

## CHAPTER 8: IMPROVE QUALITY AND ACCESS TO HEALTH CARE AND SOCIAL WELFARE SERVICES

### 8.1 SITUATION ANALYSIS

#### Concerted Efforts in Primary Health Care

Lesotho has made substantial efforts to provide affordable and accessible Primary Health Care (PHC) to the poor.<sup>45</sup> In the late 1970s Government and church health providers developed a decentralised system with designated health service areas (HSAs), each with its own hospital, clinics, village health posts, village health workers and traditional birth attendants.<sup>46</sup> Over the years, Government has sought to strengthen this system by emphasising broad-based PHC as the principal means of dealing with preventable infectious diseases that are the primary cause of serious illness and death among the poor.

The Ministry of Health and Social Welfare (MOHSW) has given high priority to interventions that reach some of the most vulnerable individuals in society, notably: family planning, ante and postnatal care, mother and child health, immunisation campaigns and nutrition interventions targeting under-fives. Unlike many African countries, whose health services were disrupted by war, Lesotho has been able to maintain vital immunisation services and has virtually no polio victims. Treatment for tuberculosis, which impacts the poor more than the better-off, is provided free of charge. Under a cost-sharing scheme consultations and medication are obtained for M10 (about \$ 1.50) at Government health centres.

#### Progress ... and then decline

By and large, the PHC approach described above was successful: life expectancy grew from 40 years in the 1970s to 59 years in the 1990s while infant mortality declined from 122 per 1000 live births to 74. Family planning measures also showed real signs of progress with a decline in the Total Fertility Rate from 5.3 to 4.9. Sadly these gains have since been reversed, as shown in Table 8.1.

**Table 8.1: The performance trend for selected indicators of quality of life**

Indicator	1970s	1980s	1990s	2000s
Life Expectancy at birth (years)	40	54	59	54
Infant Mortality (per 1000 live births)	122	84	74	80
Child Mortality (per 1000 children surviving to 1 yr)	-	34	34	38
Total Fertility rate (children per woman)	-	5.3	4.9	4.3
Maternal Mortality (per 100,000 live births)	-	282	282	419

Source: BOS - Demographic Survey 2001

#### Total engagement required

<sup>45</sup> Primary Health Care is an integrated strategy, intended to increase public awareness on health related matters, such as disease prevention, hygiene, environmental health and nutrition, and to provide basic and accessible services through community-based health workers and health centres.

<sup>46</sup> As many of the church owned health centres serve impoverished parts of the country, but are poorly funded, Government has provided them with significant support primarily through salaries for staff. A Memorandum of Understanding has been signed between Government and the Christian Health Association of Lesotho to provide a framework for this. A new dispensation providing a stronger commitment by GOL to fund CHAL health services is being phased in during the PRS implementation period.

These declines are due to the emergence of new diseases, increasing poverty and disease resistance to drugs. The health system has not been able to address the devastating effects of HIV and AIDS resulting in the resurgence of diseases like tuberculosis, sexually transmitted and other communicable diseases. It is estimated that 30% of the population aged 15-49 years are reported to be HIV positive, resulting in the deaths of 70 persons per day. Consequently, the demand for curative services has increased dramatically, beyond the capacity of existing health services to respond. The consequences of the HIV and AIDS pandemic are massive and cut across all sectors. While the MOHSW may be most directly responsible for assisting those afflicted, all sectors must actively engage in the struggle. In this sense Lesotho is on a war-footing; unless the entire society is mobilised to fight the disease all efforts to combat poverty will be in vain. For this reason Government has ranked dealing with HIV and AIDS as a special priority area (see *Chapter 12*). In this chapter, therefore, other health priorities are described.

