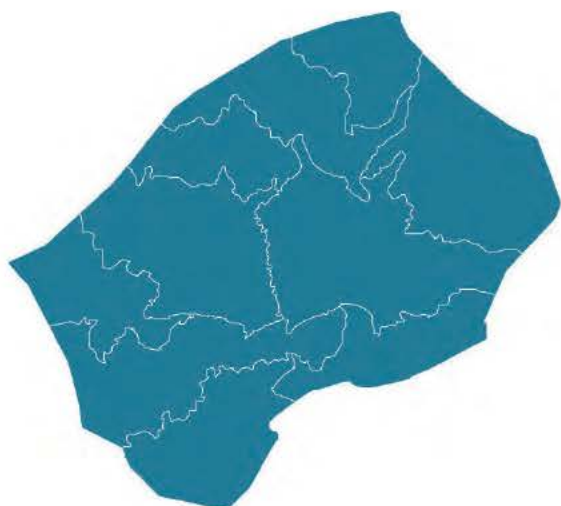


MCHIP Country Brief: Lesotho



Selected Health and Demographic Data for Lesotho	
Maternal mortality ratio (deaths/100,000 live births)	1155
Neonatal mortality rate (deaths/1,000 live births)	47
Under-5 mortality rate (deaths/1,000 live births)	117
Infant mortality rate (deaths/1,000 live births)	91
Contraceptive prevalence rate	46
Total fertility rate	3.3
Skilled birth attendant coverage	90.2%
Antenatal care, 4+ visits	70.4%

Sources: Demographic information and health systems 2010, UNICEF Annual Report on Lesotho 2011, WHO Lesotho Health Profile 2011

Health Area:

- HIV/AIDS: Pre-Service Education and VMMC



Program Dates	Pre-Service Education: January 1, 2010– June 30, 2014 VMMC: October 1, 2011–December 30, 2013					
Total Mission Funding	Redacted					
Geographic Coverage	No. of provinces	N/A	No.(%) of districts	100%	No. of facilities	50 (PSE) 17 (VMMC)
Country and HQ Contacts	Laura Skolnik, Stephanie Reinhardt, Isatou Jeng, Alice Christensen, Tigistu Adamu					

Redacted

PRE-SERVICE EDUCATION

INTRODUCTION

As a country with one of the highest HIV-prevalence rates in the world at 23.3%, Lesotho has a dire need to address the state of HIV/AIDS care and treatment by urgently and effectively preparing nurses in HIV/AIDS care, treatment, and support systems. The vision of the Maternal and Child Health Integrated Program (MCHIP) has been to accelerate the reduction of maternal, newborn, and child mortality in 30 priority countries by increasing the use of a focused set of interventions that address the major causes of death among mothers, newborns, and children under five years of age. MCHIP recognizes that successful interventions must employ multifaceted, high-impact, innovative strategies to achieve quantifiable improvements in neonatal, infant, and maternal mortality rates. One such approach—strengthening pre-service nursing education in order to improve the quality of nurse-delivered care in countries facing significant constraints in skilled human resources for health—has the potential to improve the overall level of care across national systems.

The MCHIP Lesotho nursing pre-service education (PSE) program began in May 2010 to improve the quality of nurse- and midwife-delivered care in the country. In addition to the Lesotho Ministry of Health (MOH), MCHIP worked closely with the Christian Health Association of Lesotho (CHAL) to provide technical assistance and build capacity, provide support to nursing and midwifery training institutions and clinical sites, and improve the clinical experiences of graduating nursing and midwifery students¹ to prepare them to address community health needs.

The capacity at nursing training institutions in Lesotho has been a major limitation to increasing the intake of trainees to match service demands. Poor infrastructure at some of the training institutions, particularly at CHAL schools, is an added challenge. There is a general concern about the quality of nurse preparation at these institutions. Training is mainly theoretical with limited guided skills development and practicums to enable graduates to provide services without the need for immediate in-service training. The majority of practicum training sites are inadequate due to poor infrastructure, staff shortages, lack of practice standards, and communication gaps between the schools and clinical site staff.

