administratively responsible to the District Health Officer but will receive technical supervision from their related professional counterparts at Central Headquarters.

<u>District Health Board</u>

When established, the District Health Board will meet at least twice annually to provide planning recommendations for district health services. Specifically, the Board will be asked to:

(1) identify and prioritize health needs and problems within the district

(2) generate, identify and mobilize district resources which might assist in meeting the health needs of the district

(3) provide pivotal linkage between the central level of the MOH and the peripheral level

(4) act as an advisory board to the district

(5) submit recommendations for health policy to the National Health Council

(6) review and make recommendations for implementing national guidelines at the district level.

The District Medical Officer of Health, in his role of Secretary to the District Health Board, will have added responsibilities for preparing agendas, making meeting arrangements, preparing reports and minutes for the Board meetings. The proposed composition of the District Health Board is as follows:

District Co-ordinator, Chairman
District Health Officer, Secretary
Local Administrative Officer
Principal Chiefs
Medical Director of each HSA in district
District Senior Nursing Officer
District Senior Nursing Officer - Mental Health
District Health Inspector/Health Assistant
District Public Health Nurse
District Nursing Officer
District Social Worker
Nurse Clinician(s)
Representatives from HSA Advisory Boards
Representative selected by PHAL
District Representatives from Ministries of Agriculture, Education, Rural Development and Interior
Representatives from District Development Committee
Representatives of Private Practitioners
Selected representatives of the public (including traditional healers, when possible) from each HSA
Representatives from among Principal Chiefs

D. Health Service Areas Operations

Within a district, each hospital will have a defined health service area within which all health services (i.e. inpatient and outpatient services, clinics, health centres, health programmes, and health-related activities) will be co-ordinated by the HSA Medical Director and other members of the HSA Management Team. Health centres will be assigned to an HSA and will receive their supervision and management support services from the HSA hospital staff.

The HSA Medical Director will be responsible for the curative and preventive services and other health related activities and staff within the HSA. The Medical Director will report directly to the District Health Officer. He/she will also serve as secretary for the HSA Health Board, and should expect to provide agendas, minutes, reports, arrangements and other support services necessary for the efficient functioning of the Board. When established the HSA Health Board will meet at least twice annually and more often if requested by the HSA Medical Director. Its responsibilities include the following:

- (a) Identify the needs and define programmes for communities within the HSA,
- (b) Recommend priorities for programmes,
- (c) Support programme implementation within the HSA,
- (d) Mobilize communities (for action),
- (e) Mobilize resources within the HSA,
- (f) Advise the HSA Medical Team,
- (g) Provide the link between the HSA, the District Health Board and the Health Centre Advisory Committee,
- (h) Assist the Health team with monitoring and evaluation of programmes,
- (i) Familiarize themselves with National Health Policy.

HSA Health Board composition has not been decided, but may include:

- 1 person selected by Churches,
- 1 person selected by Chieftainships,
- 2 persons selected by proprietors of HSA hospitals,
- 2 persons selected by Government of Lesotho (GOL),
- 1 person selected by each clinic advisory committee, such person is not to be from the previous categories.

The HSA Health Board Chairman would be elected by its own members. Both government and non-government HSA's would be expected to establish such an Advisory Board.

E. Health Centre Operations and Advisory Committee

The Nurse Clinician will be responsible for providing and co-ordinating the community preventive, promotive

and curative functions through the health centres. She will supervise any other staff members assigned to the health centre and will train and supervise the village health workers within the health centre area. She will also develop and work closely with a Health Centre Advisory Committee. Until sufficient Nurse Clinicians are trained, patient care will continue to be provided by staff nurses aided by regularly scheduled visits by HSA Medical Officers. In the absence of a Nurse Clinician, a nurse will be in charge of co-ordinating health centre operations and will assess and refer patients.

The HSA Medical Director will provide general professional supervision for health centres within his/her area, regardless of whether they are public or private institutions.

F. Village Health Services Operations

The Village Health Worker will be the key link between the health delivery system and the villages. The VHW is chosen by the villagers in consultation with health professionals and will provide promotive/preventive and some curative functions. She will motivate all persons needing medical care to the Health Centre and will follow up on assistance needed by patients after they leave the centre.