### **Increasing malnutrition**

The onset of the HIV and AIDS pandemic has exacerbated the high levels of malnutrition prevalent in many parts of the country. In 1996 the Government noted in its report *Pathway Out of Poverty* that:

“Malnutrition levels among children under five are unacceptably high everywhere, but urban children are considerably better off than the children in mountain areas”.<sup>47</sup>

Between 1993 and 1999 the percentage of children below standard weight for age increased from 13% to 16%, while those below standard height for age remained at an “unacceptable” 46%.<sup>48</sup> As noted earlier, by 2000 the *Multiple Indicator Cluster Survey* (MICS) showed similar results, with a slight increase to 17.8% for low weight for age while low height for age was effectively the same (45.4%).

Chronic malnutrition and chronic infections (acute respiratory infections and diarrhoea) are inversely related to the level of income, water and sanitation. There is also a significant relationship between the mother’s education and nutritional status, particularly regarding stunting and weight loss. For this reason malnutrition requires a multi-sectoral response, as discussed later in this Chapter.

### **Other contributing factors and their implications**

While HIV and AIDS is a key cause for the deterioration of the nation’s health status - and probably the main reason for health systems being overstretched - there are many other factors that are of concern to Government. These include: a poorly-functioning health system with a huge imbalance between over-crowded Government health centres with highly subsidised fees and CHAL health centres where fuller fees are paid; the high cost of medical care to all providers and users; long distances to medical facilities; and the insufficient numbers of health personnel especially in rural areas. Further, there is only one referral hospital (Queen Elizabeth II) where most specialists are concentrated, which also functions as Maseru district hospital. This makes this key facility very congested and difficult for people to use. While the highly subsidised fees (also known as ‘cost sharing’) have improved access, the imbalance between Government and CHAL fees has resulted in overcrowding of Government health centres.

### **Orphans**

The increasing levels of poverty described earlier, particularly when related to retrenchment, disability, and HIV and AIDS, have increased the number of very vulnerable

<sup>47</sup> Government of Lesotho, *Pathway Out of Poverty: An Action Plan for Lesotho*, 1996.

<sup>48</sup> Gay and Hall, 2000, p.109.

households, particularly those caring for orphans. In 2001, the Department of Social Welfare conducted a survey, which estimated that the number of orphans is over 85,000 while UNICEF estimated it to be over 117,000, from AIDS alone. The inconsistencies in the figures - possibly due to different definitions of orphans - points to the difficulties entailed in determining the exact extent of vulnerability. However, there is strong consensus that there is a large and growing orphan population that poses major challenges for the Department of Social Welfare and other stakeholders.

## **8.2 OBJECTIVES**

It will not be possible to reverse the trends described above in the three years of PRS implementation. The HIV and AIDS pandemic will continue to have devastating impacts on mortality and morbidity patterns as most of those who will fall ill and die during this period have already been infected. This makes it even more essential that the health system should operate as effectively as possible in all areas, including combating further infections. With this in mind, the Government has formulated strategies and activities which can be achieved, at least in part, over the next three years under three broad objectives. These are to:

- promote access to quality and essential health care;
- reduce malnutrition;
- improve access to social welfare services.

## **8.3 STRATEGIES**

### **8.3.1 Improve Access to Quality Health Care**

Given Lesotho's concerted efforts in Primary Health Care, which resulted in the gains made in the 1970s and 1980s, the Government is determined to reinstate the country's reputation as one capable of delivering quality curative and preventive health care down to village level. In view of the HIV and AIDS epidemic this will require renewed dedication and vigour, which should be recognised and rewarded as far as possible. A comprehensive approach will be taken, starting with the clarification of key issues through the review and renewal of policies:

- **Establish a Sustainable Health Care Financing System**  
The Health and Social Welfare Policy and Strategic Plan, recently developed, will reinforce the on-going poverty focused activities. This will include programmes that affect health and social welfare priorities, which will ensure adaptation to external and internal changes and will harmonise all interventions currently being undertaken. The policy and the strategic plan will provide guidance for the development of medium term and annual operational plans. In order to address the cost problem, the MOHSW will generate and mobilise funds for Health and Social Welfare and ensure that funds are allocated according to agreed priorities. The Government will aim to finance the Essential Health Package from national revenue, external aid and from subsidised user fees. Private funding through cost recovery user fees, health insurance and community based financing will be encouraged. To improve access to health services, criteria for exemption from user fees will be developed, based on ability to pay and nature of diseases (e.g. diseases that are infectious and require lengthy treatment, such as tuberculosis and mental health). User fees will be equal between GOL and CHAL facilities to improve equity in access to services, and the shortfall in revenue of CHAL facilities as a result of user fee equalisation policy will be compensated by the Government.