KEY ACHIEVEMENTS

The program goal has been to build sustainable capacity in nursing PSE in Lesotho, focusing on CHAL institutions. The program has contributed to increasing the number and quality of nursing and midwifery graduates in Lesotho with skills appropriate to the context of the country, taking into account the burden of disease and government priorities. The specific objectives were to:

1. Strengthen the capacity of CHAL Schools of Nursing to house and educate nursing and midwifery students;
2. Strengthen current didactic and clinical teaching practices; and
3. Support the development of an enabling regulatory environment for nursing education by strengthening the Lesotho Nursing Council.

Figure 1. Key Elements

Key Elements of PSE Activities



MCHIP's nursing and midwifery PSE program has strengthened the key element areas outlined in MCHIP's Lesotho PSE Strategic framework as shown in Figure 1. The program has developed an innovative primary health care (PHC) clinical placement program to improve the clinical education of nursing students and to strengthen the infrastructure of the nursing schools. The PHC clinical placements expose students to varied clinical activities in health centers, thereby strengthening students' clinical education experience, as well as improving the student-to-preceptor ratios at the clinical sites. Exposure to comprehensive PHC clinical services during training contributes to nursing students being more confident and competent to assess, prevent, diagnose, and treat common conditions, as well as develop skills in community outreach. Given the distribution of the population within this remote, mountainous country, it is essential to ensure clinicians, including nurses and midwives, are able to provide essential services in rural settings, which will more broadly impact the recruitment and retention of nurses to these clinics. To date, all four CHAL schools have implemented over 600 PHC clinical placements with nursing and midwifery students.



Photo: Alice Christensen

Student nurse observing patient education techniques

Since strengthening the current didactic and clinical education practices has been a key area of focus in the program, MCHIP provided training to many preceptors at the CHAL schools, who consequently identified gaps in the availability of tools and resources for teaching and assessing students and also noted a lack of communication between CHAL schools and clinical sites. As a result, MCHIP supported the development of standard tools, checklists, and logbooks to facilitate capacity building efforts, and facilitated communication between the CHAL schools and clinical sites to foster collaboration. Overall, MCHIP improved the clinical teaching practices among nurse clinicians and educators by providing training in clinical teaching methodology and student

performance assessment, and by conducting related supportive supervision visits.

In the area of policy and regulatory development, MCHIP developed a very close working relationship with the Lesotho Nursing Council (LNC). MCHIP developed scopes of practice for nursing, midwifery, and nursing assistants in partnership with the LNC and provided a tool to ensure that standard qualifications are met. This focus on regulation has aimed to ensure that the quality of education, service delivery, and safety of the public meets established quality standards. To further strengthen the LNC's regulatory work, MCHIP provided technical assistance in drafting a revised Nurse and Midwifery Act and developed a framework for the accompanying rules and regulations. Furthermore, MCHIP supported the LNC by providing logistical and technical assistance, including building the capacity of the LNC's board to undertake regulatory work needed to strengthen nursing and midwifery education.

Notably, MCHIP worked hand-in-hand with the LNC in the development and implementation of LNC's five-year strategic plan and two-year operational plans to outline specific regulatory activities that will strengthen the nursing profession. MCHIP also worked with the LNC to develop an electronic database of all nurses in Lesotho. This database has been vital to ensuring that nurses are correctly licensed and qualified to work in hospitals and clinics.

MCHIP's approach to improving the quality of nursing care has centered on strengthening nursing education, the primary health care system, and the accrediting bodies.

All of these are important structures in ensuring retention of nurses in Lesotho and the provision of quality health care. MCHIP's approach to building the capacity of nurse educators and clinicians to provide supportive supervision to students has also had a positive influence on their job satisfaction and retention. Finally, the documents that MCHIP assisted the LNC to develop have created a sustainable enabling environment for the growth and development of the nursing profession in Lesotho. In order to expand upon these achievements, it is critical that nursing and midwifery institutions and students continue to be supported to improve the quality of health care in Lesotho.

WAY FORWARD

Since a large proportion of the Basotho people live in rural areas, access to health care remains a challenge. PHC is as an important strategy that addresses the main health problems in communities through the provision of promotive, preventive, curative and rehabilitative services. MCHIP developed a unique and sustainable strategy that unifies three key elements for provision of quality nursing care, namely strengthening nursing education, PHC and the accrediting bodies (See Figure 2). All these are important structures in ensuring retention of nurses in Lesotho, which also remains a challenge.

