LESOTHO VILLAGE HEALTH WORKERS' PROFILING AND MAPPING EXERCISE REPORT

JULY 2013

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Acronyms

AIDS -	Acquired Immune Deficiency Syndrome
ANC-	Ante-Natal Care
BOS-	Bureau of Statistics
CHAI-	Clinton Health Access Initiative
CHAL-	Christian Health Association of Lesotho
CHBC-	Community Home Based Care
DHMT-	District Health Management Teams
DOTS-	Direct Observatory Treatment System
FDG-	Focus Group Discussion
GF-	Global Fund
GoL-	Government of Lesotho
HC-	Health Centre
HRAA-	Human Resources Alliance for Africa
HIV-	Human Immunodeficiency Virus
HSA-	Health Service Area
HRH-	Human Resources Health
HH-	House hold
IHRIS-	Integrated Human Resources Information System
LFDS-	Lesotho Flying Doctor Service
MOH-	Ministry of Health
PHC-	Primary Health Care
PMTCT-	Prevention of Mother-to-Child Transmission
SA-	South Africa
TB-	Tuberculosis
TBA-	Traditional Birth Attendant
USAID-	United States Agency for International Development
VC-	Volunteer Counsellor
VHW-	Village Health Worker
VCT-	Voluntary Counselling and Testing
WHO-	World Health Organization

1. Executive Summary

A key to health services delivery is the existence of strong human resource base that is supported by adequate infrastructure.

The Ministry of Health in Lesotho in its attempt to revitalize the Primary Health Care System, launched initiatives to assess and validate its human capital at the community level through technical assistance of Human Resources Alliance for Africa (HRAA) which commissioned a study on the "Mapping and Profiling of Village Health Workers in Lesotho". The objectives of the study were to;

- Establish the current number of Village Health Workers
- Location of each VHW and the relationship with health centers
- Whether the VHW's have been adequately trained
- Recommend interventions that will bridge any gaps identified

The study was carried out in all health centers owned by both Government of Lesotho (GOL) and The Christian Health Association of Lesotho (CHAL) in all districts. The number of health facilities covered was one hundred and sixty six (166). During the assignment, a total of seven thousand, one hundred and three (7103) Village Health Workers (VHWs) were identified. The key study methods were key informant interviews which were undertaken with health facilities nurses, records and documents review and focus group discussion undertaken mainly with the target group (VHWs)

The average age of a VHW was established as approximately 60 years and the profile of VHWs between the ages of 55 and 70 provided an indication that VHW's population is aging and requires concerted effort to bring the age threshold to below 55years of age.

Training of VHW on the other hand yielded encouraging results, though some were trained more than 10 years ago, but continue to learn through health centre attachments and from peers who have gone through formal training.

The assignment identified some ***risks*** associated Village Health Workers and service provision. These included among others; training status of some VHWs, either newly recruited VHWs or long in-service, Village Health Worker–client care ratio, distances travelled by VHW to patients/clients and health centers respectively, irregularity in payments of stipends which was identified at almost every contact, and other life commitments which were identified as more stable source income i.e. domestic work in South Africa.

In conclusion, the Village Health Workers System of health service delivery is a corner stone of Lesotho Primary Health Care System and service delivery support. The system requires a concerted effort for its strengthening in consultation and with and support of all stakeholders.

2. Introduction

According to WHO, Primary Health Care (PHC) is defined as essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at the cost that community and the country can afford to maintain at every stage of their development in the spirit of self –reliance and self- determination. It forms integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of individual, the family and community with the national health system bringing health care as close as possible to where people live and work. (***Alma Ata Declaration Article VI)***

The Alma Ata Declaration adopted at the International Conference of Primary Health Care (PHC), was the first international declaration to underline the importance of PHC and community involvement. Following Alma Ata Declaration, PHC was adopted in Lesotho and 1978 found Lesotho ahead of many other countries in the delivery of PHC and in community participation. Lesotho adopted Alma Ata, and began to strengthen the PHC program through the introduction of the Nurse Clinician Program to serve areas of the country where there was no doctor and ensure realization of access to quality health services, the principles of PHC, and the Village Health Worker Program to strengthen PHC at the community level.

The Lesotho Ministry of Health has a 25 year HRH development and Strategic Plan (2005-2025) that has been used to guide policy and implementation of various Human Resources Health (HRH) activities. Decentralization of health services is at an advanced stage in Lesotho and with support from the Health Strengthening Systems Strengthening Project, there has been development of management tools for District Health Management Teams (DHMTs). These include management, planning, and supervisory as well as clinical guidelines. The main challenge is implementation of these tools in a coordinated manner in order to achieve desired outcomes. Though there are mentioned challenges around implementation, the Ministry of health has development partners, supporters and role players that provide technical and financial support to the ministry in order for the MoH to achieve its objectives and mandate

The Human Resources Alliance for Africa (HRAA) Project provides technical support to the Ministry of health in Lesotho to strengthen the human resources capacity and promote recruitment, engagement and sustainability through comprehensive employee retention strategy and package. The goal of HRAA is to improve health workforce policies, planning, development and support systems for retention and productivity in order to increase access to and improve the quality of health services. In Lesotho, HRAA will ensure that its programmatic activities are in line with the country's Health Strategic Plan and Health Services Decentralization Strategic Plan. HRAA partners will design interventions and work collaboratively with MoH for a unified response to the Human Resources Health challenges in Lesotho.

3. Background

The combination of an increasing disease burden on the one hand, and the limited capacity of Human Resources Health (HRH) on the other have brought immense challenges with it. Insufficient numbers of trained health personnel, low recruitment rate, mal-distribution of staff and unattractive remuneration packages, all these together contribute to high levels of burnout and staff turnover.

The shortage of health workforce and its distribution has contributed to sub-standard delivery of health services in Lesotho and the problem is worse in the rural areas. The situation has compromised the delivery of health services in an era when the country has been battling with a high disease burden of communicable and non-communicable diseases compounded by HIV& AIDS. From the early 20th century, the Lesotho health care system was overwhelmed with the disease burden and had to develop and establish reactive health care strategies to expand its capacity and cater for the affected populations from health facility to community levels, hence the establishment of numerous support and care groups across the country. This system worked well as a relief method; however the ministry had to revise its strategies for more long-term results and the sustainable Primary Health Care system. Looking at the impact of the epidemic, and how it has seriously challenged PHC system, the Ministry of Health with support from key partners like the Global Fund in the mid-century then introduced the incentive system to Village Health Workers.

A unique asset of Lesotho's health system is the engagement of Village Health Workers to provide basic health services at the community level. Over years, VHWs contributed significantly to the health care system and expanding the human resource capacity that includes this cadre, will increase the Ministry's ability to effectively accelerate prevention of mother to child treatment (PMTCT) of HIV.

The community health care system and support service is a long-term phenomenon and continuing practice in Lesotho. The VHW program was the first national program to really extend to the grassroots level where the services were most needed and this approach attracted a lot of donors. Since the start of the program, Village Health Workers worked as volunteer workers with minimal training and no stipends whatsoever. At that time, VHWs were offered free medical service at PHC level as an incentive

The country had initially engaged about 6,000 VHWs who play a key role in community mobilization, promoting access and utilization of health services. However, over time, with the advent of HIV, other community health workers like Community based care givers, lay counselors and expert patients play a key role in health service delivery at community level. These cadres came in with monetary incentive. Currently, MOH provides stipend to the VHWs and other health partners also use VHWs in different projects resulting in double or triple payment.

