

Baseline Study for the Maternal and Newborn Health Performance Based Financing Project in Lesotho

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Acronyms

Ministry of health	MOH
Adults equivalent	AE
Antenatal care	ANC
Christian Health Association of Lesotho	CHAL
Enumeration area	EA
Health management information system	HMIS
Integrated Management of Childhood Illness	IMCI
Lesotho demographic and health survey	LDHS
Maternal and child health	MCH
Maternal and Newborn Care	MNH
Performance based financing	PBF
Postnatal care	PNC
Principal component analysis	PCA

Executive Summary

This report presents results from baseline survey for the Maternal and Newborn Health Performance-Based Financing Project in Lesotho. Data has been collected in the districts of Mafeteng, Mphahle's Hoek, Mokhotlong and Thaba-Tseka through household surveys and facility assessments of health centers. The objective of the survey was to measure outcomes prior to the implementation of the PBF intervention. Almost all health centers managed by the Ministry of Health (MOH) and the Christian Health Association of Lesotho (CHAL) in the four districts were included in the sample. In the catchment area of each health center, a sample of households was selected. Households were eligible to be included in the sample if they had a female member who was either recently pregnant or was an adolescent. The fieldwork was implemented by a local firm, Leads Services, from March to June 2015. The final sample included 53 health centers and 2120 households.

Key Findings

- Almost all women receive at least some antenatal care during pregnancies. However, about a quarter of women have less than the recommended number of four visits and only 36 percent initiated the care during the first trimester of their pregnancy as recommended by international and local guidelines.
- Seventeen percent of women received antenatal care in hospitals rather than at the health centers providing primary health care.
- The content of antenatal care is overall good according to the women's reporting of the components of their antenatal consultations, including being offered HIV testing and iron supplementation. The rate of women receiving two or more tetanus injections is 76 percent and can be improved.
- Seventy-seven percent of women reported delivering in a formal health facility. The main reasons cited by women for not delivering in a health facility were the long distance to facilities and lack of time to reach the facilities.
- Seventy-seven percent of women reported receiving postnatal care by a skilled health provider but only 39 percent reported to receive the care within the first two days after delivery.
- Only 44 percent of children under-5 were measured in the six months before the survey to determine their nutritional status.
- Thirty-five percent of households reported having had a health-related financial shock in the 12 months preceding the survey. In Mokhotlong district, 49 percent of the household reported such shocks while Mafeteng the rate was 28 percent. Many of these households had to sell possessions or borrow from others in order to cover the healthcare costs that exceeded what the households could afford with their usual income. In
- Almost all health centers offer the services targeted by the PBF program. However, about 18 percent of health centers reported to not provide delivery services. All health centers also report operating around the clock.
- Structural quality is overall good. For example, almost all facilities have access to an improved source of water, all have safety boxes and high share of facilities have functioning toilet facilities and telecommunication abilities.

- There is room for improvement practices of disposal of medical waste and sterilization of medical equipment. As well, 17 percent of MOH centers did not have soap and water available in all consultation rooms.
- It is not uncommon for health centers to run out of supplies of very basic drugs and vaccines. For example, 21 percent of MOH centers and 25 percent of CHAL centers reported running out of paracetamol in the 30 days prior to the survey.
- Responses of health providers to questions using clinical vignettes as well as exit interviews of patients suggest a big variation in actions taken by providers when treating common cases and potential lack of understanding or knowledge of treatment protocols by some providers.

1. Survey Methodology

This report presents results from the baseline survey for the Maternal and Newborn Health Performance Based Financing Project in Lesotho. The baseline survey covers four districts: Mafeteng, Mohale's Hoek, Mokhotlong and Thaba-Tseka. The PBF is implemented in health centers managed by the Ministry of Health (MOH) and Christian Health Association of Lesotho (CHAL). Table A.1 in the appendix shows the 2006 census population in terms of households for each of the catchment areas for health centers in the four districts.

Lesotho is a small, mountainous kingdom, surrounded by the Republic of South Africa. The country is divided into 10 administrative districts and further divided into four ecological zones: Lowlands, Foothills, Mountains, and Senqu River Valley (Ministry of Health [Lesotho] and ICF International, 2016). This report occasionally uses a crude measure of the ecological zones and refer to the district of Thaba-Tseka and Mokhotlong as highland districts (Mokhotlong is entirely mountainous, whereas Thaba-Tseka is mostly mountainous except for the part of Senqu River Valley), and Mafeteng and Mohale's Hoek as lowland districts (Mafeteng has lowlands and foothills whereas Mohale's Hoek covers all four ecological zones).



Figure 1-1: Administrative Districts of Lesotho
Provided by MOH, Lesotho

The baseline data consists of two main sources of data: 1) a household survey and 2) a facility-based survey. The HRITF survey instruments was used as a starting point and tailored to the Lesotho context.

A local firm, Leads Services, was contracted to implement the baseline survey for the study, for both households and health centers. Leads Services was responsible for all aspects of the baseline survey implementation under the supervision and guidance of the research team.

The national Health Institutional Review Board authorized to conduct the survey on February 13th, 2015.

1.1. Household survey

The household sampling follows a two-stage strategy. Enumeration areas (EAs) were initially defined by the 2006 census but in case the enumeration area covered two different catchment areas, the EA was split into smaller units defined by the catchment areas. First, EAs within the catchment area of each health center were ranked for listing by random drawing. In each of the villages in the EA ranked first, a dedicated listing team did a household listing, collecting information on the presence of women who were pregnant in the preceding two years and of adolescent females. The listing team did a complete listing whether eligible or not. In cases in which the EA had less than 80 households or if less than 18 eligible households for any of the two samples were listed, the next ranked EA was added. Listing was always done at the EA level, i.e. all households in the EA were listed unless a village was not found by the listing team.

Second, up to 50 households were then randomly selected by the research team for survey. The selection of households was according to the following two criteria: (a) 25 households with at least one birth or pregnancy, regardless of the outcome of the pregnancy, in the two years preceding the survey; (b) 25 households with at least one adolescent girl. In cases with less than 25 eligible households listed, all eligible households were selected for the survey. The selection of the 'recent pregnancy' and of the 'adolescent' sample was done separately. However, in some cases, the same household was randomly selected for both samples.

The overall selection probability of a household is the product of the selection probabilities of the two stages.

$$p = \frac{\text{\# of listed households within catchement area}}{\text{\# of households in catchment area}} \times \frac{\text{\# of selected households}}{\text{\# of eligible households}}$$

The research team calculated the sample weights as the inverse of the selection probability.

The survey instrument was administered to women in the sampled households. The main themes covered in the household survey include:

- Socio-economic characteristics of the household
- Health behaviors for MNH services
- Health seeking behaviors, barriers to use and health service use
- Household health expenditures
- Fertility
- Maternal health (recent pregnant sample)
- Anthropometric of children less than five (recent pregnant sample)
- Reproductive decisions
- General experience with Health Center (adolescent sample)
- General perceptions of health service quality
- Interactions with VHWS

Household survey team organization

Four field teams were trained to do the household survey and the survey was pre-tested before the implementation. Each team consisted of one supervisor and five interviewers. The interviewers reported directly to their supervisor, while the supervisors reported directly to the manager. Given the potentially sensitive topics related to reproductive health covered in the survey, all interviewers and supervisors were women.

Final household sample

The final household sample includes 2120 households. From these the research team was able to link 1252 female questionnaires and 972 adolescent questionnaires. Deleted from the raw sample were 41 female questionnaires and 9 adolescent questionnaires that could not be matched to a household roster.

1.2. Facility-based survey

The facility survey was conducted in all MOH and CHAL health centers in the four districts, except for three randomly excluded health centers and one health center that was not accessible for the survey team. The facility-based survey includes multiple components; a facility assessment, health provider interviews, and patient exit interviews.

Facility assessment module

The facility assessment module collects data on key aspects of facility functioning and structural aspects of quality of care. The respondent for this module was the individual in charge of the health facility at the time when the survey team visited the health center. The main themes covered by the facility assessment include:

- Facility staffing, including the staffing complement of the facility, staff on duty at the time of the survey team's visit and staff present at the time of the survey team's visit
- Facility infrastructure and equipment
- Availability of drugs, consumables and supplies at the health center
- Supervision
- Record keeping and reporting to the Health Management Information System (HMIS)
- Facility management

Health worker interview module

A sample of up to three health providers with maternal and newborn health service delivery responsibilities at health facilities were interviewed as part of this module. The main themes covered include:

- Role and responsibilities of the interviewed health worker
- Staff satisfaction and motivation
- Technical knowledge on Maternal and Newborn Health. This was assessed through the use of vignettes.

Eligible health workers include doctors, nurses, midwives, and any other health worker providing maternal and newborn care. However, no doctors were available for interview in the health centers. In facilities with less than three health workers on the staff roster, all eligible health workers were interviewed.

Patient exit interviews

A sample of two caregivers of children less than five visiting the facility for curative care with (preferably) a new complaint were interviewed to record the patient's experience and assess the patient's perception of quality of care and satisfaction at all health centers. In addition to this, exit interviews were conducted with two (preferably) first time ANC clients.

Health Facility survey team organization

One field team was trained to conduct the facility survey and the survey was pre-tested before the implementation. The team consisted of two supervisors and two interviewers. The interviewers reported directly to their supervisor, while the supervisors reported directly to the manager.

Final facility sample

The final sample includes 53 health centers, 107 health provider interviews, 106 exit interviews with women who visited the health center for ANC, and 105 exit interviews with caregivers of children less than five who visited the health center at the day of the survey.

2. Descriptive Statistics - Household Survey

2.1. Background Characteristics of the Samples

This section provides background information on the socio-demographic characteristics of the households and on the dwelling characteristics.

