

Provision of Family Planning Services in Lesotho

CONTEXT: One of Lesotho's population goals is to achieve replacement-level fertility by 2011, but the contraceptive prevalence rate of 41% is considerably below the target of 70–75%.

METHODS: A situation analysis framework was used to assess family planning providers' readiness to provide services and women's perceptions of service delivery. Data were collected in 1997–1998 through surveys of 38 service delivery points and 52 providers, and focus group discussions with 50 women.

RESULTS: Most facilities were open five days a week, during working hours; closure during lunchtime and on weekends restricted access by employed people. There were no clear guidelines on the provision of family planning methods, and providers created their own rules and restrictions. Some women were discouraged by provider bias, lack of visual privacy and recurrent shortages of their preferred brand of pills. Although the government had a uniform pricing policy for contraceptive methods, costs varied and generally were higher in rural than in urban areas. In rural areas, transportation costs increased the overall cost of using family planning methods.

CONCLUSIONS: Expanding women's access to service sites, developing guidelines for family planning providers and ensuring that standard prices are adopted should be government priorities if contraceptive prevalence is to increase. *International Family Planning Perspectives, 30(2):77–86*

By 'Maletela
Tuoane,
Nyovani Janet
Madise and
Ian Diamond

'Maletela Tuoane is lecturer in demography, Department of Statistics and Demography, National University of Lesotho; Nyovani Janet Madise is reader in social statistics, Division of Social Statistics, University of Southampton, UK; and Ian Diamond is chief executive, UK Economic and Social Research Council, Swindon.

For a long time, little was known about fertility in Lesotho. The 1977 Lesotho Fertility Survey reported that the total fertility rate averaged five births per woman, a moderate level by Sub-Saharan African standards. Because only 7% of married women of reproductive age were using contraceptives in 1977, this moderate fertility level may have resulted from long periods of postpartum abstinence due to male labor migration to South African mines.¹ The last three national censuses (conducted in 1976, 1986 and 1996) have documented a decline in the total fertility rate from 5.6 to 4.1 births per woman.² Nevertheless, the government considers fertility too high. To prevent adverse consequences of rapid population growth, such as a high unemployment rate, poor economic performance, a high demand for social services and a decrease in resources, the government adopted a population policy in 1994 whose aim is to achieve replacement-level fertility (a total fertility rate of about 2.2 children per woman) by 2011.³

A major strategy of the population policy has been to expand the family planning program so that contraceptive prevalence increases to 70–75% by 2011. Specifically, the policy aims to provide a wide range of family planning methods as an integral part of health care at all service levels; to equip hospitals and clinics to provide IUDs, sterilization and injectable contraceptives; and to provide adequate information, education and communication. An initial goal was to raise contraceptive prevalence to 31% by 1996. In 1998, prevalence was estimated to be only 23%,⁴ but it increased to 41% in 2001.⁵

The 1994 population policy had several limitations. For

example, its demographic targets were not all based on research and were overly optimistic, and maternal mortality and HIV/AIDS were not given adequate consideration. In addition, because the policy predated the 1994 United Nations-sponsored International Conference on Population and Development, it did not reflect the conclusions and recommendations contained in the conference's Programme of Action (for example, on issues of reproductive health and rights, adolescents' and young people's health concerns, gender equality, equity and empowerment of women).⁶ As a result, a revised version of the policy has been under review for several years.

Although critics have questioned the magnitude of family planning programs' impact on fertility reduction, programs unquestionably still have a vital role to play in the demographic transition of Sub-Saharan African countries.⁷ As young people enter the reproductive years, the demand for family planning services will increase, and programs need to be equipped to satisfy this demand. Thus, studying family planning outlets' readiness to provide contraception is one way of assessing whether a country is likely to achieve its reproductive health goals.⁸ In the early 1980s, Mauldin and Ross rated Lesotho's family planning program as "weak," whereas they rated programs in neighboring countries as "moderately strong" (South Africa and Zimbabwe) or "strong" (Botswana).⁹ Lesotho's family planning program has improved since then,¹⁰ but further improvements are required. In this article, we describe current practices in family planning service provision in Lesotho, and make suggestions for improving contraceptive prevalence.

BACKGROUND

Lesotho is an independent kingdom in southern Africa, bordered completely by the Republic of South Africa. The country is divided into four ecological zones: the mountain region, the lowlands, the Senqu River Valley and the foothills. The mountain region comprises 59% of the land area and is home to 23% of the population. The major urban areas are in the lowlands, which account for 59% of the population.

Lesotho's economy is heavily dependent on agriculture and exportation of labor. In 2001, the unemployment rate was 43%. A large proportion of men (26% of those aged 30–39 and 31% of those aged 40–49) migrated to South Africa for temporary employment in the mines, leaving their families in Lesotho.¹¹ This pattern of migration may help explain some unusual features of the Basotho society¹²—for example, in 2001, 52% of females 15 and older were literate (i.e., had completed primary school), compared with 37% of males.¹³

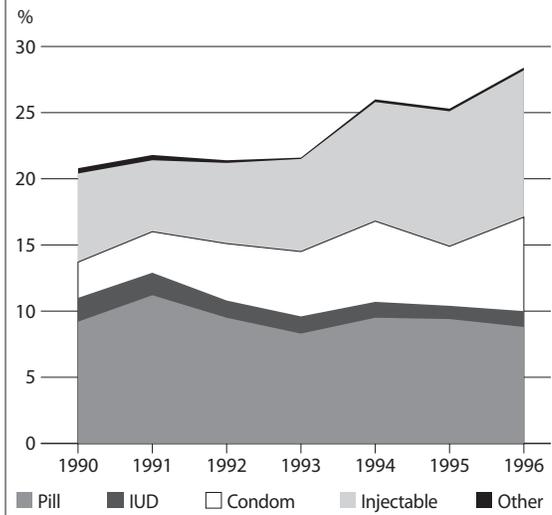
From the time of independence in 1966, the government of Lesotho recognized the constraints that rapid population growth was placing on economic development. However, fearing a negative response from the generally pronatalist society, it was initially cautious about offering modern family planning methods as part of its health promotion activities, although it encouraged private-sector activities.¹⁴ In 1968, the government approved the formation of the Lesotho Family Planning Association, now known as the Lesotho Planned Parenthood Association (LPPA).