4. Assignment Rationale

The Ministry of Health is in the process of revitalization of Primary Health Care and Village Health Workers are the key health service providers at the community level. It is therefore proper for the Ministry to revitalize knowing the workforce it has at that level. The exercise did not only focus on the VHWs numbers, but also on their age, activity status, training record as well as incentives.

The Human Resources Alliance for Africa Project technically supports the Ministry of Health to strengthen the human resources system and the project recently supported the ministry to launch the retention package for nurses who work in hard-to reach-areas.

HRAA further intends to support MoH to escalate the PMTCT program and this can be achieved by mostly strengthening the Primary Health Care system with VHWs as key to the program. One of the key activities of the project is to develop the human resource information system (HRIS), therefore the results of the profiling and mapping exercise will enable the project to develop the most reliable and updated data. This data will further enable the Ministry of Health to plan accordingly in the process of revitalization of the PHC system.

5. Methodology

The Village Health Workers profiling and mapping exercise covered the entire country. All facilities whether belonging to Government of Lesotho, Christian Health Association of Lesotho (CHAL) or Red Cross were visited. The exercise ran for forty five working days whereby a combination of methods was applied to fulfil the mandated scope. The consultant undertook desk review, consultations with stakeholders and data collection (***data collection details below***).

Data collection activity was core to this exercise hence the consultant undertook extensive travel to all health facilities in the country. Each health facility was visited to collect data on Village Health Workers ***(data collection form attached as an annex).*** Important information that was collected during this exercise included VHWs names, date of birth/age, activity and training status as well as incentives received. Key informant interviews were undertaken with Health facilities' personnel, mostly professional nurses who were quite informative on Village Health Workers' roles and responsibilities.

Focus Group discussions were undertaken with Village Health Workers at different health centres and the purpose of these discussions was to further establish VHWs view and understanding of their own scope of work and roles and responsibilities thereof. Health centres professionals were served as key informants as they are responsible for VHWs supervision and training. Further discussions were sporadically undertaken with village chiefs and other local authorities to ascertain consistency of information provided.

The consultant with health centre personnel at Sehlaba-Thebe HC- Key informant Interviews

Health centre nurses served as key informants as they are primarily responsible for the training and supervision of Village Health Centre. While collecting VHWs data, discussions with health centre personnel took place at almost every health centre as means of verification of literature on Village Health workers including selection criteria and other important information like training status of VHWs.

VHWs monthly meeting at Rothe Health Centre – Focus Group Discussion method engaged

6. Results-Profiling (Key Informants & Group Discussion Method applied)

Definition of VHWs and their selection criteria is tabulated below to provide background of these workers and its relationship to their roles and responsibilities:

The following headings provide basic information about Village Health Workers ***(Village Health Workers Training Manual - August 2011)***

Definition of a Village Health Worker

A Village Health Worker is a Primary Health Care (PHC) Worker, a resident member of the community where s/he works and is selected by the community members with the approval of local authorities for training in Primary Health Care. Upon completion of training, a VHW becomes a member of Community Health Workers who provide PHC services within the community

Criteria for selection of a Village Health Worker

- Must be a full-time village resident with no other official responsibility
- Must be an adult from age 25-70 years
- Must be selected by community or village members
- Must have basic literacy and be able to read and write Sesotho
- Must complete the Village Health Worker training Programme which meets the minimum standards set by the Ministry of Health
- Must be able to participate in the continuing/ refresher training courses
- Must be in good Health

Selection Attributes for a VHW

- *Must be a respected member of the community*
- *Must be a dedicated person to serve own community*
- *Must be a person who maintains confidentiality*
- *Must be trainable*
- *Must be prepared to work on voluntary basis*

6.1. Roles and responsibilities of Village Health Workers

The below information was gathered through focus group discussions with Village Health Workers at various places and verified through key informant interviews (health centre nurses as key informants)

1. Promotion of good health practices in the communities

Village health Workers work closely with chiefs and other local authorities to organize and hold community gatherings (Pitso's) to disseminate information on health matters that the public need

to be aware off. The gatherings are further held to advocate for good health and hygiene practices as a continuing strategy to maintain healthy living style e.g. developing and maintaining safe water supply and sanitation. These workers identify village health needs and facilitate village resources to meet these needs e.g. material and labour for building latrines. VHWs further assist village chiefs with vital statistics (birth and death registrations)

2. Direct Observatory Treatment System

For decades, Village Health Workers have successfully been providing the community based support to the National TB programme through Direct Observatory Treatment System (DOTS) and this significantly contributed to the country's high success rate (86%) in the mid to late 80's as rated by the World Health Organizations.

3. Maternal and Child Health Care Promotion

Village Health Workers play a significant role in maternal and child health care promotion through:

- Referral of pregnant mothers to start ante-natal care at health centres, thus promoting PMTCT
- VHWs perform skilled deliveries where situation warrants
- Support to mothers during post-natal care
- Provide child care- support to breast-feeding and non-breast mothers and advice on child care and nutrition
- Weighs children at community level and monitor growth
- Identify gaps in child immunization record and make referrals
- Referral to family planning clinics
- Follow-up of clients and defaulters

4. Provide Home Based Care Services

Village Health Workers have been providing community home based care (CHBC) services over a long period of time even before the HIV & AIDS era and interventions thereof. For a long time these services have been offered at the community level with community members offering support to families of the sick and providing relief to care for the sick. In fact this system is one of the strongest cultural practices in Lesotho that has kept community members' relations strong and valuable. In addition to CHBC services, Village Health Workers also provide first aid services prior to referral to health centres.

5. Patient support and follow-up

While this task may be interpreted as closely linked to home based care, patient support and follow-up entails counselling services and emotional support to patients. The support service is not limited to bed-ridden patients, but also patients who need motivation and encouragement to

treatment adherence and practice health living styles e.g. people on TB and ARV treatment are mostly the beneficiaries of this support system. Village Health Workers recognize, refer and organize follow-up of HIV&AIDS patients and those on TB treatment

6. Patient Referral

As a result of the support and follow-up service, Village Health Workers further refer patients to health centres for more advanced and technical health. VHWs encourage pregnant women to initiate ante-natal care services, breast feeding mothers for post-natal care and FP services. They further recognize and refer people who have early signs of tuberculosis and also promote VCT.

Patients'/clients referral system is a two-way process as patients who need follow-up and support at the community level are again linked with VHWs for continuum of care whilst they make periodical visits (mostly monthly) to the health facilities.

7. Keep and Update patients'/Clients' records and reports monthly activities to the Health Centre

Whilst performing their respective roles at the community level, Village Health Workers record all services provided to patients at the community level. These records (***a small black note book)*** are kept with patients themselves and each time a home visit is done, services are recorded and records updated accordingly. VHWs compile reports on monthly basis and these reports are submitted at health centres during monthly meetings. The reports are compiled statistically i.e. by means of tallies for each service provided e.g. number of patients on TB (DOTS) & ARV treatment, number children weighed, number of HBC patients, number of referrals etc.

8. Attachment to Health Centres

The current common practice at the majority of health centres (85%) is that Village Health Workers are attached to health centres on a day-to-day basis. The rationale for attachments is part of continued supervision by health centre nurses and also for VHWs to provide assistance with basic health centre routine i.e. conducting health talks as a major responsibility, assisting with patients and children's weight and dispensation of prescribed medications to certain extend. This strategy seems to be working very well as on-the-job-training strategy and most VHWs benefit a lot.