Demographic Characteristics of Households

Table 2.1.1 shows household composition. Households in the sample are composed, on average, by 5.9 members, about half of which are adults (older than 17 years). The households have on average 0.9 children under five. Households in Mokhotlong district are the largest with an average of 6.3 members and those in Mafeteng are smallest with an average of 5.7 members. An average of 1.7 household members are reported to be employed.

Table 2.1.1: Household Composition									
		HH members	HH head (% male)	Children <5	Children 5-17	Adults > 17	AE ¹	Employed HH members	Sample size
District									
	Thaba-Tseka	6.1	73.8	0.9	2.2	2.9	3.1	1.7	623
	Mokhotlong	6.3	76.4	1.0	2.3	2.5	3.2	1.8	334
	Mafeteng	5.7	58.2	0.8	2.0	2.8	3.0	1.6	625
	Mohale's Hoek	6.0	60.0	0.8	2.0	2.9	3.1	1.9	538
Total		5.9	64.3	0.9	2.1	2.8	3.0	1.7	2,120

Table 2.1.1: Household Composition

The table includes households selected for both samples. ¹) Adults equivalent (AE) is calculated using the following weights; 1 for the first adult, 0.5 for each subsequent household member age 14+, and 0.3 for all children less than 14 years of age

Table 2.1.2 presents background characteristics of the sample of women aged 15-49 selected for a recent pregnancy. The sample used for the analysis of fertility preferences and family planning is a subsample of these women who are not currently pregnant and report to have a sexual partner (observations=894). The sample used for the analysis of maternal health outcomes is a subsample of these women with a live birth since January 2013 who are not currently pregnant (observations=1078). Note, in cases with more pregnancies since January 2013, the most recent live birth pregnancy is used.

Table 2.1.2: Characteristics of Women aged 15-49 interviewed for a Recent Pregnancy							
		Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	All	Miss. Obs.
Age (mean)		27.2	28.2	26.0	26.1	26.6	0
Marital status							
	Never married	9.4	7.1	20.3	27.0	17.8	16
	Married	83.5	86.3	69.2	66.0	73.8	
	Divorced	2.4	3.4	6.0	4.9	4.7	
	Widowed	2.8	3.2	4.3	1.3	3.1	
	Other	1.9	0.0	0.3	0.7	0.6	

Relationship to head of household							
	Head	3.6	4.6	9.5	4.7	6.5	17
	Spouse	61.8	74.8	32.4	36.0	45.5	
	Son/Daughter	12.5	11.0	24.7	28.9	21.4	
	Son/Daughter in-law	14.7	7.0	20.3	13.3	15.3	
	Grandchild	4.8	1.3	6.9	10.8	6.6	
	Other	2.6	1.4	6.1	6.3	4.8	
Educational level							
	Primary or less	62.8	65.7	43.3	44.2	50.6	19
	Secondary	27.8	28.7	40.6	39.6	36.2	
	High school or more	9.4	5.6	16.1	16.3	13.2	
Literate		94.5	90.4	96.7	96.8	95.2	31
Employment status							
	Subsistence agriculture	26.0	24.7	7.3	13.9	15.0	29
	Employed (other)	22.3	23.9	27.1	31.4	26.8	
	Looking for work	39.5	30.0	45.6	41.3	40.8	
	Unemployed, but not looking for a job	3.5	18.1	11.5	12.3	11.6	
	Other	8.6	3.3	8.5	1.2	5.7	
Sample size		372	186	380	314	1252	

Table 2.1.2: Characteristics of Women with a Recent Pregnancy

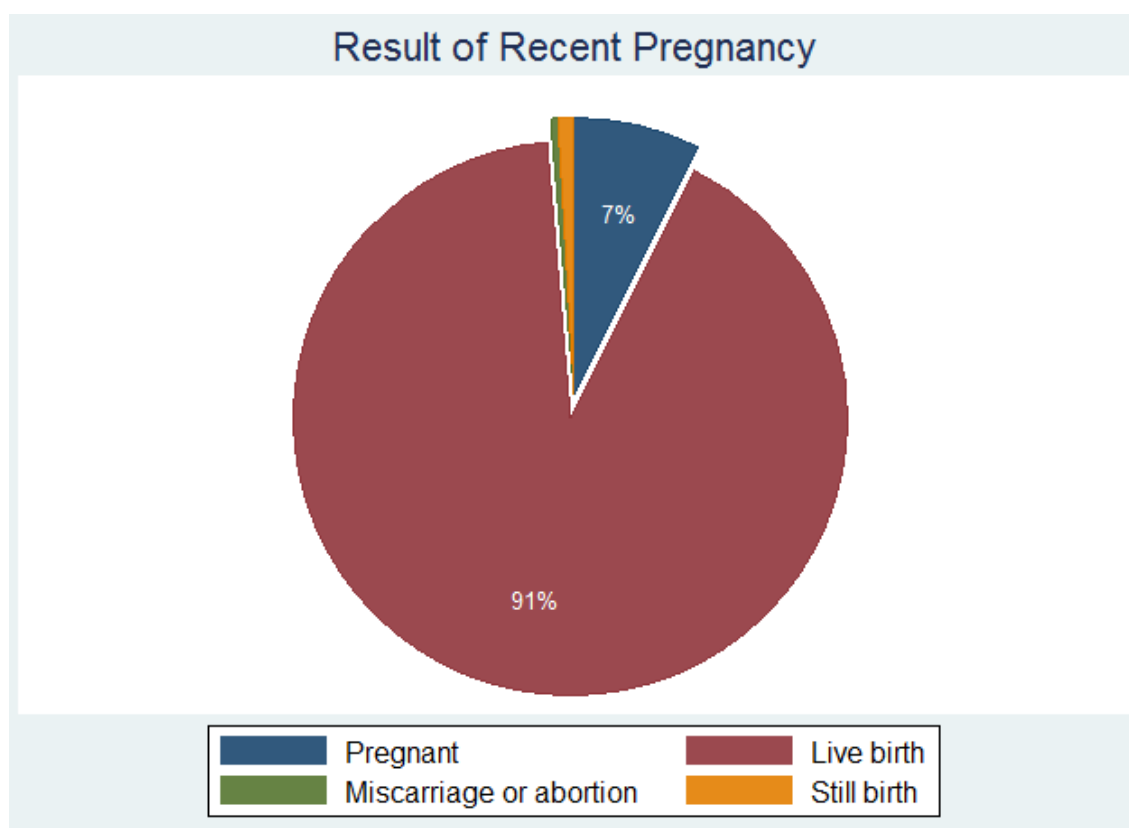


Figure 2-1: Result of Recent Pregnancy

The sample for this figure includes all women aged 15-49 interviewed for a recent pregnancy (1252) except 86 with missing information about the result of the pregnancy.

Table 2.1.3 shows the sample used for the child health section. This sample includes children of women in table 2.1.2. The survey team were supposed to interview all children less than five of the women selected for a recent pregnancy. However, this was not properly implemented in the beginning of the survey and part of the survey only includes information about the youngest of the children. The child sample is therefore restricted to the youngest child aged 0-35m.

Table 2.1.3: Characteristics of most Recent Child less than 36 months of Women with a Recent Pregnancy							
		Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	All	Miss. Obs.
Gender (% male)		51.5	43.9	54.3	53.9	51.8	21
Age							
	0-11m	27.2	31.6	26.7	34.4	29.7	0
	12-23m	59.9	47.6	51.6	40.8	49.3	
	24-35m	12.9	20.8	21.7	24.8	21.0	
Relationship to head of household							
	Son/Daughter	68.2	80.1	44.8	42.7	54.5	12
	Grandchild	29.2	17.5	50.4	49.2	40.6	
	Other	2.6	2.4	4.8	8.1	4.9	
Sample size		296	166	308	259	1,029	

Table 2.1.3: Characteristics of Child Sample

Table 2.1.4 shows the sample of adolescent girls. This sample is used for the section on adolescent fertility preferences.

Table 2.1.4: Characteristics of Adolescent Girls							
		Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	All	Miss. Obs.
Age (mean)		14.8	14.9	14.9	15.0	14.9	5
Marital status							
	Never married	99.4	100.0	99.2	98.8	99.2	42
Relationship to head of household							
	Son/Daughter (incl. in-law)	66.9	74.9	58.6	56.6	61.0	
	Grandchild	21.4	18.7	32.1	33.4	29.6	
	Other	11.6	6.4	9.3	9.9	9.5	
Educational level							
	Primary or less	73.8	63.6	44.3	50.0	52.0	3
	Secondary	24.7	31.9	49.0	45.2	42.8	
	High school or more	1.5	4.5	6.7	4.8	5.2	
Literate		97.9	99.3	99.3	98.6	98.9	36
Employment status							
	Employed	1.1	3.4	3.0	3.1	2.8	
	Looking for work	5.5	2.3	3.2	2.8	3.3	
	Unemployed, but not looking for a job ¹	91.5	92.8	93.5	93.0	93.0	
	Other	2.0	1.5	0.3	1.1	0.8	

Sample size	224	123	335	290	972	
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Table 2.1.4: Characteristics of Adolescent Girls

¹⁾ Not looking for a job includes being a student

Housing Characteristics

In Mafeteng and Mohale's Hoek, households tend to reside in modern houses. However, in Mohale's Hoek 22 percent of the households live in the traditional Rondavel. In Thaba-Tseka and Mokhotlong, the traditional Rondavels are the most common type of dwelling. Differences in material used for housing across districts in Lesotho are also observed (see figure A-1 and figure A-2 in the appendix).