The government became directly involved in family planning activities in the late 1970s, when it adopted primary health care as the cornerstone of its health delivery system. This led to the establishment of 182 registered health facilities—21 hospitals and 161 freestanding clinics.¹⁵ These hospitals offer integrated health care, including family planning consultation, treatment of sexually transmitted infections (STIs), immunizations, maternal and child health care, and curative services. In addition, all government health facilities offer family planning consultation, immunization, maternal and child health care, and basic curative services.

Currently, 148 registered health facilities remain in operation; 87 of them offer modern family planning services. The Ministry of Health and Social Welfare (MOHSW) has the overall responsibility for managing the national family planning program. This ministry and LPPA are the main providers of family planning services; other providers are the Christian Health Association of Lesotho, the Red Cross and private practitioners.

Funding for family planning comes from various donors, including the United Nations Population Fund and the United States Agency for International Development. The government allocates 5% of its budget to MOHSW, and 40% of this allocation goes to the Maternal and Child Health and Family Planning Department.¹⁶ LPPA is supported mainly by the International Planned Parenthood Federation; some funds come from revenue generated from its op-

FIGURE 1. Percentage of married women aged 15–49 using contraceptives, by method, Lesotho, 1990–1996



Source: Ministry of Health and Social Welfare, *Family Health Support Project: Final Report*, Maseru, Lesotho: Ministry of Health and Social Welfare, 1997.

erations and from fund-raising activities. Since 1988, the government has required all facilities that offer family planning services (except small surgical facilities and clinics run by private practitioners) to charge uniform, subsidized prices for family planning commodities. To compensate for the loss of revenue resulting from the uniform pricing policy, LPPA receives a grant from the government.

The Christian Health Association owns about 40% of all health facilities in Lesotho.¹⁷ The government pays the salaries of all health-related personnel in these facilities, but member churches have a major say in the facilities' administration. For example, sites operated by the Roman Catholic church, which constitute about half of the association's facilities, do not provide artificial methods of contraception, although individual staff sometimes do.

Lesotho does not have an explicit family planning policy. Service providers have few guidelines to follow and often make their own rules because of ambiguities. For example, parity-related restrictions exist for surgical contraceptive methods, but the number of children that a client must have is vague.¹⁸ Some providers require the consent of the partner, and others do not. Surgical methods can be provided only at hospitals, while injectables and IUDs can be provided at family planning clinics or hospitals. Advertising of contraceptives is not restricted.

The methods available in Lesotho are vasectomy, female sterilization, combined and progestin-only pills, injectables, IUDs, spermicides, diaphragms, cervical caps, condoms and, to a lesser extent, female condoms and implants. Official statistics are thought to underestimate contraceptive prevalence, because about 20% of health facilities do not send records to the Health Statistics Unit. Nevertheless, available data indicate that prevalence increased moderately between 1990 and 1996 (Figure 1). The pill was the most commonly used method through 1994, after which

it was overtaken by the injectable. Use of condoms, the third most prevalent method, has generally increased throughout the years, except for an unexplained drop in 1995. The prevalence of condom use would be higher if sales from outlets such as supermarkets, pharmacies and private physicians were included. Use of natural family planning and other methods is negligible. Prevalence of IUD use has been almost constant.

DATA AND METHODS

Our aim was to assess the readiness to provide services and the quality of selected family planning facilities in Lesotho. Primary data came from three sources: the Lesotho Facility Survey, the Lesotho Family Planning Providers' Survey and focus group discussions, all conducted by the first author between December 1997 and February 1998. The surveys were designed to supplement the 1995 Lesotho Safe Motherhood Initiative–Women's Health Survey (LSMI-WHS) with detailed, community-level data on family planning service delivery.* The facility survey was undertaken to assess the availability and functioning of family planning services, the providers' survey to evaluate staff readiness to provide quality services, and the focus group discussions to examine Basotho women's attitudes toward contraception and perceptions about family planning service delivery in the country.

The facility survey was conducted through face-to-face interviews and personal observation. Data were collected from 38 sites offering family planning services (11 hospitals, 19 health centers and eight LPPA facilities), representing 41% of all facilities in the country. Sites operated by private physicians were excluded, as they are not involved in the national family planning program; they charge higher fees, and thus they serve relatively few, atypically privileged individuals. Facilities within the communities or nearest to the communities sampled in the LSMI-WHS were selected for inclusion. These communities are primary sampling units constructed in the 1996 census. Each community includes about 300–500 households. For the providers' survey, all 52 family planning providers in the selected facilities participated in semistructured interviews. The survey instruments were adapted from the situation analysis approach for assessing family planning and reproductive health services.¹⁹

Seven focus group discussions were held with 50 female contraceptive users from the urban and rural areas of Maseru District (Table 1). The discussions explored women's contraceptive decision-making, experiences with service providers, and views about service delivery and availability of methods. Although the data are not statistically representative of the total population, they provide insights into norms and rationales for what people do.

Identifying contraceptive users and bringing women together for about an hour and a half was hard, particularly in the rural areas. In addition, it was not possible to select women randomly. Therefore, a snowballing approach was used. In the rural areas, where contraceptive use was low,

TABLE 1. Composition of focus groups and selected characteristics of participants, Lesotho family planning assessment, 1997–1998

Group	No. of living children	Educational level	No. working
Urban unmarried women 17–19 (N=7)	0	Complete high school/some college	0
Rural unmarried women 16–19 (N=7)	0	In high school	0
Urban unmarried women 22–27 (N=6)	0	Complete high school/some college	5*
Urban married women 23–27 (N=9)	1–3	Complete primary/complete high school	6†
Rural married women 24–28 (N=5)	2–3	Complete primary/complete high school/unknown	2
Urban married women 32–38 (N=7)	2–5	Complete high school/complete college	6
Rural married women 30–37 (N=9)	3–5	Complete primary/some high school	4†

*The sixth woman was looking for a job. †Includes self-employed women.

family planning providers helped to recruit women for the discussions; participants were assured of confidentiality, and the discussions were held away from the health center. The findings may be biased if the providers chose women most likely to speak favorably of the quality of care. However, a comparison of the findings from the groups in which the providers assisted in the recruitment and those in which they did not revealed no such bias.