Eventually the Nurse Clinician at each Health Centre will supervise the VHW, but until there are enough Nurse Clinicians, the nurse that is in charge will provide VHW supervision. Most villages will also have a health or development committee to help guide the VHW activities.

Note: See reverse side for suggestions on the Health Centre Advisory Committee.

The Health Centre Advisory Committee will likely have the following membership:

Village Health Workers from each village. Where no VHW exists, a representative of the village development committee would be invited to participate.

Representative of Chiefs.

Representative of traders.

Representative of teachers.

Representative of churches.

Representative of traditional healers.

Representatives of extension, agriculture, rural development (nutritional) where they exist.

Any local representatives who are on the HSA Advisory Board.

Local community representatives selected at pitsos.

PHN and health inspector (ex officio).

Nurse clinician (as secretary to the Committee).

The Committee would elect its own chairman and would meet three or four times a year and as needed. Its duties would include the following:-

a. Identify and define health needs in the communities.

b. Advise on health programme priorities.

c. Identify and mobilize health care resources in the service area.

d. Interpret and support primary health care programmes in the communities.

e. Assist health centre staff with evaluation of services.

f. Become knowledgable about national health policies and programmes.

- W.H.O. – Dr. Tembo
- MINISTER / PERMANENT SECRETARY – Mr. P. Lehloenya, Mr. Thabane
- NATIONAL HEALTH COUNCIL
- P.H.A.L. – Mr. Pokeche
- FACULTY OF HEALTH SCIENCES – Dr. Ngakane
- PLANNING AND STATISTICS – Mrs. Boratho
- DEPUTY PERM. SEC. FOR ADMIN. – Mr. Chabane
  - TRAINING – Mr. Mosetsel, Mrs. Ntoampe
  - FINANCE – Mr. Lejaha
  - PERSONNEL – Mr. Matamane
  - TRANSPORT & MAINTENANCE – Mr. Makuta
  - COMMUNICATIONS
- DIRECTOR OF HEALTH SERVICES (D.H.S.) – Dr. Maruping
- SENIOR DEPUTY DIRECTOR (MENTAL HEALTH SERVICES)
- SENIOR DEPUTY DIRECTOR (Supt. QE II Hospital) – Dr. Moji

DEPUTY DIRECTORS OF: – DR. Raditapole, Miss Boikanyo, Mr. Ferguson

- DISEASE CONTROL
  - COMMUNICABLE DISEASES
  - E.P.I. – Mr. Webster
  - ENVIRONMENTAL HEALTH – Mr. Moshoeshoe
- LABORATORY SERVICES
- FAMILY HEALTH
  - MCH PROGRAMMES
  - COMMUNITY HEALTH EDUCATION – Mr. Petlane
- NURSING SERVICES (CHIEF NURSING OFFICER) – Mrs. Kuoe
  - PRINCIPAL N.O. MENTAL HEALTH – Mrs. Moremoholo
  - PRINCIPAL N.O. QE. II – Mrs. Mokhali
  - PRINCIPAL N.O. TRAINING – Mrs. Rakhetla
  - PRINCIPAL N.O. PUBLIC HEALTH – Mrs. Thakhisi
  - PRINCIPAL N.O. NURSE CLINICIANS – Miss Rankhethoa
  - PRINCIPAL N.O. MCH FP – Mrs. Seipobi
- DRUG AND MEDICAL SUPPLY SERVICES
- HSA HOSPITAL SERVICES

- DISTRICT MEDICAL OFFICER OF HEALTH – DISTRICT HEALTH BOARD
  - DISTRICT HEALTH INSPECTOR
  - DISTRICT NURSING OFFICER
  - DISTRICT PUBLIC HEALTH NURSE
  - DISTRICT ADMIN. STAFF
- H.S.A. MEDICAL DIRECTOR(S) – H.S.A. HEALTH BOARD
  - H.S.A. HOSPITAL STAFF
  - H.S.A. ADMIN STAFF
- NURSE CLINICIAN HEALTH CENTRE – HEALTH CENTRE COMMITTEE
- VILLAGE HEALTH WORKER – VILLAGE HEALTH [illegible]

HURD STAFF

Mrs. M.A. Lerotholi, Adm.Assist.
Miss A. Fice, Clerk.typist/Receptionist
Miss G.L. Mokhethi, Clerk/Typist/Recept.
Miss N. Rankhethoa, Dept. CNO for NC Admin., Course Coord.
Mrs. Mpota, NC Tutor (MCH, Commun.)
Mrs. Tachoe, NC Tutor (Cont. Educ. NC Clin. & Follow-up)
Miss [illegible], NC Tutor, Clinical Rotation
[illegible], [illegible]
[illegible], [illegible]

Mr. [illegible] Hettle, Management Advisor
Mr. Cliff Dixon, COP, Planning Advisor.