Table 2.1.5: Type of Dwelling								
		Type of dwelling ¹				Number of rooms	Number of rooms (per AE)	Sample Size
		Traditional hut	Improved traditional hut	Rondavel	Modern house			
District								
	Thaba-Tseka	19 . 6	6 . 8	46 . 3	24 . 6	2 . 1	0 . 7	623
	Mokhotlong	35 . 4	4 . 8	47 . 8	11 . 0	1 . 7	0 . 6	334
	Mafeteng	2 . 9	1 . 8	7 . 6	73 . 8	2 . 7	1 . 0	625
	Mohale's Hoek	8 . 7	4 . 3	21 . 7	62 . 2	2 . 3	0 . 8	538
Total		12 . 7	3 . 7	24 . 3	52 . 1	2 . 3	0 . 8	2 , 120

Table 2.1.5: Type of Dwelling.

¹⁾ Excluded are answers labeled as 'other'

Table 2.1.6 shows that overall 87.5 percent of households in the covered districts have access to improved source of water. However, 25 percent have an improved source of water more than 10 minutes away. Figure 2-2 shows that the most common source is a public tap or standpipe. Access to improved source of water within 10 minutes distance is more common in Mafeteng and Mohale's Hoek. Treatment of drinking water is most commonly used in Thaba-Tseka with 15.8 percent boiling the water and an additional 3.7 percent straining the water before drinking it.

Table 2.1.6: Household water source							
		Access to improved source of water ¹		Treatment of drinking water ²			Sample Size
		Within 10 min distance	More than 10 min distance	Boil	Strain	No treatment	
District							
	Thaba-Tseka	58 . 9	22 . 8	15 . 8	3 . 7	78 . 9	623
	Mokhotlong	55 . 0	32 . 9	6 . 6	0 . 5	86 . 8	334
	Mafeteng	64 . 4	24 . 5	8 . 5	1 . 6	88 . 8	625
	Mohale’s Hoek	67 . 1	21 . 6	3 . 9	1 . 0	94 . 8	538
Total		62 . 5	25 . 0	8 . 2	1 . 6	88 . 3	2 , 120

Table 2.1.6: Household Water Source

¹⁾ Improved water source includes piped into dwelling, piped into yard/plot, public tap / standpipe, tube well / borehole, protected well or spring, and bottled water. ²⁾ Excluded categories are chlorine, filter and other

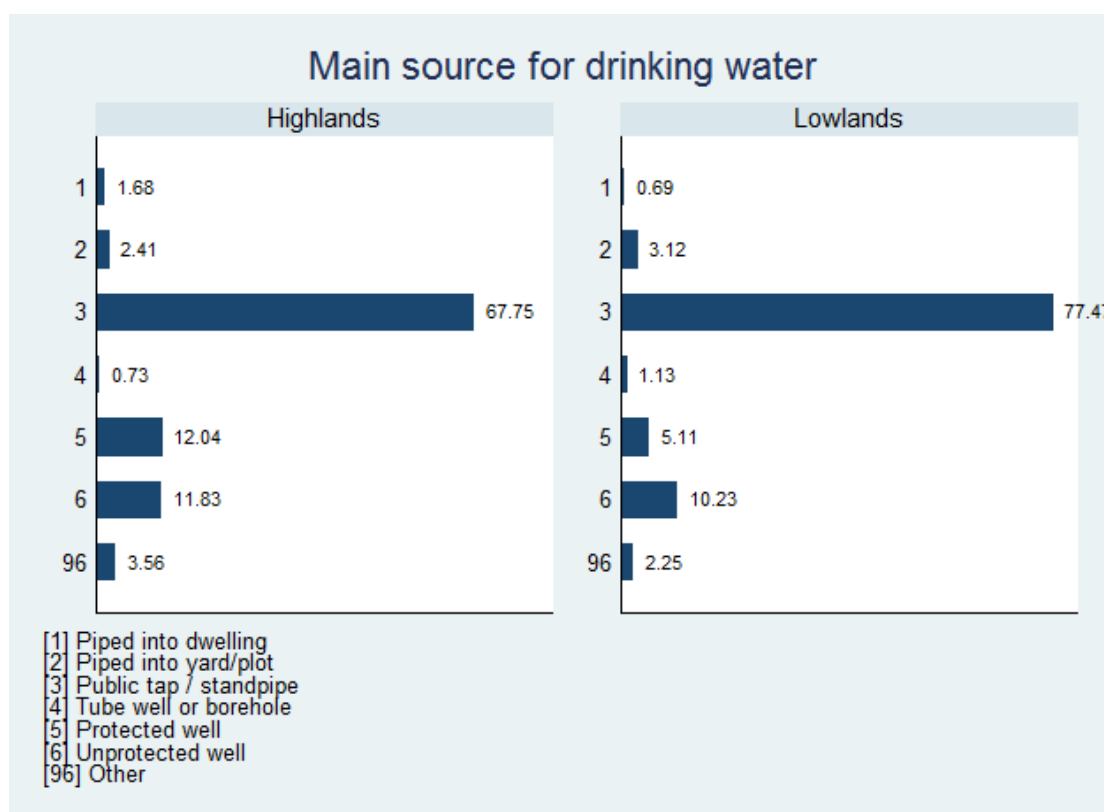


Figure 2-2: Main source of drinking water

Table 2.1.7: Household Sanitation						
	Access to improved sanitation facilities ¹		Deal with rubbish ²			Sample Size
	Not shared	Shared	Thrown into a pit	Burn	Thrown onto street / public area	
District						
Thaba-Tseka	69 . 6	23 . 6	2 . 5	14 . 1	83 . 0	623
Mokhotlong	66 . 7	33 . 1	0 . 5	5 . 8	93 . 8	334
Mafeteng	71 . 7	12 . 4	4 . 5	21 . 6	73 . 1	625
Mohale's Hoek	67 . 9	23 . 1	3 . 2	13 . 4	82 . 6	538
Total	69 . 7	19 . 9	3 . 2	15 . 6	80 . 6	2 , 120

Table 2.1.7: Household Sanitation

¹) Improved sanitation includes flush to piped sewer or septic, ventilated pit, pit latrine with slab, and composting toilet. ²) Excluded categories are refuse collected and refuse buried

Table 2.1.7 shows that 69.7 percent has access to improved non-shared sanitation with an additional 19.9 percent with access to improved shared sanitation¹. Rubbish is mainly dealt with by throwing it onto the street or a public area.

¹ The rate of improved sanitation is found to be much higher than reported in (Ministry of Health [Lesotho] and ICF International, 2016)

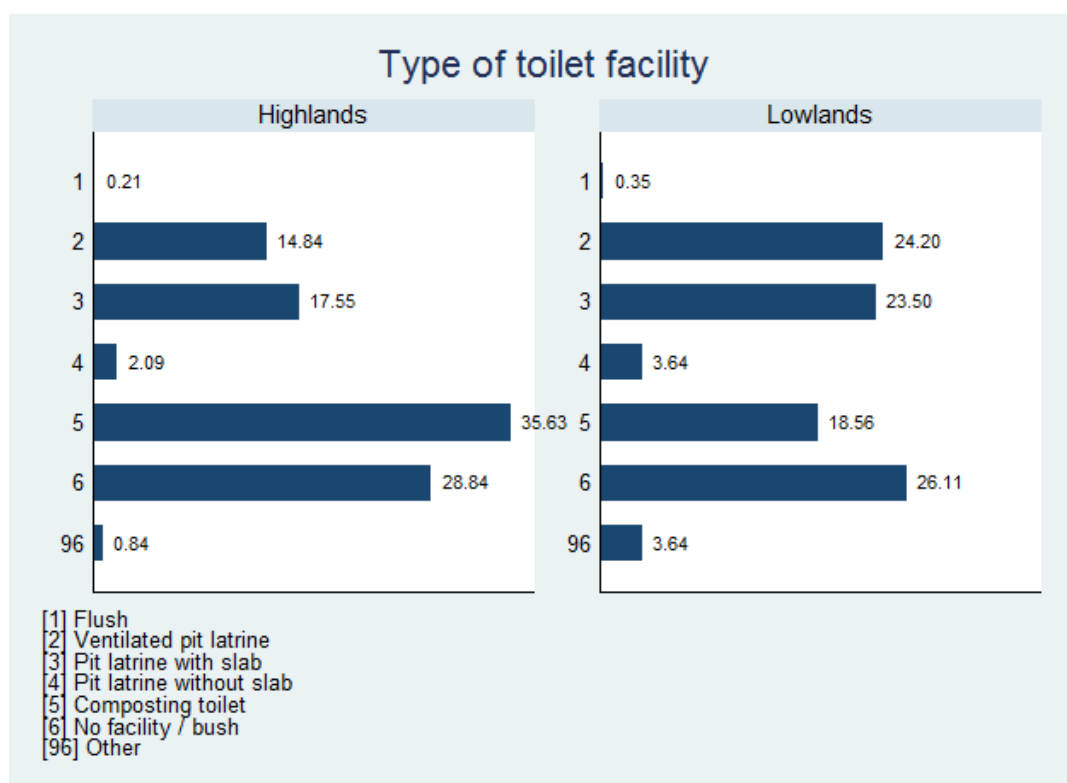


Figure 2-3: Type of toilet facility

As seen in Table 2.1.8, the most common source of energy (for cooking and heating) is wood or charcoal with around three-in-four of households using it.