The development of nurses from the early stage of their education and training - so that by the time they complete their training, they are well prepared to be placed anywhere in Lesotho - motivates them as young professionals to see that there is growth and development in nursing. When placed at these facilities, student nurses acquire critical thinking and problem solving skills. Placement at PHC settings further instills a love and willingness among nurses to serve people in primary health care settings – another important aspect for retention. Supportive supervision for students as well as for the clinicians has been found one of the key issues in the retention of staff working in rural settings. Therefore, building capacity for educators and clinicians to provide supportive supervision to students has a positive influence to the nurse educators and clinicians' job satisfaction and retention.

The LNC has developed a continuing professional development (CPD) program which is a prerequisite for all nurses to renew their licensure annually. One of the aspects to acquire a CPD point is reading/studying relevant nursing/medical literature. Placement of SLC and PCs at the PHC settings will assist these nurses to access reading resources at their working sites and to acquire the needed CPD points for re-licensure with LNC, while at the same time studying will improve the quality of work-life for these practitioners. The documents that MCHIP assisted the LNC to develop have created a sustainable enabling environment for the growth and development of the nursing profession in Lesotho.

The MCHIP program has worked hand-in-hand with local nursing professionals for all program activities, ensuring skills building and program sustainability. These important initiatives should be continued for the betterment of nursing and the provision of quality health care for Basotho.

Continue improvements in clinical education

- Clinical placements relevant to the country context should be continued to close the gap between theory and practice.
- Education and practice should be strongly linked to ensure that education changes at the same time (or before) practice does. Educators should be included in policy discussions so that they can prepare nursing and midwifery graduates with the required skills.
- Clinical placements should be institutionalized, with schools and facilities taking joint responsibility. Co-funded pre- and in-service preceptorship training initiatives should be explored to ensure competency in specific clinical skills.

- There is a continued need to find housing solutions for students in clinical placements, as some of the housing was inadequate.
- Model sites for clinical placements should be developed to showcase best practices, through ensuring preceptors are trained and remunerated for their role in precepting students, addressing the issue of housing sites, and ensuring that patient volume is adequate for the clinical experience to be fruitful.

Continue training preceptors and nursing educators for skills improvement

- Continue to support the education of nurse educators to ensure they are delivering effective didactic and clinical education to students.
- Continue to support the teaching of clinical skills for nursing and midwifery students and ensure the teachers themselves are up-to-date.
- Support the development of a formal job description for clinical preceptors, in order to make this position desirable and competitive. The position should include remuneration.
- Follow-up a cohort of students to assess the long-term aspect of clinical placements and education particularly in the area of recruitment and retention.

LNC should continue to implement the systems and tools developed with MCHIP to increase the effectiveness and quality of nurses in Lesotho

- The LNC should be supported to increase registration and licensure rates of nurses in Lesotho to ensure nurses are working legally and professionally in the country.
- The LNC should continue to implement its advocacy plan as well as the strategic plan to increase its effectiveness as a regulatory body.

On-going support is needed to continue strengthening and expanding the effectiveness of the LNC. Examples of future support and collaboration possibilities include:

- LNC is still in need of office space to accommodate the needs of the organization.
- LNC should be supported to hire a Support Education Officer, Professional Practice Officer and Registration and Licensure Officer to support the registrar's heavy workload and increase its ability to implement key regulatory activities.
- LNC should be supported to implement a registration and licensure campaign. Ensuring that nurses and midwives are working with current licenses is important for the regulatory structure as well as the financial stability of the LNC.
- LNC should be provided with IT support to improve the efficiency of current systems.
- LNC should be provided with support to accredit training institutions:
 - Support national and internal SBM-R teams;
 - Provide technical support to accredit clinical sites;
 - Collaborate with Council on Higher Education (CHE) on accreditation activities.
- The LNC should be supported to expand the continuing professional development (CPD) program:
 - Provide support to the LNC to register CPD providers;
 - Develop LNC courses for CPD credit and as income generators for LNC;

- Conduct formal evaluation of CPD program at 2 years.
- LNC should be supported to ensure national competencies are integrated into curriculum, as the current curriculum uses unknown competencies.
- Roll out a PSE Regulation Module to all nursing and midwifery schools to increase graduates knowledge in the importance of regulation and licensure.

Continue to support the MOH to implement practice standards related to nursing and midwifery

- Support national and internal SBM-R/MOH accreditation teams.
- Provide technical support to develop QA tools in collaboration with the MOH to integrate nursing standards with their current QA tools.