Persons Interviewed by the Evaluation Team

Yaw Adu-Boahene	Financial Consultant to LRHD Project
Mrs. M. Africa	Director, Statistics Unit, MOH
Mr. B. Bahl	Assistant Director, USAID
Mr. Bereno J. Bakker	LDA Production Manager
Mr. Dean Bernius	Project Coordinator, USAID
Miss Maud Boikanyo	Manager, NDSO
Mrs. N.T. Borotho	Chief Planning Officer, MCH
Mr. Rick Carbone	Catholic Relief Service
Mr. Joe Carney	Manpower Office, USAID
Mr. C. Clewlow	Manpower Advisor, Cabinet Personnel
Mr. Frank Correl	Director, USAID
Mr. Charles Debose	USAID Southern Africa Regional Health Advisor
Rosemary Desanna	HMDS Project Coordinator for Lesotho
Mr. K. Eilbert	Assistant Program Officer, UNICEF
Mr. Theo Ferguson	Ex-Manager, NDSO
Mr. Kess Hottle	Management Specialist, LRHD Project
Mr. Phil Howard	Program Office, Rural Work and Sanitation Project
Mr. Kotsokoane	Senior Permanent Secretary
Mr. R.P. Kuoe	Chief Nursing Officer, MOH
Dr. J. LaRose	Physician Trainer, LRHD Project
Miss Mary Liefo	Nurse Clinician, Seshote
Ms Nthabiseng Mabitle	Tutor, Nurse Clinician Training Program
Sister Agnes Makhele	Nurse Clinician, St. Rodriques Health Centre
Mr. M.A. Makhetha	Health Inspector
Dr. A.P. Maruping	Director of Health Services, MOH
Mr. Mareta	Div. Environmental Sanitation, MOH
Mr. Matamane	Personnel Officer, MOH
Mr. Fanana	Central Planning Office, Desk Officer to MOH
Dr. C.N. Moji	Medical Superintendent, Queen Elizabeth II Hospital
Mrs. Moji	Deputy P.S., Central Planning Office
Dr. P. Ngakane	Director, Faculty of Health Sciences
Mr. Nkhlapo Nkhetho	Chief Field Operations Officer, EPI
Mrs. Nkuebe Nkuebe	Programme Manager, EPI
Mr. L.K.L. Moshoeshoe	Chief Health Inspector

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Dr. H. Notter	Director of Primary Health Care, St. Joseph Hospital, HSA
Mr. Cliff Olson	Chief of Party, LRHD Project
Dr. H.L. Palsenberg	District Health Officer, Mohotlong
Mr. M Petlane	Chief Health Educator, MOH
Mrs A.M. Rakhetla	Principal Nursing Officer for Nursing Education
Miss N. Rankhethoa	Principal Nursing Officer for Nurses Clinicians, MOH
Mr. O.T. Sefako	Director, Cabinet Personnel
Ms Monica N. Sekhopha	Nurse Clinician, Nazareth Health Centre
Ms Sandy Tebben	Nurse Clinician Trainer, LRHD Project
Dr. D. Tembo	Regional Director, WHO
Mr. M.T. Thabane	Permanent Secretary for Health
Mrs. C.M. Thakhisi	Principal Nursing Officer for Public Health Nurser, MOH
Dr. R. Verhage	PHC Director, Scott Hospital
Mr. D.L. Wadsworth	Chief of Party, Rural Water and Sanitation Project
Mr. C. Webster	Director, EPI Programme, and WHO Technical Officer
Sister Yvonne	Family Nurse Practitioner, St. Ann's Health Centre

APPENDIX E

CONTINUATION SHEET	DEPARTMENT OF STATE AGENCY FOR INTERNATIONAL DEVELOPMENT ☐ PIO/C ☐ PIO/P ☒ PIO/T ☐ PA/PR	☐ Worksheet ☒ Issuance	PAGE 5 OF 12 PAGES
		1. Cooperating Country Lesotho	
		2a. PIO Number 632-0058-3-10100	2b. ☒ Original OR Amendment No. ____
		3. Project Number and Title 632-0058 Rural Health Development	