A male Village Health Worker at clinic attachment - Linotsing Health Centre –Leribe district

6.2. Key Findings – Village Health Workers' Profiling

6.2.1 Village Health Workers Age Range

The Village Health Workers training manual specifies VHWs age range as 25-70 years. The ble below shows the age range of VHWs:

Leribe and Mokhotlong districts have the highest number of village health workers whose ages are above 70 years i.e. >older than 70 years (188 and 157 respectively). Records and discussions with health centre nurses showed that VHWs in age range 55-75 years are very active with extreme cases of those above 80 years still going strong. VHWs in this specified age category are reported to be stable, committed and highly respectable within their communities. They even provide mentorship to younger colleagues who just joined the programme

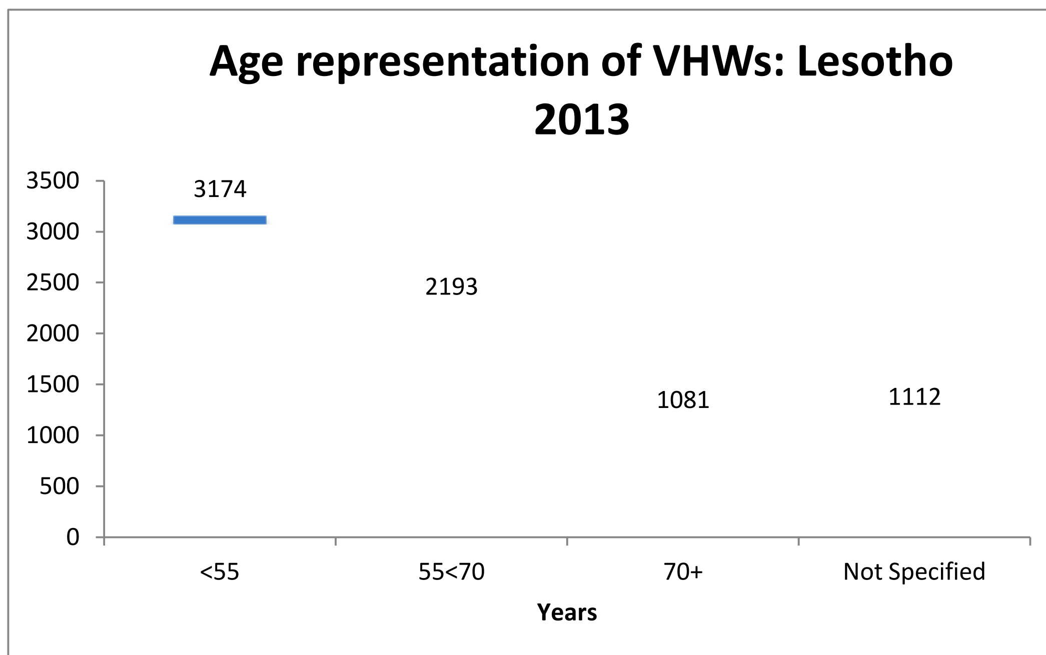


Figure 1 shows Village Health Workers age analysis

6.2.2 Village Health Worker-Household Ratio (Patient/HH care Ratio)

Theoretically one VHW is supposed to provide care and support services to twenty households (1:20HH), however the practical situation as reported by VHWs themselves and HC nurses is that many (75%) of these workers extend their support services to forty households per VHW (1:40HH). Some villages do not have VHWs therefore on board workers have to extend their services to cover such villages

6.2.3 Training status of Village Health Workers

Village Health Workers receive training and supervision from the Health Centre nurses. Due to the latest disease pattern, the VHWs trainers' manual was revised (August 2011) to incorporate the current health challenges. Many of these workers have undergone a two weeks basic training and seventy (70%) of health centres reported training activities that are currently being rolled out on HIV & AIDS and PMTCT.

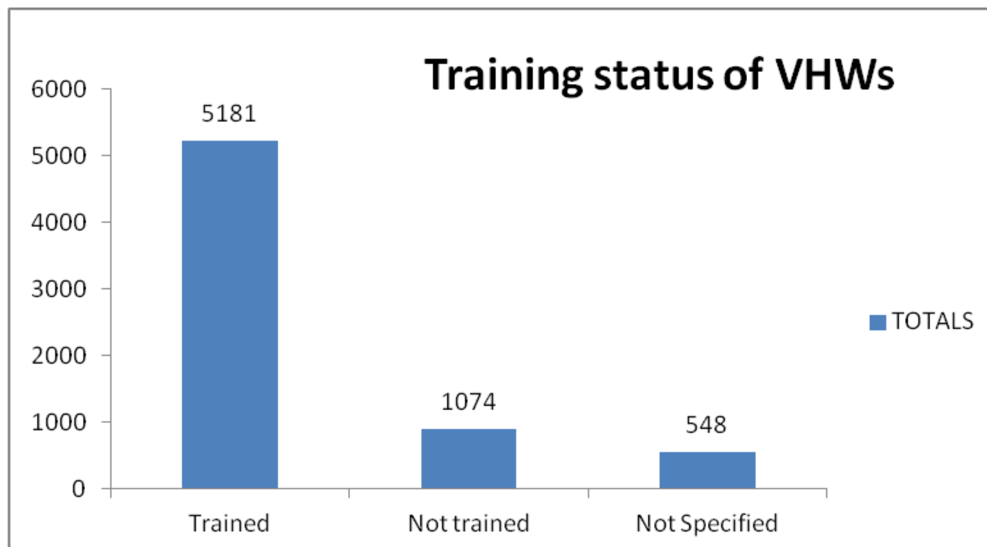


Figure 3 shows the training status of VHWs country wide in 2013.