VOLUNTARY MEDICAL MALE CIRCUMCISION

INTRODUCTION

In 2011 the Government of Lesotho, facing an HIV prevalence rate of 23 percent, revitalized its HIV prevention strategy. As part of these revitalization efforts, the Lesotho Ministry of Health (MOH) asked MCHIP to introduce and scale up voluntary medical male circumcision (VMMC) services throughout the country.² The government’s willingness to introduce VMMC services, based on advocacy by MCHIP and other stakeholders, was seen as a major achievement by the international community, as Lesotho was the last of the 14 priority countries to launch services.³

The Lesotho MOH’s approach to introducing and scaling up VMMC service delivery has been to integrate facility-based services in all hospitals in the country. Due to cultural sensitivities related to traditional initiation practices, the MOH initially focused on keeping services confined to hospitals, with limited demand creation and no outreach at the outset of the program.⁴ The shortage of providers in facilities presented a challenge. In most government facilities doctors who are assigned to work in male circumcision (MC) clinics must maintain their roles in other departments concurrently, making it difficult to keep up with demand during the winter season when demand for MC services is at its peak. To date, doctors are the only cadre that can perform male circumcision, and nurses may only assist.

“My brother came to Carewell and got circumcised. He said the doctors and nurses did a good job and it decreases the chances of getting HIV and it will be easier to keep myself clean. And my brother said it was a good service.”
—Client at Jhpiego’s Carewell Clinic, October 2013

Against this backdrop, MCHIP worked hand-in-hand with the MOH to implement a “step-wise” approach to VMMC, scaling up services to a few hospitals at a time, engaging in limited demand creation activities, and training a large number of providers. Using this approach, the program has achieved remarkable results within a short two-year timeframe. Through an intensive scale-up effort, between February 2012 and December 2013, more than 43,900 VMMCs were

² VMMC refers to adult/adolescent male circumcision, while MC refers to both adult/adolescent circumcision and infant circumcision.

³ The VMMC program began in late 2011 with the receipt of MOH concurrence for program implementation and USAID approval to proceed. MCHIP had been working with USAID since late 2009 (with a USAID-approved work plan) in collaboration with the MOH and stakeholders as the MOH began its deliberations about whether to implement a VMMC program.

⁴ The traditional circumcision procedure performed during initiation is not protective against HIV as it is only partial removal of the foreskin.

conducted at 17 MCHIP-supported sites, made possible by the training of 311 doctors, nurses, and counselors. This effort has dramatically increased the number of men accessing services (from less than 1,000 per year before MCHIP). According to the Lesotho modeling study, approximately 7,000 future potential new HIV infections will be averted due to MCHIP's work.⁵ This is a major contribution in a country that has an estimated incidence of 26,000 new HIV infections annually.

MCHIP's goal has been to increase the number of circumcised men in Lesotho. The program has three objectives:

1. Support and strengthen MOH capacity to scale up VMMC services
2. Scale up facility-based VMMC and introduce early infant male circumcision (EIMC) services in selected hospitals and health facilities
3. Increase demand for VMMC and EIMC services

KEY ACHIEVEMENTS

MCHIP has significantly strengthened the MOH's capacity to scale up VMMC services, providing technical assistance and mentorship to the MOH and collaborating on the development of VMMC guidance documents and national tools, including monitoring and evaluation (M&E) and quality assurance (QA) tools such as client records forms and VMMC registers. In addition, through MCHIP technical support, the Lesotho national VMMC program has developed standard operating procedures (SOPs) for service provision, tools for data collection, and other guidance documents.

After the initial introduction of VMMC services at 10 district hospitals, MCHIP successfully scaled up facility-based VMMC services to 17 sites throughout the country. The program has trained providers on VMMC service provision and oriented stakeholders at the district level to ensure follow up with VMMC clients.

Through its innovative branding of *Rola Katiba* ("take your hat off"), MCHIP was able to define VMMC as a concept distinct from traditional initiation practices and increase demand for VMMC services in health care facilities throughout Lesotho. MCHIP has also established partnerships in both the public and private sectors with private clinics, international organizations such as the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO), and local organizations such as Apparel Lesotho Alliance to Fight AIDS (ALAFa) and Lesotho Planned Parenthood Association (LPPA) to support the rollout of VMMC services.