Indicate block numbers	Use this form to complete the information required in any block of a PIO/P, PIO/T or PA/PR. For PIO/C, furnish the item number, quantity, description/specifications, including catalog stock number and price when available.
18	ATTACHMENT A: STATEMENT OF WORK

ATTACHMENT A: STATEMENT OF WORK

A. Overall Evaluation Scope of Work

The technical assistance identified in Block 14 of this PIO/T is required to undertake an evaluation of the Rural Health Development Project (632-0058). This evaluation, which will occur after three years of project implementation, was envisioned in the Project Paper (Section IV.C. - Evaluation Plan) in ProAg 77-L-13 and PIO/T 632-0058-3-90671 which initiated the commencement of Phase II of the Project. The evaluation shall determine if the Project objectives are being met, insure that data is being collected to permit measurement of progress and make recommendations to further assure that the Project inputs are realistic and can be achieved. The evaluation will also recommend, as necessary and appropriate, modifications or alterations in the Project's design and/or implementation which will assure attainment of the Project objectives. The necessary background information on the Project is included in item D of this attachment (Attachment A). In conducting the evaluation, the services of three technical specialists will be required. The contractor, whose services as Nurse Clinician Training Specialist are described in detail in this PIO/T, shall perform as one member of the team.

A draft report of the evaluation will be prepared by the evaluation team for discussion with appropriate Ministry of Health (MOH), project, USAID/Lesotho and University of Hawaii backstop personnel. This draft report shall include findings of the evaluation team and recommendations for Project modifications or alterations, if necessary. This draft report shall be submitted for discussion with all concerned parties at least two days before the team's departure from Lesotho. This will allow adequate time for the team to incorporate the necessary corrections or changes in the draft which will then be passed to USAID/Lesotho prior to the team's departure for final typing and distribution.

In determining if the objectives of this project are being achieved, the evaluation shall address and examine the following subjects (not in order of priority):

1. assess the evolving roles of the Nurse Clinicians (NC's and Village Health Workers (VHW's) including consideration of continuing education needs; training, supervision, and support; [illegible] support; possible role of NC's in out-patient departments when rural health center needs have been met; government regula-

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tions contributing to formalization of roles, etc.;

2. assess whether the individual activities and accomplishments in training, management and planning, do contribute, in fact, significantly to the institutionalization of a primary health care system in Lesotho;

3. evaluate the viability of those processes through which the role f expatriates will be diminished and the role of MOH counterparts will expand as the Project approaches the project completion date of December 31, 1983. (This will include counterpart relationships, NC training responsibilities and other contributing mechanisms).

4. assess the number of NC's graduating from the training program in relationship to the projected needs of Lesotho's primary health care system. Consider the additional resources required and the potential disruptions created by expanding the number of students versus the importance of meeting existing needs more quickly;

5. evaluate the management specialist services that may be required beyond the planned termination of that position, i.e., August 1982, and consider the possibility of recommending the continuation of that position through the end of the Project;

6. examine the existing data collection processes: the manner of data collection and compilation, data relevance and accuracy, and importance to the Project objectives;

7. to the extent possible, predict which Project objectives will not have been achieved at the completion of the Project. Recommend strategies for the accomplishment of these objectives;

8. examine the effectiveness of coordination between the nurse clinician training program and the management/planning sector, between the RHDP and the MOH, and between the RHDP and other relevant health projects active in the country;

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9. suggest methodologies for assessing the performance to date of nurse clinicians in the field. These methodologies should be appropriate to the time and resources available; and

10. assess progress in developing joint public/private sector delivery systems with attention to management systems.

Recommendations on project modification, as appropriate and necessary, should result from the above analysis.

The evaluation will require 3 complete weeks of service for 3 technicians. The other members of the evaluation team shall include a Health Planner/Management Specialist and a Public Health Advisor from the AID/Washington Southern Africa Division of Health and Nutrition who will act as Team Leader.