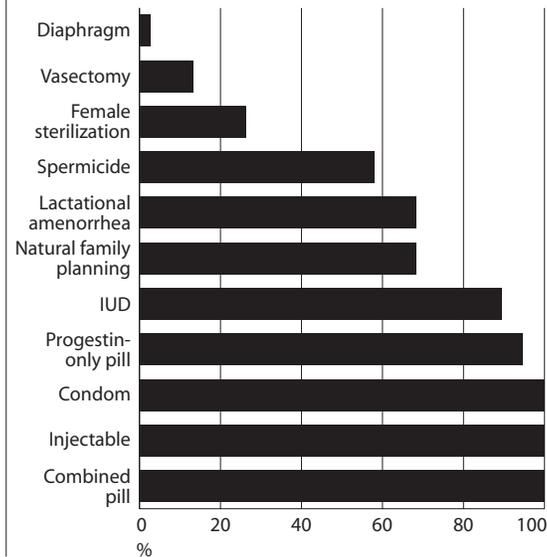
Although it was difficult to find participants for the focus group discussions, women who attended were willing to speak openly. A trained moderator led each discussion, another person took notes and the first author was present. The discussions were tape-recorded. They were conducted in Sesotho (the local language) and later translated into English by the first author.

RESULTS

Accessibility of Services

Potential clients are able to use family planning services only if the services are accessible to them. Nearly all the facilities surveyed opened at 8:00 A.M.; only two opened earlier. About two-thirds closed at 4:30 P.M.; fewer than 10% closed at 5:00, and the rest closed earlier. Most facilities reported that they closed at lunchtime (12:45–2:00 P.M.). Four out of five offered family planning services five days a week; the rest offered them on six or seven days, but charges for

*The LSMI-WHS collected information on individual women's health, including their use of family planning. An analysis of factors affecting contraceptive use established that in addition to individual characteristics, factors not measured by the LSMI-WHS were associated with women's uptake of contraception, thereby necessitating a study of family planning service delivery in the communities that were included in the LSMI-WHS. (Source: Ministry of Health and Social Welfare, *Lesotho Safe Motherhood: Women's Health Survey Report*, Maseru, Lesotho: Ministry of Health and Social Welfare, 1995.)

FIGURE 2. Percentage of facilities offering each contraceptive method, Lesotho Facility Survey, 1997–1998 (N=38)

services were higher on weekends than on weekdays.

Most focus group participants who were not working mentioned that the opening times were acceptable. However, they added that working women frequently received preferential treatment:

“[Providers] often start with the workers, even if they already found you there, which is not fair.”—*Married urban woman in her 20s*

In both urban and rural areas, those who were working indicated that facilities' hours were not convenient, particularly because most sites closed at lunchtime. This influenced their choice of provider:

“If you work, you can go to Queen II Hospital, because you know that they open at half past seven in the morning ...or you can also go to a private doctor, because you are sure they even open at lunchtime.”—*Married urban woman in her 30s*

We asked providers about the ease with which clients reached facilities. They reported that where facilities were located within communities, clients walked for up to 30 minutes, but that women in some urban areas used public transport. In the mountain region, where the only way to reach some facilities was by foot or horseback, some clients walked for as much as six hours to reach a facility. Vans were available in some rural areas, but the average cost of 8.50 maloti (approximately U.S.\$1.36) for a single trip was too high for many rural people.

Characteristics of Facilities

A facility needs a high-quality infrastructure to provide high-quality services. Overall, 84% of facilities had piped water, 70% had electricity, 95% had toilets and 90% had sufficient seating for clients. In rural areas, solar energy or generators provided electricity. Generally, hospitals had the best infrastructure. (Hospitals serve as the first line of referral in Lesotho; Queen Elizabeth II Hospital in Maseru, which

was included in the study, is the national referral hospital.) All of the hospitals visited had piped water, electricity, toilets and sufficient seating for clients. By comparison, 79% of health centers had water, 47% had electricity, 95% had toilets and 90% had sufficient seating. Among LPPA clinics, 75% had water, 88% electricity, 88% toilets and 75% sufficient seating.

The conditions of the examination room can affect the quality of care given, as well as clients' satisfaction with the facility. For example, lack of adequate water may indicate that the provider is not able to wash her hands. More than 80% of facilities offered auditory and visual privacy, adequate water and adequate light. In addition, all the facilities were clean at the time of the visit. In the facilities that did not have visual or auditory privacy, curtain screens were used for examinations, but counseling took place in the waiting room. Lack of privacy was a problem for some women, as the following comment demonstrates:

“Where I used to go, there was no privacy at all. What separated me and other clients was just a counter; they could see when [the nurse] checked my breast and could hear every word of the conversation....That is why I stopped going there.”—*Unmarried urban woman in her 20s*

Materials and Supplies

Information, education and communication materials can be useful in communicating messages to clients. Flip charts or posters were available at 84% of facilities, brochures or pamphlets at 65%. Four facilities did not have any of these materials.