Main interventions have included:

- Assessing facilities
- Training providers
- Introducing VMMC services
- Scaling up VMMC services
- Providing VMMC services throughout country
- Revitalizing the MC technical working group
- Building capacity at the MOH
- Developing national tools and standards
- Implementing QA practices
- Providing supportive supervision
- Creating partnerships with NGOs, the UN, and private sector partners
- Developing *Rola Katiba* demand creation strategy

⁵ Njeuhmeli E, Forsythe S, Reed J et al. 2011. Voluntary medical male circumcision: Modeling the impact and cost of expanding male circumcision for HIV prevention in Eastern and Southern Africa. *PLoS Med* 8(11): e1001132.doi:10.1371/journal.pmed.1001132



A key innovation is the program's integration within the health system. Hospitals and providers have benefited from the assessment and upgrade of MC services, and learned from MCHIP's approach to quality assurance. The MOH gained the capacity to lead a national health program, and MOH staff were mentored in technical and program management issues. The VMMC program was implemented as part of a comprehensive HIV prevention package, also positively affecting men's uptake of HIV testing and counseling (HTC). VMMC clients who test HIV-positive have been actively

linked to referrals for HIV testing and counseling and other care and treatment services.

WAY FORWARD

Over the last two years, MCHIP has quickly and efficiently scaled up VMMC services in Lesotho. Within this short timeframe, the program has worked successfully with the MOH to provide quality services, strengthen MC sites, train providers, and create demand. Scale-up of MC services will make a deep and lasting impact on the HIV/AIDS epidemic in Lesotho. To achieve a broader impact and continue to meet national targets, VMMC and EIMC services should be continued. Barriers to access should be assessed to determine effective strategies for overcoming obstacles to efficient service delivery, including continued advocacy for task-shifting for nurses, working with private providers, and launching a PrePex™ acceptability and safety study.

It is vital to continue to scale up services to reach 80% of the eligible male population and to maintain the momentum of VMMC in Lesotho as part of a comprehensive approach to HIV prevention.

- Continuity of services should be maintained through district hospitals, ISDs, and health center outreach to ensure that demand is met.
- VMMC sites should be supported to ensure quality service delivery and to maintain current national geographic service coverage.
- VMMC in Lesotho has also demonstrated success in encouraging men to get tested for HIV; the work on expanding innovative linkages between VMMC services and HTC/ART treatment should be continued. The strong progress on linking VMMC with HTC and referral for HIV-positive individuals should be continued through expanded application of innovative point-of-care diagnostics.
- Health center collaboration should be continued and expanded to enable health center nurses to book clients for VMMC and support VMMC client follow-up.
- Research should be conducted to bridge the “research-to-use” gap for the PrePex™ device for circumcision (through a safety and acceptability study).
- Quality assurance efforts should be continued to ensure high-quality VMMC services.
- EIMC scale-up should be continued.

Partnerships for VMMC and EIMC should continue to be scaled up.

- Expanded private-sector collaboration should be explored, including training of private providers and collaboration with private organizations for service delivery.
- Partnerships and innovative service delivery models should be continued.

Human resources for MC should be continuously developed and trained.

- Advocacy for task-shifting to allow nurses to perform MCs should be continued.
- Training and supportive supervision for MOH providers and sites should be continued to ensure quality MC and satisfaction of providers.

The MOH should be supported to continue its leadership of the VMMC program.

- Support for the MOH's leadership of the VMMC response in Lesotho, including the effort to address adequate pharmaceuticals and stock-outs, should continue.
- The national VMMC database should be fully operationalized and linked to the national electronic medical records system.
- Collaboration with the Global Fund, the UN, and other stakeholders should be continued to ensure a coordinated VMMC/EIMC response.

Demand for VMMC and EIMC services should be further increased.

- The innovative *Rola Katiba* campaign should be expanded to encourage service uptake, particularly among men ages 10–29, in collaboration with a range of partners (UN, NGO, local organizations).
- Innovative methods of increasing demand and matching supply and demand for MC should be continued (e.g., transportation reimbursement, collaboration with health centers on client booking).
- Partnerships with local organizations, district officials, and community mobilizers to promote VMMC service uptake should be expanded.
- EIMC demand creation activities should be scaled up after the pilot phase is concluded.