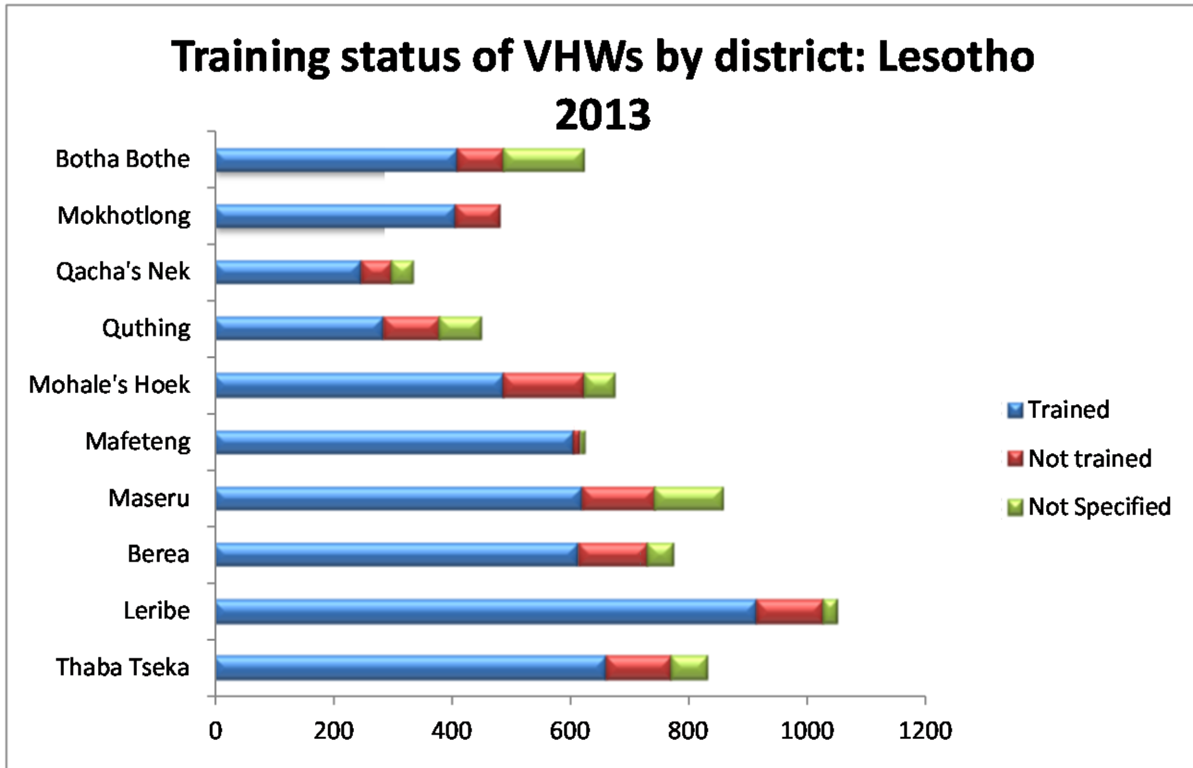
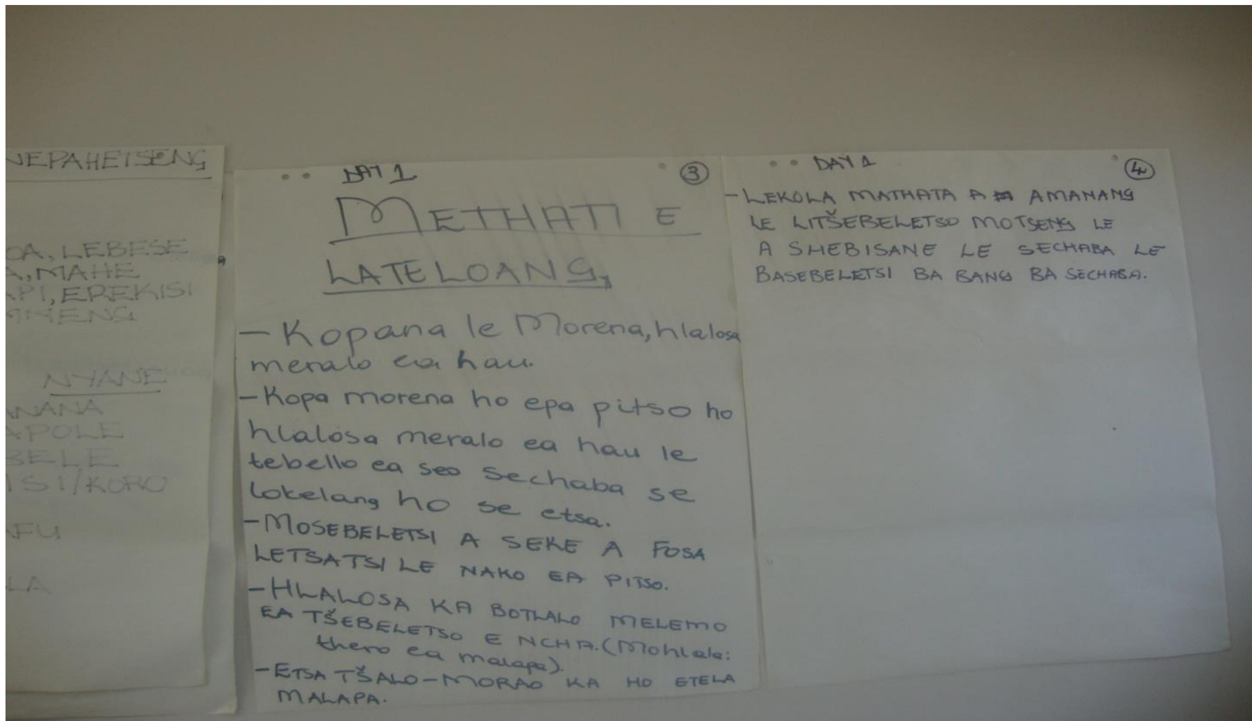


Figure 3 shows the training status of VHWs by district

Pictures below show Village Health Workers during training at the health centre. Training material & content in Sesotho language. Forty five (45) VHWs from villages under Ts'akholo catchment area attended training

VHWs' training at Ts'akholo Health Centre- June 2013



DHMT and HC Nurses respectively conducting VHWs training -Ts’akholo HC

6.2.4 VHW Activity Status

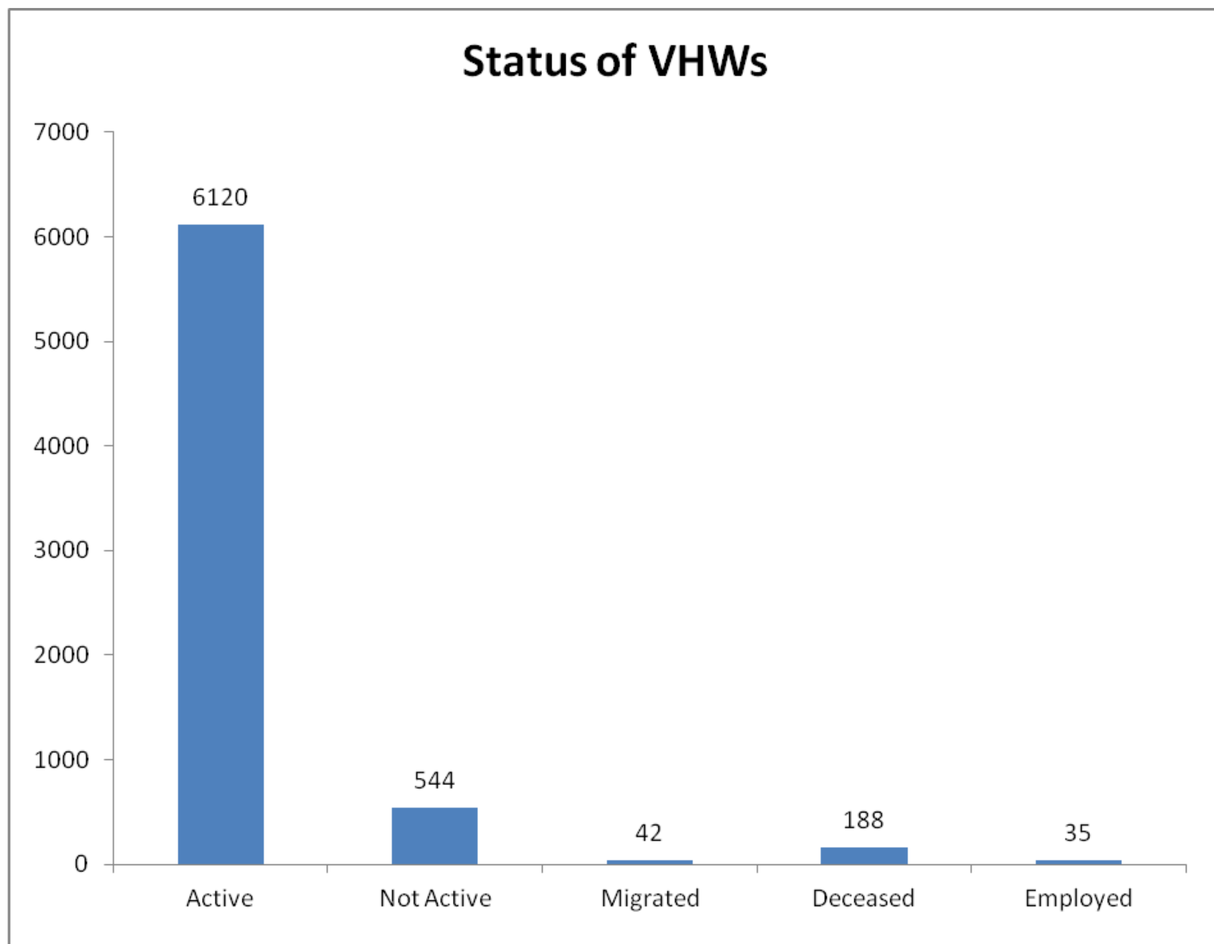


Figure 4: Activity status of Village Health Workers throughout the country in 2013