- **Improve health infrastructure, equipment, maintenance and supplies.** The efforts to improve and maintain health facilities will be accelerated over the next three years. Specific activities will include:
  - rationalising health service facilities with construction or renovation;
  - improving the procurement, storage, distribution and maintenance of equipment, drugs and dressings.
  - establishing village health posts and mobile health care for unserved areas;
  
- **Improve the capacity of health personnel.** The Government recognises the enormous contribution made by its health personnel at all levels across the country. In the struggle against HIV and AIDS they are in the front line and deserve to be supported as far as possible. Specific activities include:
  - Training health personnel at all levels;
  - reviewing and improving working conditions of health personnel to address the high rate of staff turnover and brain drain;
  - training additional Village Health Workers and introducing incentives for them;
  - establishing training for traditional healers to complement health delivery.
  
- **Improve health care management.** Government expects that resources and processes should be well managed. During the implementation period, high priority will, therefore, be given to strengthening management capacity at service provision level. Better management of resources will reduce wastage and curb pilferage and will ensure that the Basotho get better value for money through proper, effective and efficient service delivery. To accomplish this, four activities have been prioritised under which the MOHSW will:
  - upgrade the health management information system for measuring, monitoring and evaluating the sector's performance;
  - strengthen research and data management systems for disease control;
  - intensify and diversify training of health management staff to include effective use of funds;
  - introduce financial controls and management audits to address the problems affecting use of resources and service delivery.
  
- **Strengthen disease prevention programmes.** The most cost effective way to manage diseases is to prevent their spread. A concerted effort will be made to expand the programmes involved in prevention, including HIV and AIDS. The strategy is considered to be of particular importance for the PRS as it has far reaching implications for particularly vulnerable groups. In year one of the PRS, Government will outsource health education activities to the private sector with a view to making these as creative and as effective as possible. The outcomes will be closely monitored with the best being selected for up-scaling by year three.

In health education campaigns emphasis will be placed on the use of preventive services, especially childhood vaccinations, family planning, monitoring pregnancy, ante-natal care (ANC) and mother's health after birth, as well as post-natal care

(PNC). A particular focus will be teenage health in order to reduce teenage pregnancy.<sup>49</sup> Information will be provided on youth friendly services, free supply of contraceptives and empowerment programmes for women to be able to negotiate their sexual rights (especially in view of the HIV and AIDS threat to this group).

The promotion of sanitation and good hygiene practices is an important part of disease prevention and will continue to be given priority. As repeated studies have shown that the biggest constraint to the wider adoption of VIP latrines is their cost, an effort will be made over the next three years to pilot new low-cost prototypes that provide adequate protection against disease at a price that is more affordable for the poor. Soak way and refuse pits will also be encouraged around the homesteads. Water quality surveillance and spring protection will be enhanced. Medical waste management around health facilities will also be given priority.

### 8.3.2 Improve nutritional status of vulnerable groups

Where there is a significant shortage of food, vulnerable groups such as children under five years suffer the most. This, therefore, is a very high priority area for the PRS, as confirmed by the Basotho in community consultations.

The institutional arrangements to combat malnutrition require clarification. Four ministries or departments (other than MOHSW) play a role at different levels, including: Food and Nutrition Coordination Office (FNCO); Disaster Management Authority (DMA); Ministry of Education and Training (MOET); and the Ministry of Agriculture and Food Security (MOAFS). Given this complexity clear guidelines are required. Activities to address this and other concerns during the PRS period include:

- refining the National Nutrition Policy;
- improving disaster preparedness for emergency food distribution;
- maintaining the school feeding programme;
- strengthening systems of supplementary feeding of malnourished children;
- promoting good nutrition practices through community awareness campaigns, meetings, distribution of pamphlets etc;
- providing nutritional food packages and micro-nutrient supplements to the vulnerable and other relevant groups.