Although these materials are useful during counseling and for providing additional information, they are not a substitute for counseling, especially where literacy levels are low. During the focus group discussions, some women reported that they were asked to read the information provided on posters and to choose their preferred method before going into the consultation room:

“The only chance you get to know of other methods is just reading the posters provided. When you get inside [the consultation room], the nurse just asks you which method you prefer.... If you say the pill, she gives you the pill.... The only thing she will explain is how to take the pill.”—*Married urban woman in her 30s*

The number of methods provided and the availability of supplies are essential for an effective family planning program. All of the facilities offered combined pills, injectables and condoms (Figure 2). About nine in 10 facilities offered progestin-only pills and IUDs, while nearly seven in 10 offered counseling in natural family planning and lactational amenorrhea. This method mix is comparable to that observed in the 12 African countries that participated in the Population Council's situation analyses.²⁰

Fewer than 30% of facilities offered female sterilization or vasectomy. This low proportion is not surprising, because these methods can be offered only at hospitals in Lesotho. Some focus group participants felt that the choice of contraceptive methods and brands of methods was limited,

particularly compared with the range of available methods in South Africa:

“In Lesotho, there is a very limited choice. Well, that may be for all poor countries. Most service delivery points only have condoms, injectables and pills. [Other methods] are very rare. If you go to clinics in the Republic of South Africa, you find almost all methods available.”—*Unmarried urban teenager*

“[In Lesotho] you’ll find just one brand of the pill at a time, and the next time you go to get a resupply, you find a different brand.”—*Unmarried urban teenager*

Some sites, according to data from the Facility Survey, provided as few as three methods. And some reported that they had run out of supplies in the six months before the survey. Injectables and condoms were out of stock in 16% of facilities, IUDs and pills in 8%, and spermicides in 5%. These results are similar to those reported for other African countries.²¹

Cost of Methods

The cost of obtaining contraceptive methods varies in Lesotho despite the government’s efforts to require uniform pricing. At all the facilities surveyed, the cost of most methods was per visit; the cost of condoms was per packet of 20, and the cost of spermicides was per tube of 20 tablets. Costs ranged from zero to 100 maloti (Table 2). The least costly methods were condoms, the diaphragm, spermicides and counseling in natural family planning and lactational amenorrhea. Female sterilization and vasectomy were the most expensive methods. Charges were uniform only in LPPA clinics and generally were higher in rural than in urban areas (not shown).

Focus group participants raised the cost of contraceptive methods as a discouraging factor, particularly after the cost of pills rose by four maloti at the beginning of 1998:

“Some women had to struggle to save one loti for family planning. Now, having to save five maloti is even worse. Which sensible woman would go for family planning and spend five maloti instead of buying two and a half kilograms of maize meal for her family?”—*Married urban woman in her 30s*

“It is especially expensive for us in the rural areas, where we have to have money for both transport and family planning services. The charges are much cheaper in town.”—*Married rural woman in her 20s*

Providers’ Training

The use of family planning services can be influenced by providers’ knowledge, skills and attitude toward clients. None of the facilities visited had a medical doctor assigned to provide family planning services. Family planning providers were mainly nursing sisters and nursing assistants; fewer than 15% were nurse clinicians. In this respect, Lesotho is no different from other African countries, where the majority of family planning services are provided by nurses.²²

Strengthening family planning providers’ technical and interpersonal skills through training can enhance the qual-

TABLE 2. Costs (in maloti) of obtaining family planning methods, Lesotho Facility Survey

Method	No. of facilities	Range	Mean	Median
Combined pill	38	1.00–5.00	2.11	1.00
Progestin-only pill	36	1.00–5.00	2.00	1.00
IUD	34	1.00–15.00	2.76	1.00
Injectable	38	1.00–10.00	2.61	1.00
Condom	38	0.00–2.00	0.93	1.00
Diaphragm	1	1.00–1.00	1.00	1.00
Spermicide	22	1.00–5.00	1.43	1.00
Female sterilization	10	2.00–100.00	34.20	20.00
Vasectomy	4	20.00–80.00	37.50	25.00
Natural family planning	27	0.00–10.00	1.41	0.00
Lactational amenorrhea	27	0.00–5.00	0.63	0.00

Notes: Condom costs are for 20 condoms; spermicide costs are for one tube of 20 tablets. For all other methods, costs are per visit.

ity of care and thus increase clients’ satisfaction with services. Training is also important for staff, as it empowers them, improves their morale and interpersonal skills, and exposes them to new ideas.²³ Twenty-nine percent of providers had received basic training that had not included the provision of family planning methods, but some of these had attended in-service courses; an additional 6% had received no health care training at all. More than three-quarters of providers had attended a refresher course in family planning within the last 10 years.

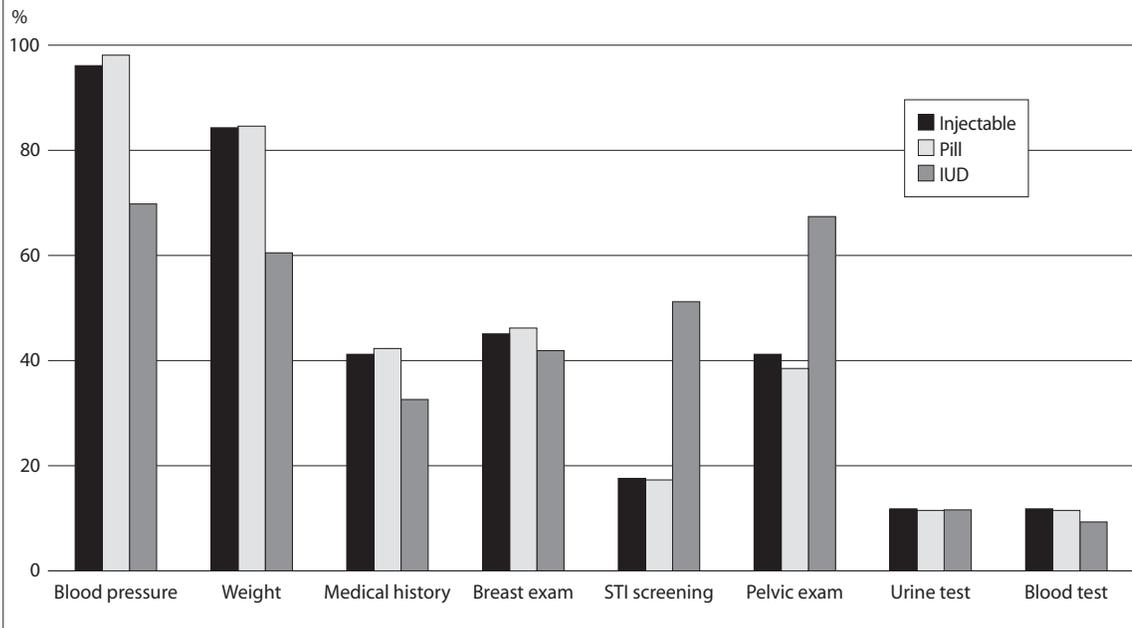
Although the implant was not being offered in Lesotho at the time of the survey, 46% of providers who had received refresher training had been trained in its insertion and removal. (LPPA now offers the method.) Of those who said that they had attended a refresher course in female sterilization and vasectomy, 39% and 31%, respectively, indicated that they were trained only to assist doctors during operations, not to carry out the procedure independently. Sixty-seven percent of providers with refresher training had attended special training in IUD insertion or removal, and 69% had been trained to provide counseling on exclusive breastfeeding. Some 77% had been trained in family planning counseling, an important service for helping clients make informed and voluntary choices about contraception.²⁴