Village Health Workers inactive status is attributed to a number of factors like those who are aged, sick, employed elsewhere and those who basically got de-motivated and lost interest. Another important factor as gathered during focus group discussions is the issue of irregularity in payment of incentives. Some VHWs got de-motivated with no incentives and the criteria for payment is not even clarified. Training status however seems to have no effect on VHWs activity status.

6.2.5 Village Health Workers Incentives

Village Health Workers' incentives are reportedly paid by GOL to a larger extend with some paid by development partners and other agencies. The criteria for incentive payment remains unclear as some VHWs who have been in the programme for a long time, have undergone training and are active do not get incentives while on the other hand some who have just joined the program with no training whatsoever get their stipends. The graph below shows VHWs incentive as paid by GOL and its partners.

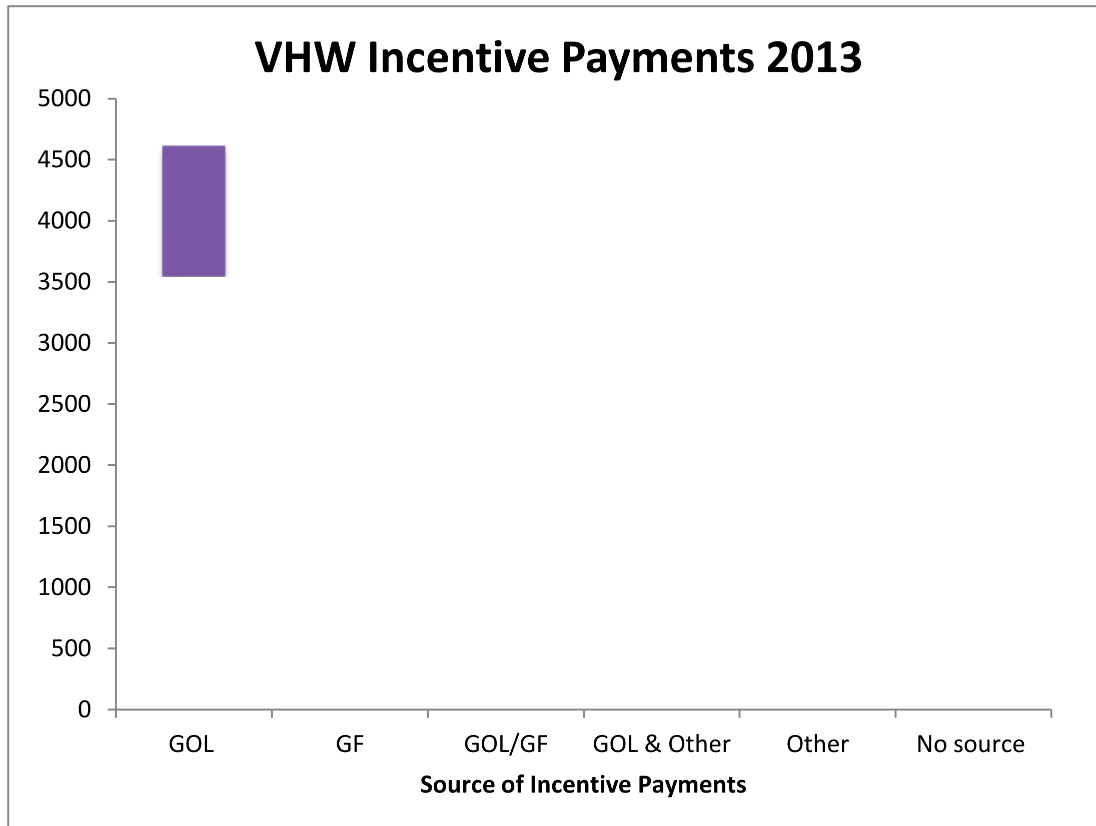


Figure 5: Village Health Workers incentives by different sources

NB: Please note that where it is indicated GoL/GF and GoL & other, it means that the government of Lesotho contributes 50% and its partners also contribute 50% for payment of VHWs incentives. Other refers to sources of payments other than GoL and GF. That includes partners and role players like CHAI, PIH etc. Where indicated ***no source***, that means no institutions or agency whatsoever is paying incentives and the bar shows number of Village Health Workers **NOT** receiving incentives.