Table 2.1.8: Household Source of Energy							
		Energy used for cooking			Energy used for heating		
		Kerosene/ paraffin, gas, electricity, diesel	Wood, charcoal	Animal dung, agricultural waste, shrubs/ straws	Kerosene/ paraffin, gas, electricity, diesel	Wood, charcoal	Animal dung, agricultural waste, shrubs/ straws
District							
	Thaba-Tseka	8 . 6	85 . 6	5 . 7	7 . 8	78 . 0	14 . 2
	Mokhotlong	6 . 4	84 . 9	8 . 7	2 . 9	79 . 2	17 . 9
	Mafeteng	22 . 0	65 . 9	12 . 1	17 . 1	67 . 4	15 . 2
	Mohale's Hoek	15 . 7	74 . 5	9 . 8	7 . 5	78 . 8	13 . 3
Total		15 . 6	74 . 5	9 . 9	10 . 8	74 . 0	15 . 1
							2 , 120

Table 2.1.8: Household Source of Energy

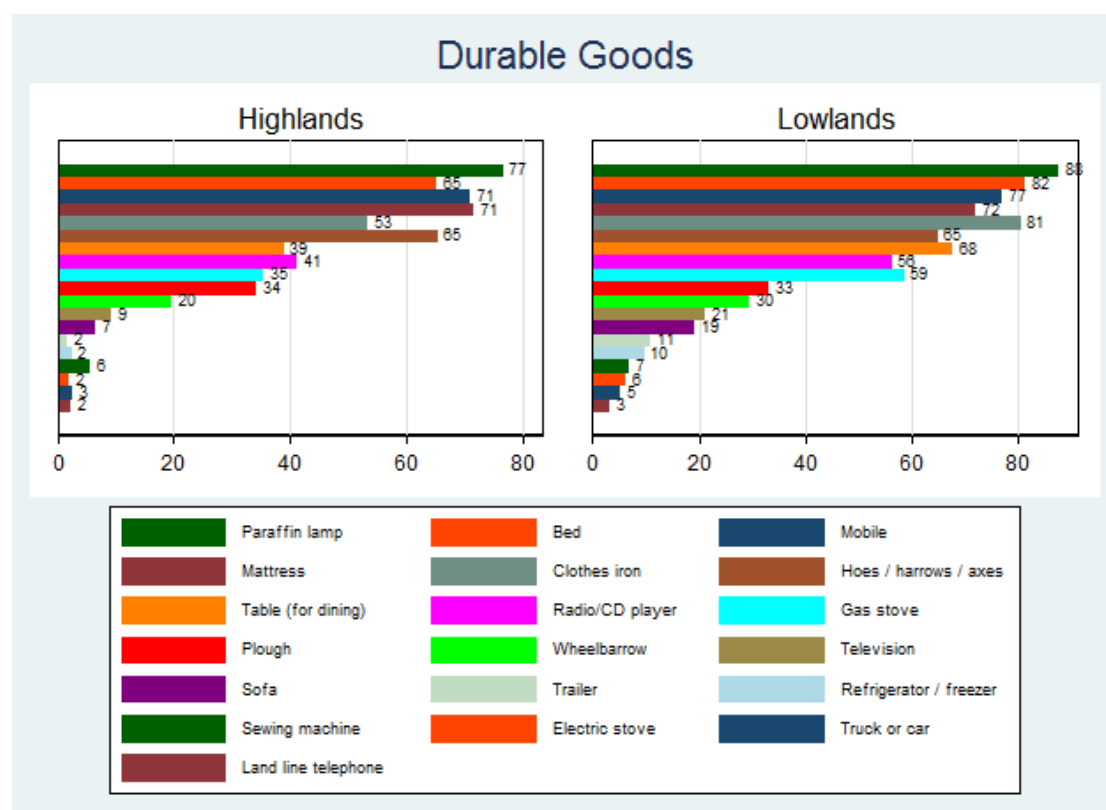


Figure 2-4: Durable goods

Figure 2-4 shows possessions of durable goods. Mafeteng and Mohale's Hoek (labeled as lowlands) are better off in terms of durable goods than Thaba-Tseka and Mokhotlong (labeled as highlands). For example, 82 percent of households in Mafeteng and Mohale's Hoek own a bed, this is only 65 percent of households in Thaba-Tseka and Mokhotlong districts. The pattern seems consistent across all durable goods.

Wealth Index

This section has pointed out some clear differences between households in the four districts covered. These differences are likely to represent differences in wealth across the districts. For the purpose of the remaining analysis, a wealth index is created using principal component analysis (PCA). Included in the PCA are dummy variables for the following indicators:

- Type of dwelling
- Number of rooms per adult equivalent
- Main material used for walls, rooftop, and floor
- Access to improved source of water: Within 10 minutes or more than 10 minutes away
- Access to improved sanitation facilities: Shared or non-shared
- Source of energy: For cooking and heating
- Possession of durable goods

Table 2.1.9 : Wealth Quintiles		1 st	2 nd	3 rd	4 th	5 th	All
District							
	Thaba-Tseka	24.2	23.1	10.4	13.2	9.6	16.1

Mokhotlong	31.3	22.1	18.3	10.1	5.5	17.5
Mafeteng	25.8	32.0	45.3	50.7	56.6	42.1
Mohale's Hoek	18.7	22.8	25.9	26.0	28.4	24.4
Sample Size	480	448	415	418	359	2,120

Table 2.1.9 : Wealth Quintiles

Table 2.1.9 shows how, using the wealth quintiles, Mafeteng turns out as the wealthiest of the four districts while Thaba-Tseka and Mokhotlong are the poorest districts in the sample. The wealth quintiles are not directly comparable to the quintiles calculated for the LDHS2014 as it is sample specific. However, it is reassuring that it shows a consistent pattern with LDHS2014, where the majority of the population in Mokhotlong and Thaba-Tseka is in the lowest quintile and Mafeteng has the third highest percentages of its population in the highest quintile (after Maseru and Berea; two districts not covered in the baseline survey).

Table A-2 in the appendix shows how housing characteristics are distributed by wealth quintiles.

Health Expenditure

34.9 percent of the households in the sample reported experiencing a health related financial shock. This is defined as having a health expenditure that was higher than what the household could afford with its usual income in the past 12 months. Of the households that experienced such a shock, 27.6 percent reported having to sell possessions to cover the cost, 38.8 percent reported having to borrow money, and 6.6 percent reported receiving assistance (gifts).

Table 2.1.10 : Health Expenditure		(A)		(B)			
		Had a health related financial shock	Sample Size	Had to sell any possessions	Had to borrow	Received gift	Sample Size
District							
	Thaba-Tseka	37.9	620	38.9	42.0	5.0	206
	Mokhotlong	49.1	332	40.0	38.1	3.3	139
	Mafeteng	27.5	624	15.6	38.4	9.4	165
	Mohale’s Hoek	37.2	534	23.2	37.6	7.2	161
Wealth Quintiles							
	1 st	37.4	479	25.4	36.4	4.8	146
	2 nd	39.9	447	28.8	43.6	7.8	162
	3 rd	36.8	412	30.1	40.2	6.1	147
	4 th	34.8	415	27.1	38.0	6.0	130
	5 th	27.6	357	26.0	34.2	8.4	86
Total		34.9	2,110	27.6	38.8	6.6	671

Table 2.1.10: Health Expenditure

The reference period is 12 months. The table is divided in two; the first part (A) uses the full household sample, and the second part (B) uses the conditional sample of households that had a health related financial shock in past 12 months.

2.2. Maternal Health

The maternal health section uses the sample of households with a member who was pregnant in the two years preceding the survey. The following analysis is restricted to pregnancies resulting in a live birth (after January 2013).

Antenatal Care

Antenatal care (ANC) by a skilled attendant is important to monitor the status of a pregnancy, to prevent or treat complications associated with the pregnancy, and to provide appropriate information and advice for a healthy pregnancy (Provision of effective antenatal care, 2006). All pregnant women should have at least four ANC visits throughout the pregnancy. The first one within the first trimester of the pregnancy and the last one in the last trimester (Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice, 2003).

Almost all women, 97.8 percent, attended at least one ANC visit. Only 36 percent initiated their antenatal care within the first three months of their pregnancy. On average, women were 4.2 months pregnant at their first visit. About 73 percent of the women had at least four consultations with the average number of consultations being 4.6. Seventy-seven percent reported having their last consultation in the last month of their pregnancy.

Figure A-3 in the appendix shows that the modal number of ANC visits is the recommended four visits. Figure A-4 in the appendix shows that 21.1 percent had their first visit in the fourth months of pregnancy, i.e. one months after the recommended standards.

Table 2.2.1: Antenatal Care		(A)	(B) Number of visits		(C) Timing				Sample Size
		Received ANC	Number of visits	At least 4 visits	Months pregnant at first visit	First visit in first 3 months	Months at last visit	Last visit in last month	
District									
	Thaba-Tseka	99.4	4.8	81.3	4.2	35.1	8.7	84.7	333
	Mokhotlong	97.8	4.5	68.4	4.0	43.0	8.6	66.4	170
	Mafeteng	96.4	4.6	71.9	4.3	33.4	8.6	81.5	314
	Mohale’s Hoek	99.2	4.7	72.1	4.4	35.4	8.7	72.9	261
Age									
	<20	98.7	4.7	68.4	4.4	36.0	8.6	71.2	136
	20-24	98.5	4.5	69.4	4.3	33.0	8.7	79.3	351
	25-29	97.2	4.8	77.8	4.1	37.0	8.6	77.2	265
	30-34	98.8	4.7	76.7	4.2	35.3	8.5	73.5	171
	35+	95.3	4.5	72.0	4.1	42.6	8.8	80.4	155
Educational level									

Primary or less	97.6	4.7	73.2	4.2	39.8	8.7	73.8	558
Secondary	98.6	4.6	71.5	4.3	32.2	8.7	79.1	370
High school or more	100.0	4.5	72.2	4.4	31.0	8.4	82.3	133
Birth order								
1	99.3	4.6	71.4	4.3	31.9	8.7	79.2	402
2	96.6	4.7	72.7	4.3	33.5	8.6	77.1	271
3+	97.0	4.6	73.5	4.1	41.7	8.6	75.0	369
Wealth quintile								
1 st	97.2	4.7	65.8	4.4	35.7	8.7	76.9	261
2 nd	97.8	4.6	77.5	3.9	45.9	8.6	71.9	229
3 rd	100.0	4.5	69.5	4.5	31.3	8.7	81.4	187
4 th	95.0	4.7	76.7	4.2	35.4	8.7	77.6	220
5 th	99.2	4.6	75.0	4.3	31.0	8.5	77.7	181
All	97.8	4.6	72.8	4.2	36.0	8.6	77.0	1,078

Table 2.2.1: Antenatal Care

This table is divided in three parts; the first part (A) uses the full sample of women, part (B) and (C) are conditional on at least one ANC visit. The sample size column refers to the full sample of women. We have less than one percent missing information for the ANC variables.