Methods Recently Provided

Providers were asked which methods they had supplied in the 12 months prior to the survey. (We used 12 months rather than three months, the period used in situation analyses, because in countries where contraceptive prevalence is low, lack of demand for methods or supply shortages may affect the frequency with which providers see clients who want to obtain methods.) The vast majority reported having provided injectables (98%), condoms (94%) and either combined or progestin-only pills (96% and 94%, respectively). However, focus group participants mentioned that some providers restricted their choice of injectables:

“I used to go to LPPA to use the injectable, and after three doses I was told to switch to another method, but I still wanted to use it. So, I went to another place as a new client and I got it.”—*Married rural woman in her 30s*

FIGURE 3. Percentage of providers who conduct selected tests before providing contraceptives, by method, Lesotho Family Planning Providers' Survey, 1997–1998 (N=52)



Note: Not all methods are provided by every provider.

Seventy-seven percent of providers had inserted IUDs; 54% had counseled women about exclusive breast-feeding, but most doubted its effectiveness and did not encourage women to use it. Spermicides and counseling in natural family planning had been provided by 44% and 46%, respectively, of providers in the last year. No providers had dispensed the diaphragm or performed female sterilization or vasectomy in the past 12 months. Providers whose facilities offered the diaphragm reported that women did not favor it. None of the providers who were interviewed were qualified to perform female sterilization or vasectomy, and these methods were not widely known by women in the focus groups. When female sterilization was mentioned, most focus group participants were opposed to it because of rumored side effects:

“With female sterilization, they say you end up having no sexual feelings at all.”—*Married rural woman in her 30s*

“They also say that during sexual intercourse, there is too much noise made by the vagina if a woman has been sterilized.... They say a person in the next room can hear clearly what is happening.”—*Married rural woman in her 30s*

Procedures for Providing Methods

Providers who had dispensed injectables, pills or IUDs in the last 12 months were asked about the types of examinations or tests they conducted on a new client before providing the method. Urine and blood tests were uncommon (Figure 3). More than 80% of providers said they checked women’s blood pressure and weight before giving pills and injectables. (Weight is not relevant for eligibility for combined pills, but there may be some concern regarding weight gain with injectables.²⁵)

Between 33% and 45% of providers completed a med-

ical history and breast examination for each of these three methods. Pelvic examination and screening for STIs are considered essential for the safe use of IUDs.²⁶ However, only two-thirds of IUD providers conducted pelvic examinations, and about half screened new clients for STIs. In focus groups, some women mentioned that providers conduct pelvic examinations and advise clients about appropriate methods on the basis of their findings:

“I wanted to use Copper T, but since I had a lot of vaginal discharge, I was advised against it.”—*Married urban woman in her 30s*

Almost no providers imposed restrictions on condom use (Figure 4). Providers’ influence in encouraging condom use, particularly for younger women, was evident in the focus group discussions:

“Since I started [using contraceptives] as a teenager, [providers] limited me to pills and condoms.”—*Unmarried urban woman in her 20s*

“If you are a teenager, [providers] are very positive about condoms and very negative about other methods.”—*Unmarried urban teenager*

The majority of providers indicated that they placed age restrictions on the provision of combined pills. They provided them only until clients reached age 35 (not shown), after which they advised users to switch to another method. None of the providers were aware that the 35-year age limit is a risk factor mainly for smokers. More than 40% of providers indicated that they would not provide progestin-only pills to women until they had at least one child. The majority said that they did not normally give progestin-only pills to women unless they were breast-feeding; the most commonly stated reason for this practice was that women who were not breast-feeding were at risk of becoming preg-

nant if they did not take the pills at the same time each day (not shown).

For the IUD and injectables, more than 60% of providers had restrictions based on parity. Other restrictions for these two methods were age (at least 20 years) and marital status. Some women discussed such restrictions during focus groups:

“At the clinic that I go to, the nurse tells young girls that she...does not want to be blamed if they became infertile....She makes no compromise with the injectable; she bluntly refuses.”—*Married urban woman in her 30s*

“[Providers] could even ask you to bring your husband. ...They would ask you to bring your husband after you have told them that you are not married, indirectly telling you that such things are meant only for women with husbands.”—*Unmarried rural teenager*

“I wanted to use injectable, but the nurses refused to give it to me, saying that I only have one child. They said they could give it to me after I’ve had at least three children.”—*Married rural woman in her 30s*

Another requirement imposed on women in many developing countries is that they be menstruating when they seek hormonal methods and IUDs.²⁷ This was the case in Lesotho, as focus group participants indicated:

“When you go for resupply, they need to check whether you are having your menses....[If] somebody from the consultation room tells me she was checked, I don’t even go in.”—*Married urban woman in her 30s*

About 60% of providers said they performed a pregnancy test for a new client who wanted pills but was not having her menses, although many mentioned that pregnancy tests were not 100% accurate, particularly early in pregnancy. More than 40% of providers said they asked clients to come back at their next menses but did not give them a barrier method. Only a quarter said they supplied clients with con-

doms and asked them to return to the facility during menstruation. Fewer than 10% of providers mentioned giving clients pills regardless of whether they were having menses. Fewer than 5% said they gave clients both pills and condoms so that clients could use the condoms until after their menses.