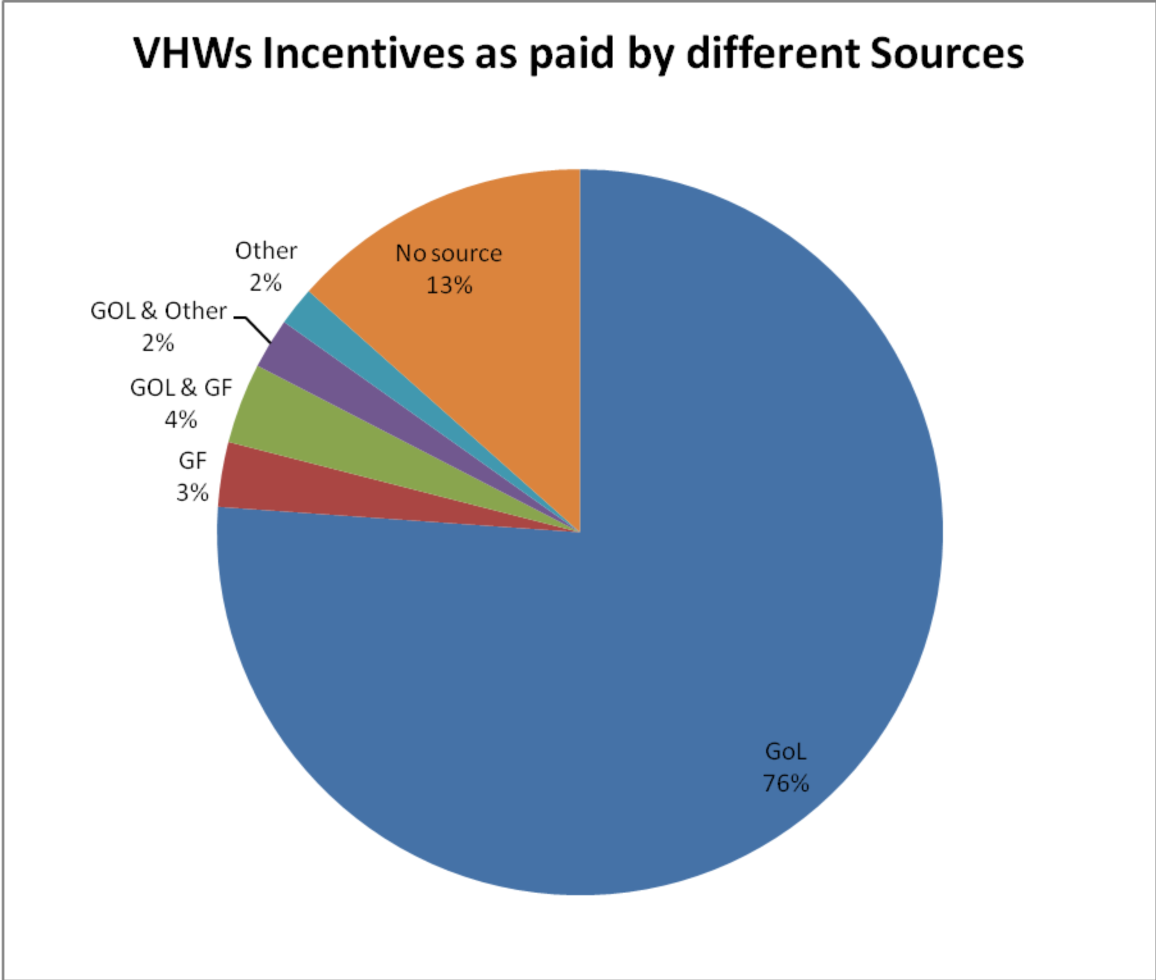


Figure 6: VHWs incentives as paid by different source as observed in 2013

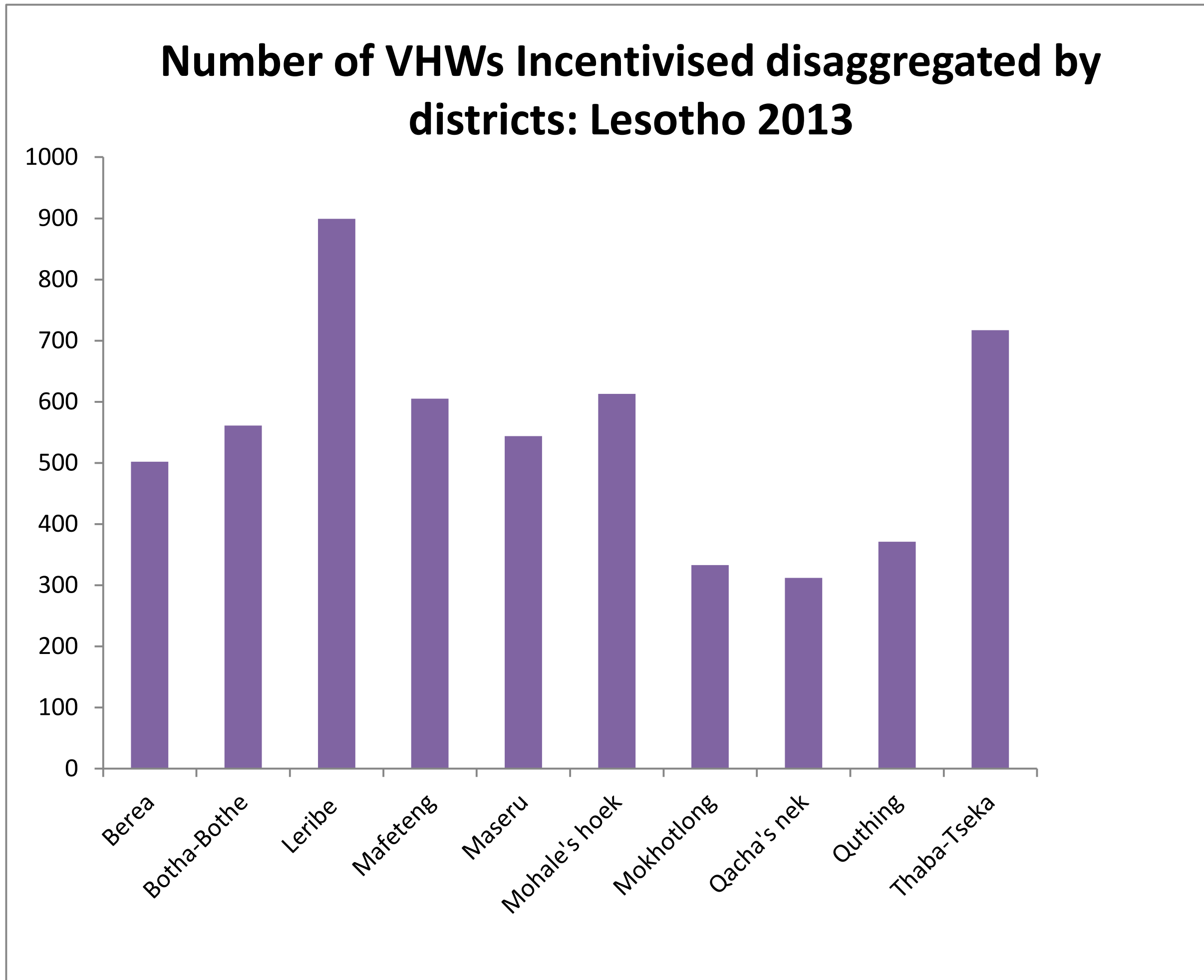


Figure 7: shows VHWs incentives by districts

6. Mapping Exercise

Lesotho Map showing all the ten districts and distribution of health facilities in Lesotho

7.1 Key Findings

7.1.1 Total number of Village Health Workers

The total recorded number of Village Health Workers in Lesotho is seven thousand, one hundred and three (7103) and there are one hundred and sixty six (166) health facilities throughout the country. The recorded number of VHWS is inclusive of all newly recruited VHWs. There are Village Health Workers who report to hospitals while the majority (90%) report to and are supervised by health centre facilities respectively. VHWs that report and are supervised by health centres were reported to be more active and involved in the program compared to those reporting to hospitals. Tebellong hospital in Qacha's nek district however has a very high number (156) of VHWs and many of them are active

Leribe district has the highest number of VHWs (1110) with twenty five (25) health centres and Quthing district in the south has the lowest number of VHWs (450). Leribe District is quite vast as indicated in the Lesotho map and health facilities area widely distributed in urban, peri-urban and rural areas, hence the high number of health facilities and Village Health Workers respectively.