The ANC coverage level corresponds well to the national level reported in LDHS2014 (Ministry of Health, Lesotho and ICF International, 2016). LDHS2014 defines skilled ANC visits to include doctors and nurse/midwives and report a coverage of at least one skilled visit to be 95 percent. In the baseline survey sample, 36 percent had their first visit during the first trimester compared to the national level of 41 percent and 77 percent had four or more visits compared to the national level of 74 percent.

Figure 2-5 shows that ANC were provided either by a medical doctor (6.6 percent), a nurse or midwife (88.4 percent) or a nurse assistant (2.8 percent). 61.5 percent had their visit at a MOH health center and 14.6 percent at a CHAL health center. 16.9 percent went to a hospital for ANC visit.

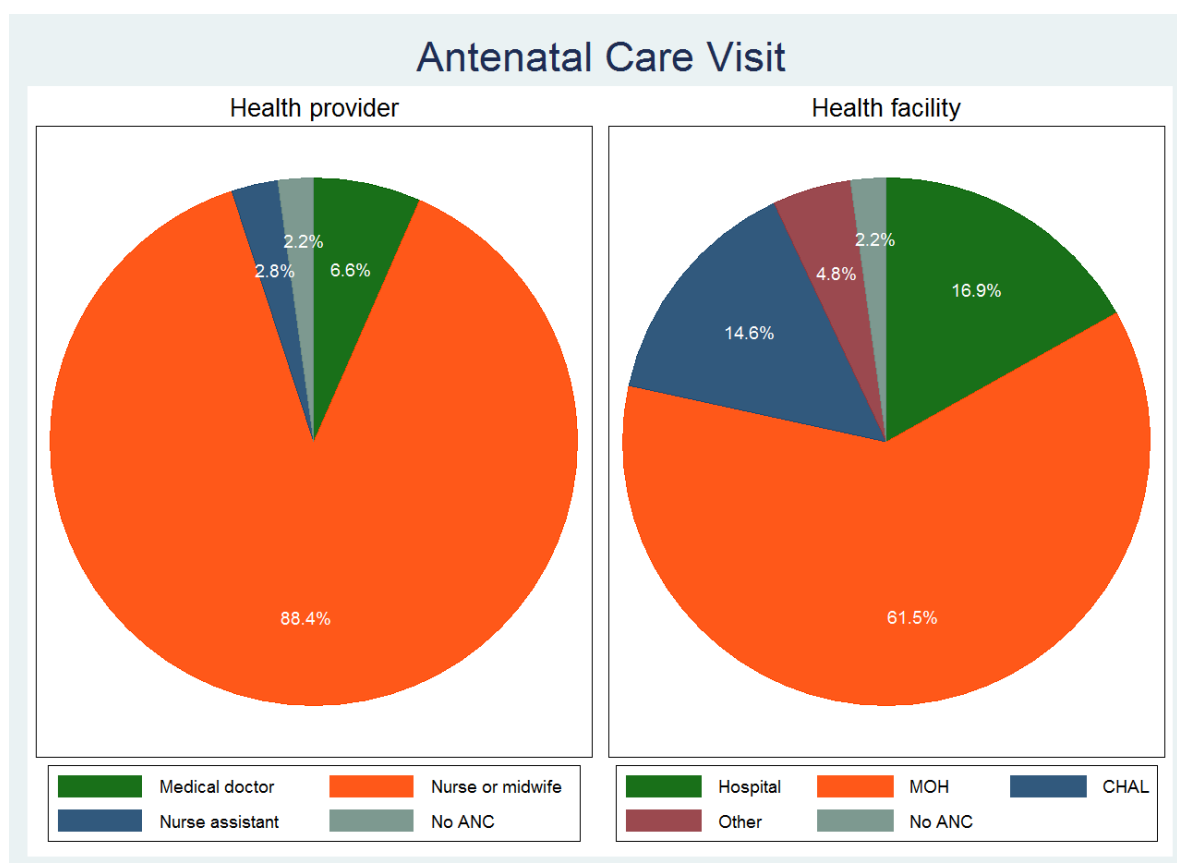


Figure 2-5: Antenatal Care Visits

The content of ANC is also very important in assessing the quality of services. Figure 2-6 shows that the majority of important tasks were done in more than 90 percent of the cases. The most pronounced exception is asking for blood type, however almost all women were asked to give a blood sample. In Mokhotlong, less than 65 percent of the women received advice on diet and on what to do in a case of emergency.

Overall, Thaba-Tseka, Mafeteng and Mohale's Hoek score around 90 percent on a content of care index (mean average across tasks); on average, a little less than 11 out of the 12 selected tasks were done during at least one ANC visit. In Mokhotlong, the level is less than 10 out of 12 tasks.

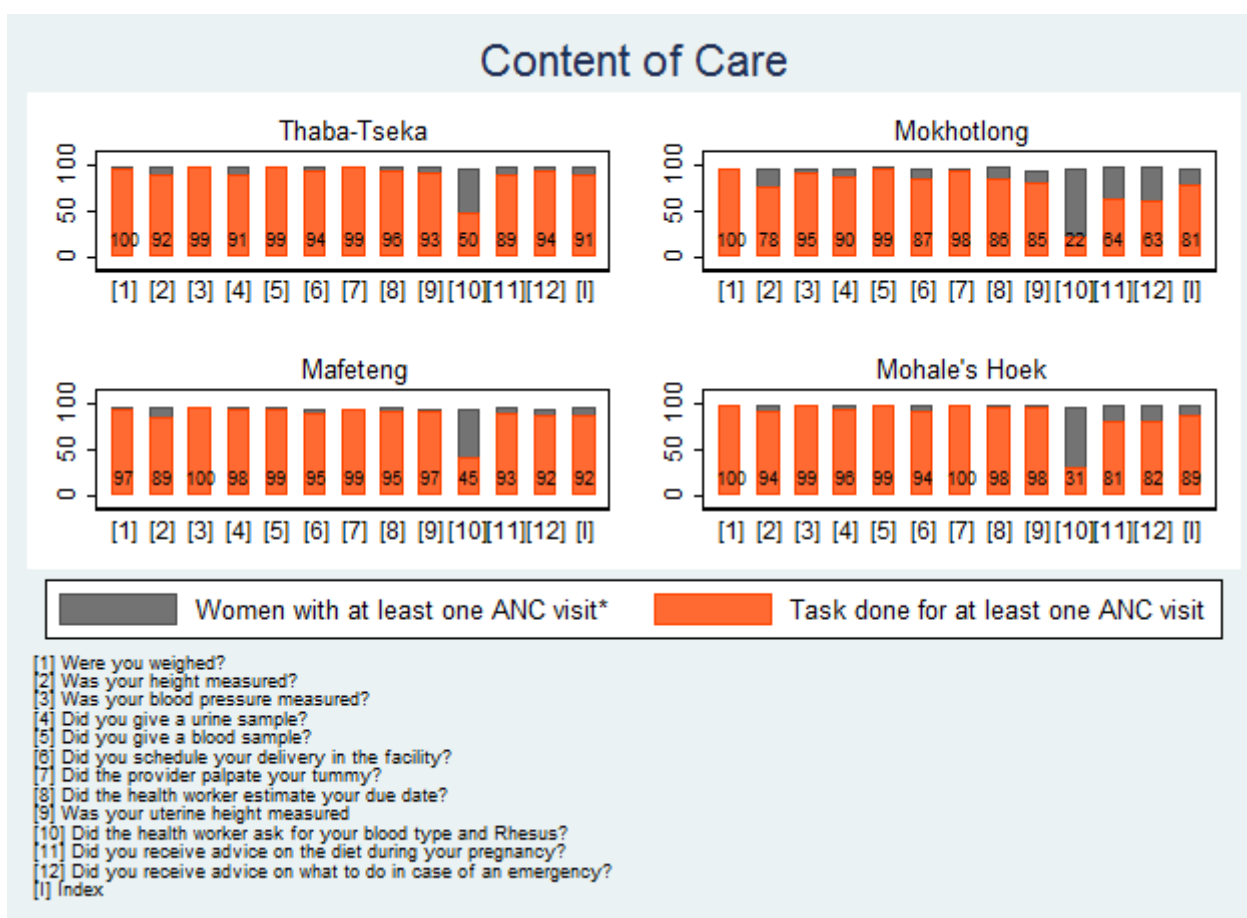


Figure 2-6: Content of Care

(*) The calculated level of at least one ANC visit has been adjusted for missing observations.

Table 2.2.2 shows that almost 98 percent of the sample were offered counseling and testing for HIV. This increases to more than 99 percent if we conditioning on women who had at least one ANC visit with a health provider. 99.3 percent of the tested women also received the result (data not shown).