Almost all providers said that they gave clients one packet of pills at the first visit. The reported reason for this practice was to ensure that a client returned so that the provider could follow up on her pill use. The follow-up visit also enabled the providers to address any problems that the client had encountered with the first packet. For clients who had successfully used pills for one year or more, the majority of providers said that they gave three packets. In the mountain region, some providers gave six packets of pills at a time because of the difficulties clients had in reaching the clinic.

A number of providers mentioned that they limit the number of packets of pills they dispense at one time because some women did not use the pills consistently and thereby disrupted the menstrual cycle, shared their pills with other women or gave them to friends to induce abortion. Another reason providers mentioned for giving only one packet was the recurrent shortage of pills.

Provider Bias

To assess providers’ knowledge about and bias toward particular methods, we asked what methods they recommended for delaying or spacing births, what methods they recommended for stopping births and what methods they never recommended under any circumstances. Most providers had a list of methods they would recommend, depending on whether the client wished to delay or stop childbearing, and assuming that she did not have an STI or reproductive tract infection. Seventeen percent said they

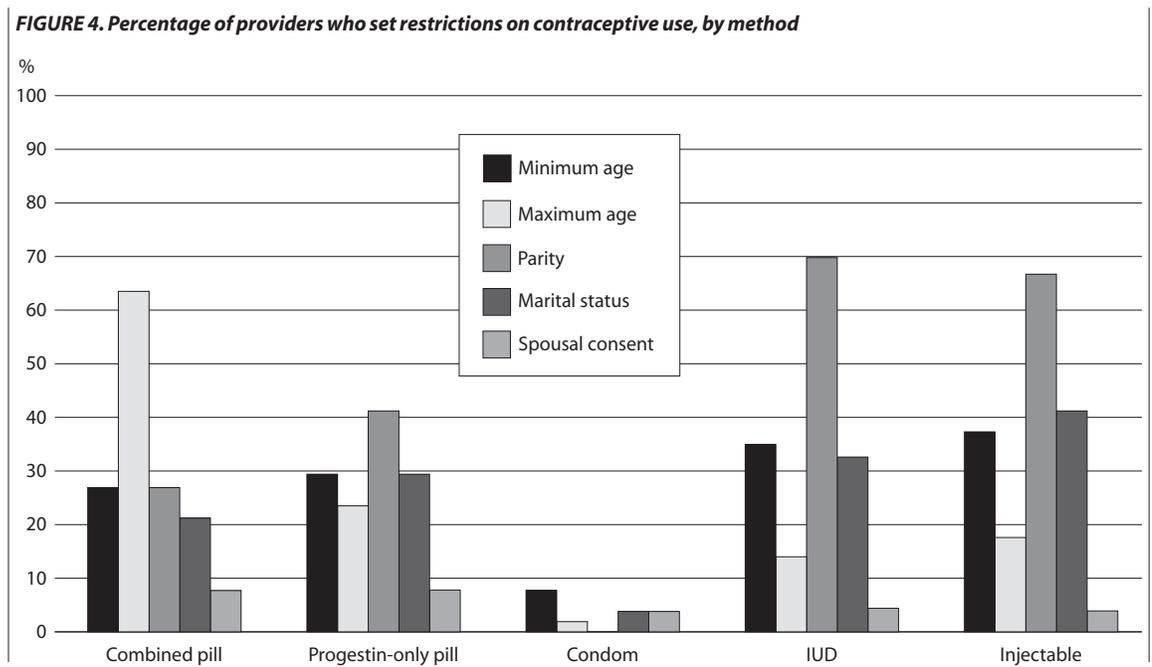


TABLE 3. Percentage of providers, by attitude toward recommending various contraceptive methods

Method	Recommend for:		Do not recommend:	
	Delaying/spacing births (N=41)	Stopping births (N=52)	For clients with STI/RTI (N=51)	In any circumstance (N=18)
Combined pill	50.0	7.7	5.9	0.0
Progestin-only pill	30.0	7.7	5.9	0.0
IUD	60.0	9.6	90.2	5.3
Injectable	77.5	40.4	7.8	16.7
Condom	25.0	0.0	0.0	0.0
Diaphragm	16.7	0.0	3.9	11.1
Spermicide	16.7	0.0	2.0	38.9
Female sterilization	0.0	90.4	0.0	11.1
Vasectomy	0.0	36.5	0.0	0.0
Natural family planning	2.5	0.0	2.0	38.9
Exclusive breast-feeding	0.0	0.0	2.0	11.1

Note: RTI=reproductive tract infection.

left the choice to clients all the time; 35% had a list of methods they would never recommend. Notably, 90% of providers would not recommend the IUD for women with STIs or reproductive tract infections, and the same proportion recommended female sterilization for stopping childbearing (Table 3). In contrast, only 37% mentioned vasectomy for stopping. A third or more of providers would not recommend spermicides or natural family planning under any circumstances.

DISCUSSION

To achieve the goals set in the national population policy, the government of Lesotho method advocates strongly for increased use of family planning, but no effort has been made to compile guidelines for service providers, leaving them to offer services at their own discretion. Age, parity and marital status restrictions that have no medical basis restrict method choice for women and prevent those most vulnerable to unwanted pregnancies from controlling their childbearing.

The accessibility of services is a key determinant of the ease with which potential clients can obtain care, and our findings highlight room for improvement. Clinics should have hours that accommodate working women without charging them extra fees; at the same time, they should not discriminate against women who are not working by attending to working clients first. Facilities' infrastructure can be considered good, but there is room for improvement to ensure that water, toilets and sufficient seating are available at all sites.