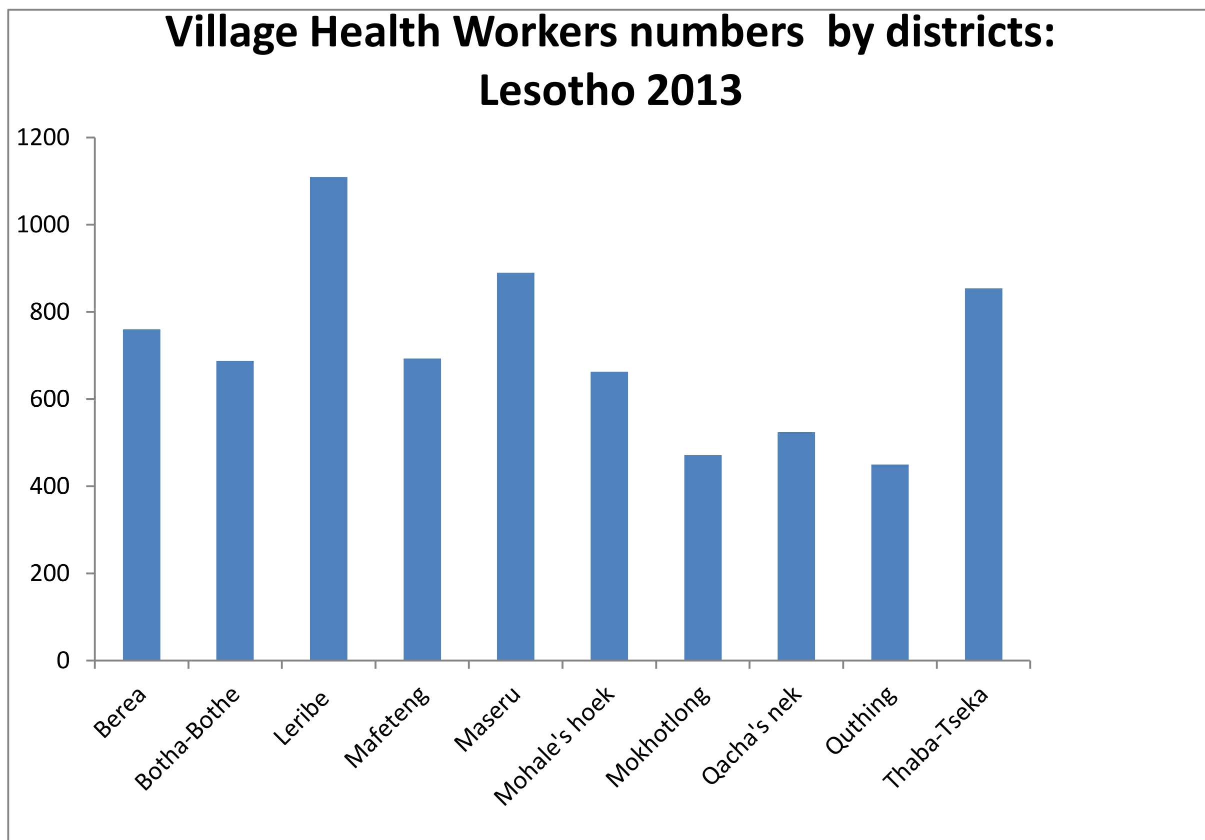


Figure 8: Village health workers statistics disaggregated by district

6.1.2 Geographical Distribution of Village Health Workers in Lesotho

Peri-Urban (foothills) and Rural Areas

The Primary Health Care system remains very strong in throughout the country with significant models in peri-urban and rural areas. This may be linked to limited health facilities and services in these areas whilst populations in the urban areas or townships enjoy multiple health services either from large public health institutions or private health practitioners.

There are higher numbers of VHWs in the rural areas where majority of them are those who started the programme with Thaba-Tseka district which is exclusively rural, and has 854 VHWs compared to lowlands or urban areas of the country. In most villages in the rural areas and some parts of urban places, there are at least two (2) VHWs from the same village i.e. two VHWs per each village and this strategy seems to be working well as they complement each other in providing basic health services. Despite challenges of the country's difficult terrain in the rural areas, long walking distances and harsh seasonal weather conditions, Village Health Workers in these areas remain highly active and committed. Some VHWs walk approximately 5 hours to health centres for monthly meetings and clinic attachments and the worst case scenario is some VHWs who have to over-night half way before they reach health centres.

A unique situation exits at Phamong health centre in Mohale's hoek where one(1) Village Health Worker serves five (5) vast villages-approximately sixty (60) households (1:60HH) and has to cross Qaqatu river to reach Phamong health centre. Local authorities at Phamong clearly stated that there is a need for a health centre at Sealuma Community Council where there are nineteen (19) villages in the council with no health services or difficult access to the nearest health centre which is Phamong Health Centre.

Urban Districts

Village Health Workers' numbers are still very high in the lowlands or urban areas and their activity status is moderately satisfactory with most of them being relatively younger compared to the pattern in peri-urban and rural areas. While the terrain is favourable in these areas and transport available for ease of travel, there are however some challenges facing VWHs in these areas such as part-time employment due to relatively high cost of living and migration to townships for variety of reason especially younger VHWs, some even get employment in South Africa as domestic workers.

VWHs in urban areas seem to be attracted and motivated by paid incentives compared to their colleagues in the rural areas who strive for excellence through hardship. The activity status is also not stable in the urban areas and this is particularly reported on younger Village Health Workers who are either employed part time or have other demanding activities. It was also observed that in some areas, elderly VHWs are replaced by their daughters-in-law or other close family members and this is attributed to incentives (**securing source of income for families)**

7.1.3 Village Health Workers' Population Density per District

The following data was calculated using BOS 2006 Populations Census

District	Total Population	Number of VHWs	VHWs Percentage in total population
Botha-Bothe	109 639	688	0.62%
Berea	253 317	760	0.30%
Leribe	298 136	1110	0.37%
Maseru	400 874	890	0.22%
Mafeteng	188 326	693	0.36%
Mohale's Hoek	175 750	663	0.37%
Quthing	119 636	450	0.37%
Qacha's nek	75 656	524	0.71%
Mokhotlong	96 533	471	0.48%
Thaba-Tseka	126 541	854	0.67%
Total	**1 844 408**	**7103**	**4.47%**

Table 1 shows Village Workers population density in Lesotho

7.1.3 Key Findings and Major Observations

Most of the VHWs who started with the program are still around, although now very old and pensionable, some serve as mentors to newly recruited VHWs and most facilities would still prefer to hold on to them because they are more reliable and mostly respected in the community. It was also observed that there are male Village Health Workers whilst in the previous years the programme was predominately females.

Another observation made was that, most health centres are now managed by recently qualified professionals who are still getting acquainted with the PHC system and as a result are only learning and familiarizing themselves with VHWs in their respective centres while most facilities that are managed by Nurse Clinicians, VHWs records were well kept and updated.

Linotsing Health Centre in Leribe recorded a highest number of deaths of VHWs (16) during the past twelve months.

Ha Khabo Health Centre in Leribe- this health facility is managed and serviced by only one professional nurse with no assistance of other personnel whatsoever. This is reportedly due to the personal attitude of the professional who keeps no working relations with others such that no one stands her behavioural problem. As a result, there are no VHWs attached daily at this health centre and the later only meet once monthly as a common practice.

Linakaneng in Mokhotlong, there are no nurses staying at the health centre and other personnel due to incomplete infrastructure and inaccessibility of the health centre. Nurses daily commute from Mokhotlong township to the facility and when a 4x4 vehicle is not available, the personnel

are not able to reach the health centre and as a result Village Health Workers do not regularly meet on monthly basis as a common practice in all facilities throughout the country.

In Maseru urban, there are fewer VHWs, hence more reliance on urban-based support groups in the primary health care level service provision.

Quthing district reported the highest number of VHWs who migrated (22) mostly of them had gone for domestic work in South Africa (SA) for a year and beyond.

Despite the ante-natal support services, follow-ups and referrals done by VHWs, some health centres and Village Health Workers reported incidences of pregnant women who deliver at home and this is attributed to variety of reasons per area.

Bethel Health Centre in Mohale's hoek district reported a significant number of home deliveries conducted by Traditional Birth Attendants despite availability of many trained VHWs and easily accessible health centre (6 home deliveries) per month. This is allegedly due to TBAs mobilizing mothers to seek help from them (TBAs) and this is attributed to incentives of some sort. Mohalinyane HC in Mohale's hoek also reported incidences of home deliveries. Village Health Workers reported that the main course for home deliveries is lack of transport to Nts'ekhe Hospital in Mohale's hoek.