Tetanus toxoid injections are given during pregnancy to prevent neonatal tetanus. The level of women that received at least one injection is above 90 percent and conditional on an ANC visit, it is 93.9 percent. However, only 76 percent received two shots during the pregnancy. This level could partly be explained by coverage from previous pregnancies. The national rate reported in the LDHS 2014 is 74 percent.²

Table 2.2.2: HIV, tetanus and iron	Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	All
HIV testing and counseling					
Unconditional	98.6	95.2	97.3	99.5	97.6
Conditional on ANC visit	99.1	96.9	100.0	99.6	99.2
Tetanus injections					

² LDHS2014 defines protection against neonatal tetanus as either (1) two injections during the pregnancy, (2) two or more injections and the last one within 3 years of the birth, (3) three or more injections and the last one within 5 years of the birth, (4) four or more injections and the last one within 10 years of birth, or (5) five or more injections at any time prior to the birth

Unconditional	96.3	92.8	89.9	91.6	91.9
Conditional on ANC visit	96.8	94.5	93.3	92.3	93.9
At least 2 injections	74.4	72.4	78.0	76.5	76.0
Iron supplementation					
Mother-baby-pack	96.0	89.8	91.3	93.6	92.3
Other source	0.9	3.9	1.9	2.3	2.2
Either source	96.9	93.5	93.1	95.8	94.4
For at least 90 days	71.7	73.1	80.4	74.5	76.3
Sample Size	333	170	314	261	1,078

Table 2.2.2: HIV testing, protection against tetanus, and iron supplementation

Pregnant women in Lesotho are supposed to receive a mother-baby-pack that among other things contains iron syrup or tablets. 92.3 percent of our sample received the mother-baby-pack and an additional 2.2 percent received iron from another source. In total, 94.4 percent of the pregnant women received iron supplement during their pregnancy. However, less than 80 percent reported taking it for 90 days or more.

Delivery

Table 2.2.3 shows that 77 percent of deliveries are attended by a skilled health provider, and 77 percent of deliveries are at a formal health facility. This is similar to the national level of 77 percent in LDHS 2014. A skilled health provider is defined as either a medical doctor or a nurse/midwife. An additional 2.7 percent of deliveries are attended by a nurse assistant, and 4.3 percent by a village health worker or a traditional healer. The remaining 16 percent were attended by family, friends or no one. 45 percent delivered at a hospital and 28 percent at either a MOH or CHAL health center.

Variations were observed across districts, with 64 percent of women in Thaba-Tseka delivering at a health center compared to the overall level of 28 percent. Family, friends or no one are assisting in 22 percent of deliveries in Mokhotlong. Some variation were also observed across age with the younger age group more likely to deliver in a formal health facility. The most pronounced variation is observed across educational level, birth order and wealth quintile. Hospital delivery is highly correlated with being in the wealthier quintiles and the difference between the poorest and wealthiest quintile is 23 percentage points for deliveries in a formal health center. The difference for primary level of education versus high school or more is 20 percentage points, and 23 percentage points for first time pregnancies vs. third or higher rank pregnancies.

Table 2.2.3: Deliveries		Who assisted with the delivery?					Delivered by a skilled provider	Where did you deliver?				Delivered at formal health facility	Sample Size
		Medical doctor	Nurse or midwife	Nurse assistant	Village health worker or tradition al healer	Family, friends or none assisting		Government Hospital	Health Center (MOH or CHAL)	Other health facility	Provider's home or own home		
District													
	Thaba-Tseka	12.6	65.8	6.4	3.3	11.6	78.4	13.5	63.6	5.3	17.2	80.4	333
	Mokhotlong	8.4	63.9	1.0	5.1	21.6	72.3	49.8	20.6	1.9	26.6	71.2	170
	Mafeteng	17.3	62.0	1.3	4.2	15.2	79.3	54.9	19.0	4.2	19.3	76.9	314
	Mohale's Hoek	15.6	60.2	3.9	4.6	15.7	75.8	49.0	25.2	3.8	21.2	77.2	261
Age													
	<20	15.6	63.0	4.1	5.4	12.0	78.6	48.1	31.2	1.2	18.8	80.5	136
	20-24	17.6	65.0	1.9	3.0	12.4	82.5	50.2	27.9	4.4	16.5	82.3	351
	25-29	11.8	60.3	3.2	6.1	18.4	72.1	42.4	28.6	3.3	24.1	73.1	265
	30-34	13.7	61.6	3.1	4.2	17.6	75.2	46.2	23.4	6.8	20.7	71.7	171
	35+	11.0	61.3	1.9	4.0	21.7	72.4	38.5	30.1	1.9	27.5	70.3	155
Educational level													
	Primary or less	10.0	58.8	2.9	6.1	22.1	68.8	34.9	30.6	2.8	29.1	67.1	558
	Secondary	16.1	68.3	3.2	3.1	9.0	84.5	57.9	26.7	2.6	12.5	86.9	370
	High school or more	29.7	62.3	0.4	1.4	6.2	92.0	59.3	20.0	12.3	7.4	87.5	133
Birth Order													
	1	17.5	70.0	3.3	2.1	7.0	87.5	57.2	28.2	3.7	10.1	88.7	402
	2	12.7	62.2	2.2	4.7	18.0	75.0	46.2	26.8	2.5	23.2	74.5	271
	3+	12.9	54.9	2.0	5.9	24.3	67.8	35.1	28.5	4.0	30.0	65.9	369
Wealth Quintile													

1 st	6.0	57.7	0.4	8.0	27.8	63.8	27.6	31.5	2.2	37.3	60.1	261
2 nd	9.8	61.1	2.9	5.5	20.7	70.9	35.7	33.8	1.8	26.3	71.3	229
3 rd	12.3	72.4	6.4	2.6	6.3	84.7	59.2	27.7	2.7	10.4	88.5	187
4 th	20.7	61.7	2.4	1.9	13.0	82.5	53.5	25.6	2.3	14.7	81.4	220
5 th	24.2	60.6	1.6	3.2	10.2	84.8	55.8	20.6	10.5	13.1	83.3	181
All	14.4	62.6	2.7	4.3	16.0	76.9	45.8	28.0	3.8	20.8	76.5	1,078

Table 2.2.3: Deliveries

Around one-in-five of the women did not deliver in a formal health facility. To address factors that potentially prevent women from institutional deliveries, the household survey asks those women why they did not deliver in a formal health facility. . Figure 2-7 shows the difference in institutional deliveries by the height of the bars. Within the bars, the level for selected explanations are indicated.

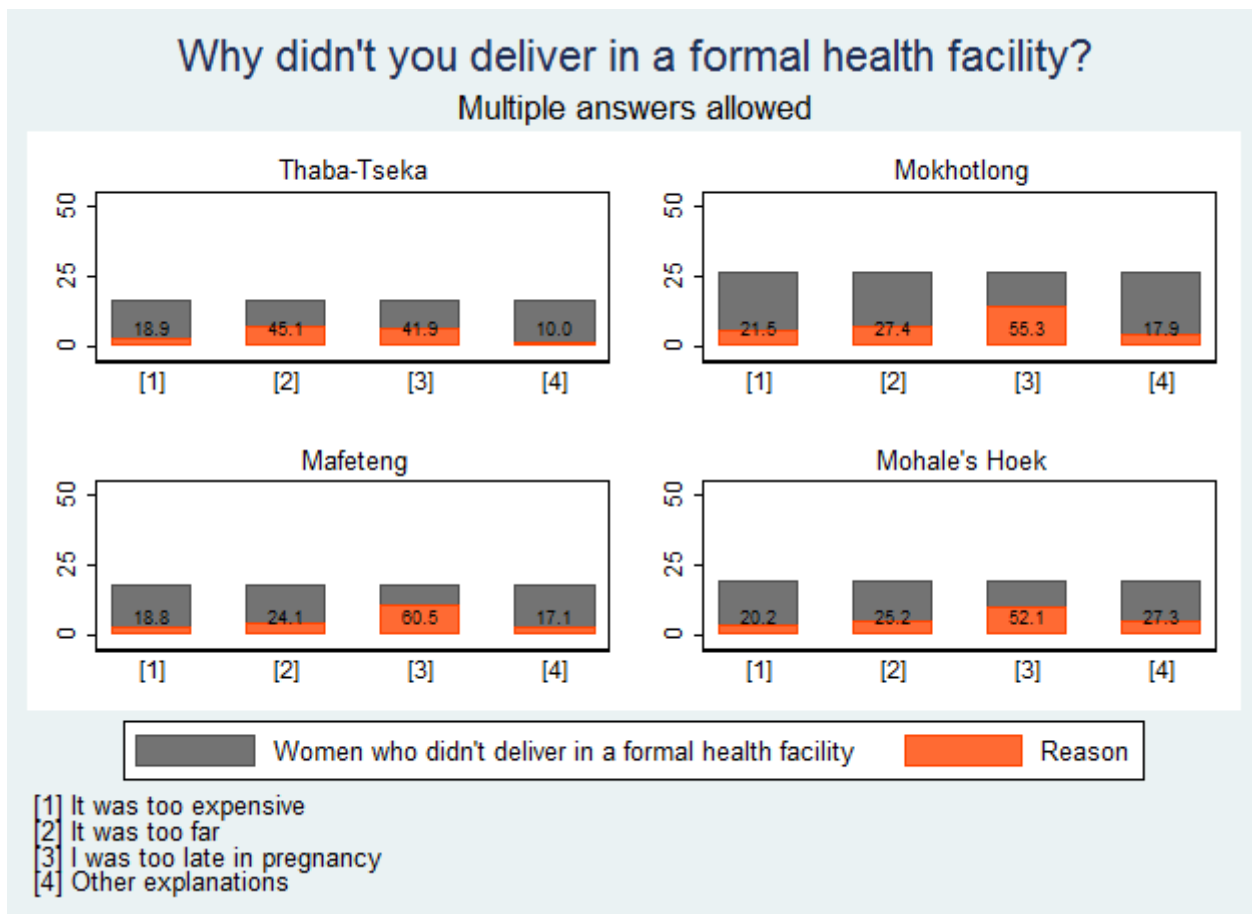


Figure 2-7: Why didn't you deliver in a formal health facility?