B. Specific Duties/Responsibilities of the Nurse Clinician (Practitioner) Training Specialist (identified in Block 14

Qualifications - Masters Degree in Nursing with Family Nurse Practitioner (FNP) certification or medical doctor with training and experience with nurse practitioner training programs. Experience should include teaching and curriculum development in a FNP program and experience in developing countries. The Specialist will evaluate the following components of the Project:

1. the MOH capacity to train and field additional categories of health workers;

2. Nurse Clinician training:

   - proposed role as related to training plans and future administrative structure of the MOH;

   - continuing education needs: training, supervision and support;

   - support systems: are the graduating Nurse Clinicians being adequately supported in terms of logistics, supervision, etc.; and

   - assess the abilities and effectiveness of the first class of Nurse Clinician graduates in terms of:

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- quantity and quality of training, relationship of training to national health delivery system, etc.;

- assignments after completion of training and performance in same;

3. Nurse Assistant training: role proposed in Project Paper, current role and future possibilties;

4. Village Health Worker training:

   - status of VHW in MOH;

   - training plans for VHW curricula; and

   - plans for utilization of non-government VHW's in the Project; and

5. relationship of training programs (NC, NA, VHW) to the major health problems of Lesotho.

B. Specific Duties/Responsibilities of the Health Planner/Management Specialist (identified in Block 14)

Qualifications - M.D. or Masters Degree in Public Health Administration or Health Planning. The Specialist should have at least ten years experience in health planning or administration on a national or state level with a minimum of four years experience in a developing country in a health planning or management capacity, or be a physician with comparable experience and training in health planning and management. Ideally, the candidate would be familiar with AID programming and evaluation methods.

The Specialist will be responsible for evaluating the following:

1. the administrative and planning capacity of the MOH. This should include the examination of:

   - the government's capacity to support these Project personnel already assigned to field positions;

   - the MOH's capacity to support these personnel who will be completing training in subsequent Project

CONTINUATION SHEET	DEPARTMENT OF STATE AGENCY FOR INTERNATIONAL DEVELOPMENT ☐ PIO/C ☐ PIO/P ☒ PIO/T ☐ PA/PR	☐ Worksheet ☐ Issuance 1. Cooperating Country Lesotho 2a. PIO Number 632-0058-3-10093 3. Project Number and Title 632-0058 Rural Health Development	PAGE 8 OF 12 PAGES 2b. ☐ Original OR Amendment No. ____

Indicate block numbers

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years; and

- the capacity of the MOH to support the expanded national rural health system;

2. determine the extent to which implementation plans are being developed for strengthening of MOH's health support systems (communications, logistics, drugs and supplies, statistics, personnnel and finance);

3. assess the level of infrastructural involvement directly related to the health planning and management component of the Project including:

   - adequacy of counterparts for consultants;

   - adequacy of planning and programming for health services;

   - appropriateness of human and physical resources procedures;

   - adequacy of the organizational development and training for structuring the primary health care delivery systems: and

   - appropriateness of budgeting, accounting and audit systems development procedures:

4. assess the success in implementing Health Services Areas (HSA) systems throughout the ten districts;

5. based on an overall assessment of the health management system as related to the Project's Management Specialist position, make a recommendation on, whether or not, the Management Specialist position should be extended for an additional year;

6. identify and assess the elements of the health manpower plan including both participant and on-the-job training. State necessary actions needed to further develop and implement an adequate manpower plan;

7. determine the extent to which data collection systems for

Team Leader/Public Health Advisor

Duration - 3 weeks

Qualifications - Masters Degree in Public Health with at least 5 years of experience with rural health development projects in developing countries. The individual will carry out the following activities:

a. as Team Leader:

1. work with appropriate MOH, Project and USAID/Lesotho personnel in arranging all necessary meetings and field trips;

2. assign individual team members tasks and responsibilities and coordinate their respective inputs;

3. act as editor-in-chief for draft and final evaluation which is to be typed by USAID/Lesotho; and

4. act as spokesperson for evaluation team when engaged in meetings and presentations of evaluation findings to all involved parties; and

b. as Public Health Advisor:

1. in conjunction with the other team members analyze the specific support demands placed upon the Health Service Areas (HSA) by the establishment of the Nurse Clinician and Village Health Worker cadres;

2. analyze the specific impact the Project will have upon the institutionalization of a national primary health care system;

3. project likelihood of attaining Project objectives by PACD. Recommend any necessary changes in order to accomplish a greater percentage of those objectives.