### 8.3.3 Provide social welfare services for vulnerable groups

During the PRS period the Government will prepare a strategic plan based on the National Social Welfare Policy which will identify top priorities, roles and responsibilities and delivery mechanisms in detail. Unlike South Africa, Lesotho does not have the resources to provide universal monetary support to vulnerable groups.<sup>50</sup> However, the Government will strive to improve social welfare service delivery to the most vulnerable groups by increasing the resources and capacity of all stakeholders through increased funding and training. In 2004/05, a pension of M150 per month will be introduced for persons over 70 years of age. Other efforts will include mechanisms to assist NGOs working directly with orphans, people living with HIV and AIDS and disabilities, and child-headed households.

<sup>49</sup> 52% of women attending antenatal care in Lesotho are in their teens.

<sup>50</sup> In South Africa, these include old age pensions, disability allowances, child allowances and caretaker allowances.

<b>Goal:</b>			
<b>NUMBER FIVE: IMPROVE QUALITY AND ACCESS TO ESSENTIAL HEALTHCARE AND SOCIAL WELFARE</b>			
<b>Indicators</b>	<b>Baselines</b>		<b>Targets</b>
<ul style="list-style-type: none"> <li>• Prevalence of malnutrition for under 5 years old by gender:               <ul style="list-style-type: none"> <li>i) % of underweight                   <ul style="list-style-type: none"> <li>Males</li> <li>Females</li> </ul> </li> <li>ii) % of stunting                   <ul style="list-style-type: none"> <li>Males</li> <li>Females</li> </ul> </li> <li>iii) % of wasting                   <ul style="list-style-type: none"> <li>Males</li> <li>Females</li> </ul> </li> </ul> </li> <li>• % of births attended by skilled health personnel</li> <li>• Proportion of &gt;1 year old children immunised against measles</li> <li>• Infant Mortality rate</li> <li>• Under- five mortality rate</li> <li>• Maternal mortality ratio</li> </ul>			
	26% in 2002		TBD
	28% in 2002		TBD
	61% in 2002		TBD
	57% in 2002		TBD
	13% in 2002		TBD
	15% in 2002		TBD
	59.9% in 2002		70% by 2006
	77.2% in 2000		80% by 2006
	81 per 1000 in 2001		70 per 1000 by 2006
	113 per 1000 live births		103 per 1000 live births by 2006
	419 per 100,000 live births in 2001		391 per 100,000 live births
<b>Key Strategies and Activities for Implementation:</b>			
<ul style="list-style-type: none"> <li>• Rationalise provision of health services through construction or renovation as necessary.</li> <li>• improve the procurement, storage, distribution and maintenance of equipment, drugs and dressings.</li> <li>• Improve and expand critical programmes, including child vaccination, family planning, ANC,PNC, reproductive health and teenage motherhood.</li> <li>• Review and improve working conditions of health personnel to address the high rate of staff turnover.</li> <li>• Train health personnel at all levels.</li> <li>• Train additional Village Health Workers and assess modalities of introducing incentives for them.</li> <li>• Upgrade health management information system for measuring, monitoring and evaluating performance.</li> <li>• Establish new village health posts and mobile health care services for unserved areas.</li> <li>• Provide nutritional food packages and micro-nutrient supplements to vulnerable groups and other relevant groups.</li> <li>• Improve access to social welfare services.</li> </ul>			
<b>Total Incremental Costs:</b>			
	2004/5	2005/6	2006/7
	M151,590,783	M189,435,017	M257,261,414
			Total
			M548,287,213
<b>Key Implementing Agencies:</b>			
<ul style="list-style-type: none"> <li>• Ministry of Health and Social Welfare</li> <li>• Civil Society Organisations</li> <li>• Private Sector</li> <li>• Christian Health Association of Lesotho</li> </ul>			
<b>Comment:</b>			