The time taken to reach a family planning service point is important. Given the difficulty that women in the mountain region of Lesotho have in obtaining services, it is not surprising that contraceptive prevalence in such communities is the lowest.²⁸ In Nepal, a country with geographic constraints similar to those of Lesotho, differences in contraceptive use by education and place of residence disappeared when traveling time to a family planning outlet was within 30 minutes.²⁹

For some women, the choice of a contraceptive is close-

ly linked to cost. The increase in the cost of family planning services that was reported at the beginning of 1998 could have caused some women to discontinue use. Further, the government's policy has failed to ensure uniform pricing of contraceptives; notably, the costs of methods were, on average, higher in rural areas, which also had higher travel costs than urban areas. Consideration of the cost of contraception should include associated travel costs, which should be kept to a minimum.

The choice of methods available is an important factor for the uptake and continuation of contraception. Jain argues that family planning programs with high rates of continuation and low rates of new acceptors will achieve higher contraceptive prevalence rates than will programs with low rates of continuation and high rates of new acceptors.³⁰ Supporters of this argument advocate that family planning programs concentrate on retaining their current clients, although not ruling out outreach activities.³¹ Mauldin and Sinding suggest that it is important to shift the method mix toward methods with high continuation, both because their use-effectiveness tends to be higher than that of other methods and because with time, the proportion of couples that can be recruited declines rapidly.³² Other researchers have demonstrated that in countries where contraceptive prevalence is low, unmet need for contraception still contributes significantly to unintended pregnancies; they argue that in these countries, targeting new acceptors should have just as much priority as retaining current clients.³³ In Lesotho, there is great need for both reversible and permanent methods of contraception, but providers' emphasis appears to be on reversible methods. Female sterilization and vasectomy should be promoted for couples who have achieved their desired family size. Clearly, this will involve making these methods more accessible and ensuring that qualified personnel are available to provide them.

An inquiry into a client's medical history is essential as a means of identifying existing conditions that may contraindicate the use of a contraceptive method,³⁴ and a breast examination is essential for women who are considering use of combined pills.³⁵ Our finding that fewer than half of providers inquired about medical histories for new clients is an indicator of low-quality services.

Whether some routine tests and procedures are necessary for some methods of contraception has been the subject of much debate.³⁶ Our argument is that for many women, a family planning clinic visit is probably their only opportunity to obtain preventive care; therefore, medical examination for new clients should be comprehensive. Similarly, the Population Council argues that if family planning programs aim to enable people to realize their reproductive intentions, then other reproductive health care, such as the treatment of STIs, should be included.³⁷ It is critical that providers be trained and encouraged to conduct tests that are important for the safe use of contraception; however, restrictions based on myths and misinformation should be discouraged. An obvious step forward is the development of guidelines for service providers.

CONCLUSIONS

Lesotho's family planning program clearly plays an important role in the provision of contraceptives. The program has many positive aspects: good infrastructure, trained personnel and some method choice. There is room for improvement in formulating guidelines for providers, expanding accessibility and ensuring availability of a wide range of methods. In particular, methods that provide long-term or permanent protection should be encouraged for couples who have achieved their desired family size. While it may be too ambitious to expect contraceptive prevalence to reach 70% by 2011, the recommended improvements can increase prevalence substantially. However, these will not be achieved without strong government commitment.

REFERENCES

1. Mpiti AM and Kalule-Sabiti I, The proximate determinants of fertility in Lesotho, *Scientific Reports*, Voorburg, the Netherlands: International Statistical Institute/World Fertility Survey, 1985, No. 78.
2. Bureau of Statistics, *Population Census Analytical Report: Population Dynamics*, Vol. IIIA, Maseru, Lesotho: Bureau of Statistics, 1998.
3. Ministry of Economic Planning, *Lesotho National Population Policy*, Maseru, Lesotho: Ministry of Economic Planning, 1994.
4. United Nations Population Fund (UNFPA), *The State of World Population 1998*, New York: UNFPA, 1998.
5. Bureau of Statistics, *2001 Lesotho Demographic Survey Analytical Report*, Vol. I, Maseru, Lesotho: Bureau of Statistics, 2003.
6. UNFPA, Programme review and strategy development report, Maseru, Lesotho: UNFPA, 1996.
7. Mauldin WP and Segal SJ, Prevalence of contraceptive use: trends and issues, *Studies in Family Planning*, 1988, 19(6):335-353; Donaldson PJ and Tsui AO, The international family planning movement, *Population Bulletin*, 1990, 45(3):1-45; and Bongaarts J, The role of family planning programs in contemporary fertility transitions, *Research Division Working Paper*, New York: Population Council, 1995, No. 71.
8. World Health Organization (WHO), Improving access to quality care in family planning: medical eligibility criteria for contraceptive use, Geneva: WHO, 1996.
9. Mauldin WP and Ross JA, Family planning programs: efforts and results, 1982-89, *Studies in Family Planning*, 1991, 22(6):350-367.
10. Ross J and Stover J, The family planning program effort index: 1999 cycle, *International Family Planning Perspectives*, 2001, 27(3):119-129.
11. Bureau of Statistics, 2003, op. cit. (see reference 5).
12. Lucas D, Fertility and family planning in Southern and Central Africa, *Studies in Family Planning*, 1992, 23(3):145-158.
13. Bureau of Statistics, 2003, op. cit. (see reference 5).
14. World Bank, Lesotho population sector review, Washington, DC: Africa Regional Office, World Bank, 1994.
15. Ministry of Health and Social Welfare, *Rapid Evaluation of Maternal Child Health and Family Planning Services in Lesotho*, Maseru, Lesotho: Ministry of Health and Social Welfare, 1993.
16. World Bank, 1994, op. cit. (see reference 14).
17. Ibid.
18. Ministry of Planning, Economic and Manpower Development, *The Situation of Children and Women in Lesotho*, Maseru, Lesotho: Ministry of Planning, Economic and Manpower Development, 1994.
19. Miller K et al., *Clinic-Based Family Planning and Reproductive Health Services in Africa: Findings from Situation Analysis Studies*, New York: Population Council, 1998.
20. Ibid.
21. Ibid.
22. Ibid.
23. Robey B, Piotrow T and Salter C, Family planning lessons and challenges: making programs work, *Population Reports*, Series J, No. 2, 1994.
24. WHO, 1996, op. cit. (see reference 8).
25. Ibid.
26. Hatcher RA et al., *The Essentials of Contraceptive Technology*, Baltimore, MD, USA: Johns Hopkins Population Information Program, Center for Communication, 1997.
27. Stanback J et al., Menstruation requirements: a significant barrier to contraceptive access in developing countries, *Studies in Family Planning*, 1997, 28(3):245-250.
28. Tuoane M, Diamond I and Madise N, Use of family planning in Lesotho: the importance of quality of care and access, *African Population Studies*, 2003, 18(2):105-132.
29. Tuladhhar JM, Effect of family planning availability and accessibility on contraceptive use in Nepal, *Studies in Family Planning*, 1987, 18(1):49-53.
30. Jain AK, Fertility reduction and the quality of family planning service, *Studies in Family Planning*, 1989, 20(1):1-16.
31. Veney J, Magnani R and Gorbach P, Measurement of the quality of family planning services, *Population Research and Policy Review*, 1993, 12(3):243-259.
32. Mauldin WP and Sinding SW, Review of existing family planning policies and programs: lessons learned, *Programs Division Working Paper*, New York: Population Council, 1993, No. 50.
33. Casterline JB, El-Canaty F and El-Zeinin LO, Unmet need and unintended fertility: longitudinal evidence from Upper Egypt, *International Family Planning Perspectives*, 2003, 29(4):158-166.
34. Technical Guidance/Competence Working Group and WHO, Family planning methods: new guidance, *Population Reports*, Series J, No. 2, 1996.
35. WHO, 1996, op. cit. (see reference 8); and Hatcher RA et al., 1997, op. cit. (see reference 26).
36. Bertrand JT et al., Access, quality of care and medical barriers in family planning programs, *International Family Planning Perspectives*, 1995, 21(2):64-69 & 74; and Stanback J et al., 1997, op. cit. (see reference 27).
37. Population Council, Reconsidering the rationale, scope, and quality of family planning programs, *Population Council Issues Paper*, New York: Population Council, 2001.