In Mokhotlong, with the highest percentage of women who did not deliver in a formal health facility, more than half of the women explained that it was too late in pregnancy. In addition, 27 percent report that it was too far and 22 percent that it was too expensive. Overall, around 20 percent of the women find it too expensive to deliver in a formal health facility.

Postnatal Care

Postnatal checkups provide an opportunity to assess and treat delivery complications and to counsel mothers on how to care for themselves and their babies. Most maternal and infant deaths occur in the first month after birth: almost half of postnatal maternal deaths occur within the first 24 hours and 66% occur during the first week. WHO recommends postnatal care in the first 24 hours after births as well as a total of four visits in the first six weeks after birth (Postnatal Care for Mothers and Newborns: Highlights from the World Health Organization 2013 Guidelines , 2015).

Overall, 78 percent of the women receive at least one postnatal check. The level is 77 percent if restricted to PNC by a skilled health provider defined as either a medical doctor (9.1 percent), a nurse or midwife (65.5 percent) or a nurse assistant (2.4 percent). Conditional on receiving at least one PNC check by a skilled health

provider, the average number of checks is a little less than two. Only 39 percent receive a check within the crucial first two days of delivery, conditional on at least one visit. This is much lower than the national level reported in LDHS2014 (with an unconditional level of 61 percent). The level is 91.4 when looking within 7 days. 7 days is also the modal observation (data not shown).

Table 2.2.4: Postnatal Care		(A)		(B)			
		Received PNC	Received skilled PNC	Number of visits	Days after delivery	First visit within 2 days of delivery	First visit within a week of delivery
District							
	Thaba-Tseka	84.7	83.7	1.9	7.5	33.3	89.1
	Mokhotlong	60.1	59.3	1.9	7.9	37.0	77.1
	Mafeteng	87.0	86.2	1.8	4.6	45.8	96.9
	Mohale's Hoek	71.5	70.2	2.0	6.4	29.6	93.8
Age							
	<20	82.4	81.6	1.7	5.7	37.5	90.7
	20-24	75.5	75.1	1.9	5.1	40.0	95.5
	25-29	80.1	79.0	2.0	7.5	35.6	86.6
	30-34	80.2	78.8	1.8	4.8	41.9	93.4
	35+	72.9	71.4	1.8	6.9	38.7	92.0
Education level							
	Primary or less	70.4	69.2	1.8	6.7	38.0	87.1
	Secondary	84.6	83.9	1.9	5.6	38.3	95.8
	High school or more	88.4	87.7	1.9	4.2	42.4	96.8
Birth order							
	1	83.0	82.7	1.9	5.26	39.5	94.4
	2	75.8	75.0	1.8	5.05	45.1	95.2
	3+	73.8	72.3	1.9	7.41	34.8	86.3
Wealth quintile							
	1 st	63.4	61.7	1.8	7.24	37.3	84.8
	2 nd	69.7	68.8	1.8	5.61	42.4	92.8
	3 rd	82.5	82.4	1.9	6.00	39.0	92.1
	4 th	85.4	84.2	1.7	5.79	41.0	95.4
	5 th	90.2	89.6	2.0	5.34	34.7	93.2
	All	77.8	76.9	1.9	5.94	38.8	91.9

Table 2.2.4: Postnatal Care

For PNC indicators, we observe much variation across wealth quintiles with 28 percentage point difference between the poorest and wealthiest quintile for at least one skilled PNC check. The same indicator shows a 19 percentage point difference between women with primary or less education versus high school or more, and 10 percentage point difference between first time birth and three or more births.

Postnatal Care Visit

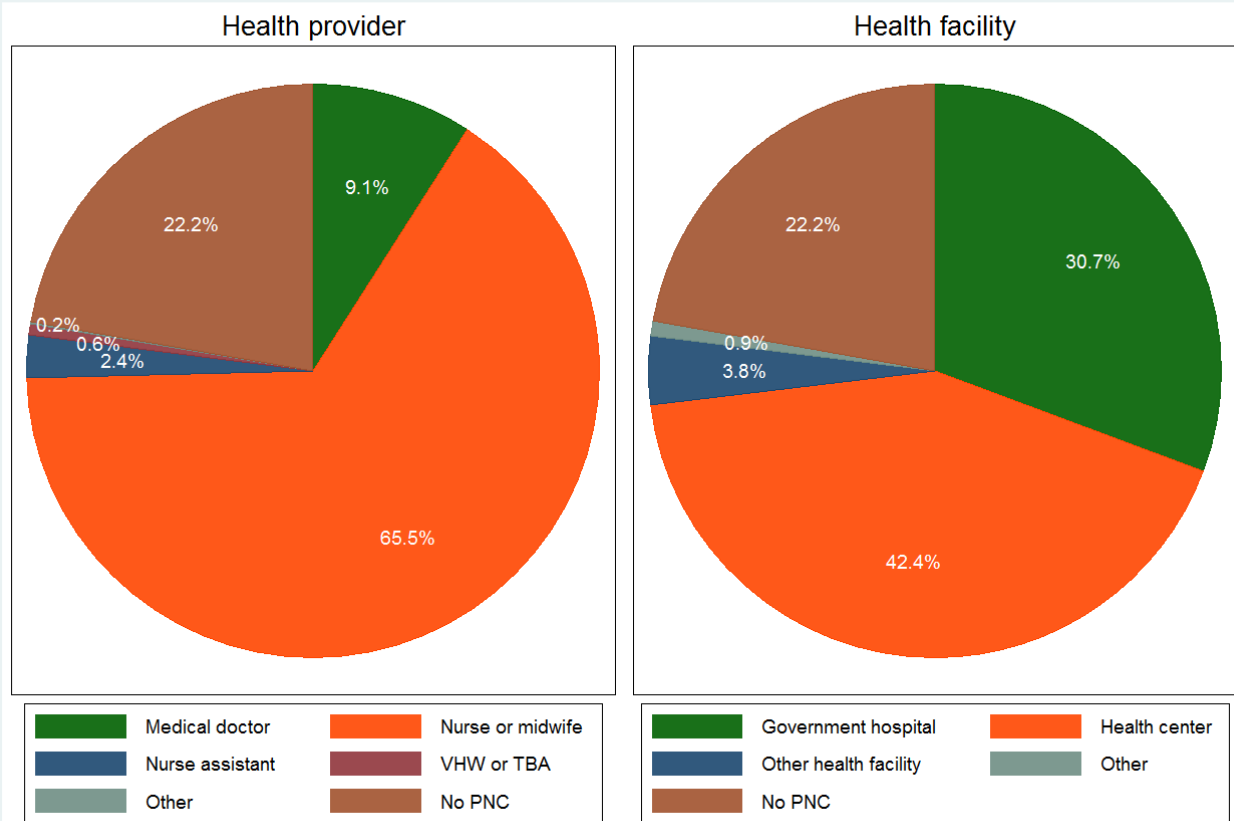


Figure 2-8: Postnatal Care Visit

Figure 2-9 shows explanations given by women who did not have a postnatal care visit. The cost of the service is given as an explanation in less than 3 percent of the cases (data not shown). The common answers given are: it was too far, the women were too busy, or thought that the check was not needed. This indicates that to increase coverage, more information about the importance of a PNC check is needed in order to have the women prioritizing spending time on a visit.

Why didn't you have a postnatal care visit?