VHWs supervised by Nurse Clinicians are much more active, dedicated and remain in the programme for longer. This was more observed mainly in CHAL institutions which still have Nurse Clinicians while in other health facilities, there are relatively new professionals with basic qualifications and less experienced in Primary Health Care system.

While there were several villages that were reported to currently having no VHWs, Phamong and Pontmain Health Centres reported the highest number of villages without VHWs. (19 and 13 respectively)

Phamong Health Centre- some Village Health Workers who serve within this area and are supervised by the health centre are seriously challenged by vast villages and extreme walking distances with some VHWs who have to over-night at some point when they travel to the health centre for monthly meetings or clinic attachments.

Although this information was not verified, there were some reports of double payments for some VHWs whilst others have not received as single payment despite the training status.

Matlameng Health Centre in Leribe district - There are seventy three (73) newly recruited VHWs who have not yet been trained. It was reported that, there was a directive from Leribe DHMT to replace all VHWs above 70years of age (>70 yrs) with younger VHWs, however there were concerns that the process was not clear especially for VHWs who have to retire and have been receiving incentives.

‘Melikane Health Centre is managed by one professional nurse who keeps all health centre records and if she is away from the HC due to many reasons, no one including VHWs has access to VHWs records.

Lesotho Flying Doctor Service –the facility serves seven (7) hard-to-reach health centres namely; Lebakeng, Manamaneng, Kuebunyane, Nohana, Nkau, Tlhanyaku and Methalaneng, and the VHW program is very strong in these areas. The LFDS Primary Health Care Division is currently conducting training for newly recruited Village Health Workers in these areas. The average number of trainees in each area is forty five (45) VHWs.

It was also observed and reported that aged Village Health Workers i.e. above 70 years (>70yrs) and some with health and age challenges, are still holding on to the program despite the fact that they are no longer active due to the said challenges. This was reportedly attributed to the paid VHWs incentives and that there is currently no clear mechanism to transfer the aged VHWs to the national old age pension scheme.

8. Challenges

In most facilities (80%), VHWs records were incomplete and in worst scenarios missing totally. In some cases, VHWs from villages nearby health centres had to be called in to assist with information. Whilst this worked to a certain level, a lot of information was still not readily available as it was no known by the informants i.e. while they knew most VHWs names and their respective villages, critical information like date of birth (age) and training status was not known by the later. This led to a very time consuming exercise and delays in data entry and analysis.

In most cases, mainly monthly meetings attendance registers and meeting minutes were kept, information on initial and refresher trainings as well as date of birth or age were not well documented. In some facilities, records were reportedly missing or were misplaced due to movement during health facilities construction works.

Some health facilities are managed by only one person and in the absence of such a person, repetitive trips or several phone calls as follow-up were warranted to obtain required data.

Another major challenge was that at some health centres, especially those managed by newly qualified and appointed professionals, the available data was all inclusive i.e. **all community based workers including lay counsellors, volunteers and data clerks**, so quality time had to be spent on identifying Village Health Worker from the rest of the lists.

9. Conclusion

There are issues that need clarity e.g. incentives or stipend payments and its linkage to training status of VHWs. It was not very clear how this is affected as some Village Health Workers were trained as far back as the year 2000, some of them are still not getting incentives though very active.

It is also evident that some VHWs need to retire from the programme because of age (above 70yrs), it is not very clear what the retirement process or strategy is, hence some are holding on to the programme.

VHWs whose training status is not specified is a major issue that needs to be addressed as this could have implications on future planning.

It is imperative that new VHWs recruitment is expedited to replace those that are not active and those that have passed away or aged. High numbers of new recruits are essential to also cater for villages that currently have no VHWs.

9. Recommendations

- Health facilities to maintain training registers for all VHWs. Such a record be continually updated and information shared with the central level and partners
- VHWs' trainings to be centrally coordinated and the curriculum shared with MoH's partners.
- The programme should also be certificated and create a career path for those who have completed a specified number of training sessions
- Recruitment and training of VHWs must be done to bridge the gap left by the VHWs who have passed away, aged, not active or those who for some reasons have dropped from the program
- Payment of VHWs incentives is a critical issue and clear information and guidelines must be set and information disseminated accordingly
- There should be national indicators for the community programming nationwide. This will facilitate monitoring of the VHW activities
- PHC program to advocate for inclusion of community based workers information into the data system (HMIS)
- There should be a uniform way of keeping and updating data (VHWs) across all health institutions for updated information

Annexure 1

Village Health Workers (VHW) Data Collection Tool

Health Centre:………………………District…………………………

#	Names	Village	DOB	Activity Status	Incentives	Last training	Contact
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							
17							
18							
19							

Annexure 2

Village Health Worker Situation by District

Districts	# of facilities	total # of VHWs	Age				Training status		
			<55	55-70	>70	not spec	trained	not yet	not spec
Berea	16	760	322	286	147	108	602	118	40
Botha-Bothe	12	688	188	279	167	56	531	98	59
Leribe	25	1110	591	288	112	43	818	75	47
Mafeteng	18	693	285	217	101	15	606	38	49
Maseru	26	890	319	402	144	87	713	93	84
Mohale's hoek	15	663	311	286	194	34	547	77	39
Mokhotlong	10	471	198	175	98	42	416	34	21
Qacha's nek	12	524	278	170	119	21	394	95	35
Quthing	9	450	196	223	89	78	259	84	107
Thaba-Tseka	17	854	587	398	262	71	456	200	198
Totals	**160**	**7103**	**2979**	**2127**	**1081**	**941**	**5232**	**704**	**979**

TO: Consultant
Human Resource Alliance For Africa
Lesotho

Challenges faced by Village Health Workers Sehlaba-thebe

As village health workers of Sehlaba-thebe H/C, our outmost challenge, is the inaccessability of health centre due to poor road infrastructure from our respective villages, equally important is the unpredictable weather, which often result in poor attendence during our monthly sittings at health centre, hence most of the time we delay to be updated.

Another challenge originates from the inconsistent monthly incentives, that is we do not know when will be paid hence become indebted to many people with the hope that we shall be paid month end. This brings the issue of November 2012 when some VHW got accumulated incentives amounting M5400.00 and others did not get and were promised to get it later but to date nothing has been given to them.

Furthermore, lack of resources and working tools such as essential medications, Savlon and bandages, which often limits their care for patients at home.

Lack of workshops and training, still pose a great challenge on our scope of practice as our last training for most of us was in 2007 at Ha Maseko. Moreover we have

the transport is too expensive for example it is roughly M80.00 bus fare return and M140.00 taxi fare return and which is not only what the woman will pay as hospital charges are not included in the above stipulated figures.

We can not over look the fact that the ratio of VHW to household is 1VHW: 50households which is a very large population hence service delivery in some days has to be compromised, so that all sectors from our departments are represented.

Last but not least of our challenges lies with patients from our respective villages, who do not report that they are either on HAART or ATT treatment and they require assistance with medication dispension. To add on that point, also most tracked patients refuse to take medication and report themselves to the health facility.

Finally, another challenge lies with the condition and state of our health centre. Our patients complain of lack of heating systems and consistent power supply for lights, so much that they have to bust in the sun for warmth while awaiting health services. Deliveries are conducted using candle lights.

We will appreciate your help with our respective