RESUMEN

Contexto: Una de las metas demográficas de Lesotho es lograr el nivel de reemplazo de la fecundidad para el año 2011, aunque la tasa actual de prevalencia de anticonceptivos del 41% es considerablemente inferior a la meta fijada del 70-75%.

Métodos: Se utilizó un marco resultante de un análisis de situación para evaluar la disponibilidad de los proveedores de servicios de planificación familiar para ofrecer esos servicios y las percepciones de las mujeres con respecto a la distribución de los mismos. Se recopilaron datos en 1997-1998 a través de encuestas realizadas en 38 lugares de distribución de servicios y con 52 proveedores, y se mantuvieron reuniones de grupos focales con 50 mujeres.

Resultados: La mayoría de las instalaciones estaban abiertas al público durante cinco días de la semana, en horas regulares de oficina; se mantenían cerradas durante la hora de almuerzo y los fines de semana, lo cual restringía el acceso a las personas empleadas. No había directrices claras sobre el suministro de métodos de planificación familiar y los proveedores establecieron

sus propias reglas y restricciones. Algunas mujeres se sintieron desalentadas por una actitud de prejuicio de los proveedores, la falta de privacidad y los frecuentes casos de escasez de la marca de las píldoras anticonceptivas preferidas. Si bien el gobierno tenía una política uniforme con respecto a los precios de los métodos anticonceptivos, el costo variaba y generalmente era más elevado en las zonas rurales que en los centros urbanos. En las zonas rurales, los costos del transporte aumentaban aún más el costo general de los métodos de planificación familiar.

Conclusiones: Si el gobierno considera que es prioritario incrementar la prevalencia del uso de anticonceptivos, se deberá facilitar el acceso de las mujeres a las instalaciones de expendio de servicios de planificación familiar, desarrollar directrices para ser utilizadas por los proveedores de estos servicios y asegurar que se respeten los precios regulares de los métodos anticonceptivos.

RÉSUMÉ

Contexte: L'un des objectifs démographiques du Lesotho est d'atteindre une fécondité de remplacement d'ici 2011. Le taux de prévalence contraceptive de 41% est toutefois largement inférieur à la cible de 70% à 75%.

Méthodes: Un cadre d'analyse de situation a servi à évaluer la disposition des prestataires de planning familial à offrir leurs services et les perceptions féminines des prestations reçues. Les données ont été recueillies en 1997–1998 au moyen d'enquêtes

menées auprès de 38 points de prestations et 52 prestataires, ainsi que de discussions de groupe avec 50 femmes.

Résultats: La plupart des établissements étaient ouverts cinq jours par semaine, pendant les heures de bureau. Leur fermeture à l'heure du déjeuner et le week-end en limitait l'accès aux travailleuses. Il n'existait aucune directive claire quant à l'offre de méthodes de planning familial. Les prestataires définissaient eux-mêmes leurs règles et restrictions. Certaines femmes étaient découragées par le parti pris des prestataires, l'absence de confidentialité visuelle et les pénuries répétées de leur marque de pilule préférée. Malgré la politique tarifaire uniforme établie par l'État pour les méthodes contraceptives, les coûts étaient variables et généralement plus élevés en milieu rural qu'urbain. En milieu rural, les frais de transport accroissaient le coût global des méthodes de planning familial.

Conclusions: Pour qu'augmente la prévalence contraceptive, l'État doit accorder la priorité à l'élargissement de l'accès des femmes aux lieux de prestations, à l'établissement de directives applicables aux prestataires de services de planning familial et à l'assurance de prix uniformes.

Acknowledgment

'Maletela Tuoane's fieldwork was funded by the Population Investigation Committee Research Fund, London.

Author contact: N.J.Madise@soton.ac.uk