Multiple answers allowed

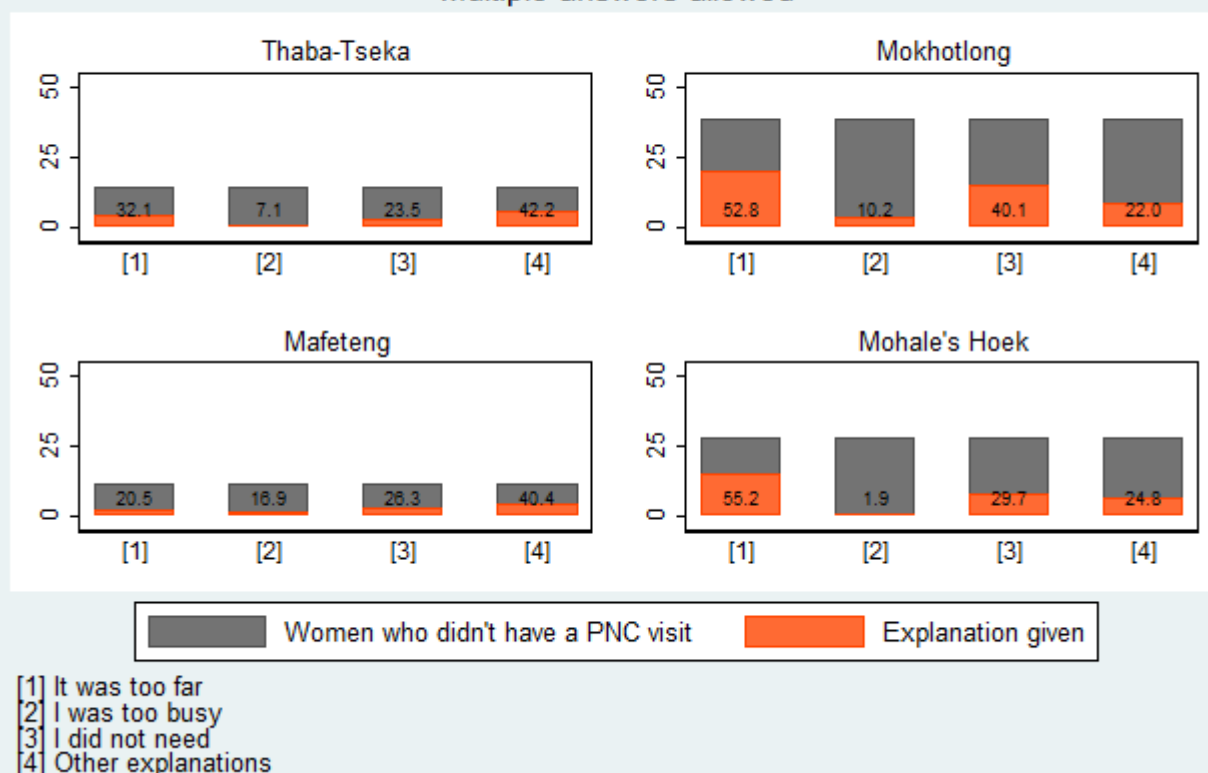


Figure 2-9: Why didn't you have a postnatal care visit?

2.3. Child health

Information on growth monitoring and vaccination coverage was collected in the household survey for children under age five of women with a recent pregnancy. The subsample of children aged 7-35 months is used for growth monitoring and children aged 12-35 months is used for vaccination coverage. If a woman has more than one child in the age range, the youngest is included in the sample used to calculate the statistics.

Growth Monitoring

Malnutrition is an underlying cause of childhood diseases and early identification and proper management is therefore highly important. Less than half (43.5 percent) of the children aged 7-35 months were measured in the past 6 months before the survey. Among these children, around half only had their weight measured. The majority of the children were measured at a health center. However, in Mphahle's Hoek 48 percent were measure by a village health worker. According to the mothers' recall, the result of the growth measurement were in 94 percent of the cases green (child is well nourished), in 5 percent of the cases yellow (the child is at risk for acute malnutrition), and 1 percent of the measured children were categorized as red (indicates severe acute malnutrition).

Table 2.3.1: Growth monitoring		Measured ^a	Method ^b				Facility ^b					Sample Size ^a
			Height only	Weight only	Height and weight	MUAC	Government Hospital	Health Center (MOH or CHAL)	Other health facility	Village Health Worker	Provider's home	
District												
	Thaba-Tseka	54.6	1.7	35.2	56.4	6.7	2.0	55.3	11.3	24.8	5.3	278
	Mokhotlong	29.1	0.0	39.0	50.0	11.0	18.2	40.1	7.1	22.3	4.3	160
	Mafeteng	43.6	2.0	54.1	41.8	2.1	14.2	38.4	4.7	28.5	14.2	295
	Mohale's Hoek	47.4	3.0	53.5	42.4	1.1	7.9	31.1	2.3	48.2	6.7	246
Total		43.5	2.0	48.6	45.7	3.8	10.7	39.8	5.6	32.4	9.3	979

Table 2.3.1: Growth monitoring

^a) The sample includes children aged 7-35 months. ^b) The sample is conditioned on being measured.

Vaccination Coverage

The vaccination schedule up to the age of one in Lesotho is comprised of:

- 1) BCG given at birth or at first contact
- 2) Polio 0 given from birth to two weeks of age
- 3) Polio and Pentavalent given at six weeks (dose 1), ten weeks (dose 2), and fourteen weeks (dose 3) (interval between doses is 30 completed days)
- 4) Measles given when a child has completed 9 months of age

Since late 2008, pentavalent has been given to infants in Lesotho. This vaccine is DPT combined with other antigens that protect against hepatitis B and Haemophilus influenza type b. However, in many cases it was observed that the Bukana mentions DPT instead of Pentavalent. This was not communicated well enough to the survey team and the data reports a level of pentavalent coverage that do not represent the true level in Lesotho. For the purpose of this report, the pentavalent level is not shown but is referred to as the level of polio I, II, and III. According to the vaccination schedule, the polio vaccines and pentavalent are to be given at the same visit to the health center. The assumption is that the level of pentavalent coverage is similar to the level of polio coverage. This assumes that the pentavalent vaccine is not more likely to be out of stock at the health centers than the polio vaccine.

Table 2.3.2 shows that almost all children have a Bukana. However, in 20.3 percent of the cases the Bukana was not available at the time of interview.

Table 2.3.2: Bukana		Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	All	Sample size
	Yes (seen)	73.3	77.9	78.5	80.7	78.1	525
	Yes (not seen)	26.5	17.1	20.2	18.8	20.3	140
	No	0.2	5.0	1.3	0.6	1.6	8
Sample Size		205	106	199	163	673	

Table 2.3.2: Bukana

Table 2.3.3 shows the vaccination coverage. A child is considered to have received all basic vaccinations, if the child received a BCG (against tuberculosis), at least three doses of polio vaccine (assumed three doses of pentavalent), and one measles vaccine.

Table 2.3.3: Vaccinations Coverage									
			BCG	Polio	3+ polio	Measles	All basic	None	Sample Size
District									
	Thaba-Tseka	<i>Bukana</i>	70.6	72.5	70.5	57.4	55.1	0.2	207
		<i>Recall</i>	26.4	27.3	14.4	26.2	14.4	0.4	
		Total	97.0	99.8	84.9	83.6	69.5	0.6	
	Mokhotlong	<i>Bukana</i>	75.1	75.1	68.4	60.0	57.1	0.0	109
		<i>Recall</i>	19.8	20.3	6.0	20.3	5.3	3.3	
		Total	94.9	95.4	74.4	80.3	62.4	3.3	
	Mafeteng	<i>Bukana</i>	79.1	79.6	75.7	72.4	70.6	0.5	193
		<i>Recall</i>	13.9	14.4	8.4	13.5	8.3	5.5	
		Total	93.0	94.0	84.1	85.9	78.9	6.0	
	Mohale’s Hoek	<i>Bukana</i>	81.4	81.4	76.9	74.5	72.1	0.4	159
		<i>Recall</i>	17.6	17.7	11.6	17.1	11.3	0.5	
		Total	99.0	99.1	88.5	91.6	83.4	0.9	
Age									
	12-23	<i>Bukana</i>	77.8	78.5	73.9	67.8	65.3	0.5	492
		<i>Recall</i>	18.3	18.7	8.6	17.8	8.3	2.0	

		Total	96.1	97.2	82.5	85.6	73.6	2.5	
	24-35	Bukana	77.0	77.0	73.4	68.9	67.3	0.0	176
		Recall	16.9	17.4	12.1	17.2	11.9	5.6	
		Total	93.9	94.4	85.5	86.1	79.2	5.6	
Total		Bukana	77.6	78.1	73.8	68.2	65.9	0.3	668
		Recall	17.9	18.3	9.7	17.6	9.4	3.1	
		Total	95.5	96.4	83.5	85.8	75.3	3.4	

Table 2.3.3: Vaccination Coverage

The vaccination coverage for children age 12-23month is 5.6 percentages points higher than the national level reported in LDHS2014. Vaccination coverages are similar to LDHS2014 for Thaba-Tseka and Mafeteng and higher for Mokhotlong and Mohale's Hoek. Vaccination coverage reported in LDHDS2014 for Mohale's Hoek is 65 percent, compared to 84 in this sample (data not shown).

2.4. Fertility Preferences & Family Planning

Information on fertility preferences allows for an understanding of the desire for children and — in combination with data on contraceptive use— the demand for family planning methods. Due to the selection of the sample, unmet demand is not estimated in this report. . The nationally representative level for unmet need for family planning among currently married women is estimated in LDHS2014 to 18.4 percent. The total demand for family planning is estimated in LDHS2014 to 78.6 percent.

This section will provide information about fertility preferences and contraceptives used for the sample of women with a recent pregnancy. The sample is restricted to include women who report to have a sexual partner and are not currently pregnant. It is likely that this will exclude some women with a husband living and working outside the country. In general, it is important to keep in mind that these women are selected for maternal health purposes and the sample is not representative of all women aged 15-49. For this reason, a direct comparison to LDHS2014 is not possible. The report finds a higher level of approval and use of contraceptives compared to LDHS2014.

Table 2.4.1: Fertility preferences		If you could choose for yourself, how long would you wait from now until the birth of your next child?					Sample Size
		Would not wait	Less than two years	More than two years	No more children	Have not decided	
District							
	Thaba-Tseka	0.8	4.4	69.4	15.1	10.3	276
	Mokhotlong	0.4	4.4	74.6	13.5	7.1	134
	Mafeteng	0.1	2.0	64.1	20.2	13.6	274
	Mohale's Hoek	2.5	1.6	67.9	23.5	4.6	210
Age Group							
	15-19	3.3	3.4	72.4	6.9	14.0	88
	20-24	0.3	3.4	74.9	8.0	13.4	298
	25-29	0.9	0.8	72.7	17.0	8.6	230
	30-34	0.0	4.2	61.8	25.8	8.2	147
	35-39	0.5	0.7	53.4	43.3	2.1	85
	40+	2.9	6.8	34.0	54.4	2.0	46
Number of living children							
	0	1.7	1.7	73.9	6.4	16.2	34
	1-2	0.9	3.0	72.8	10.8	12.5	580
	3-4	0.5	1.4	61.0	33.4	3.7	202
	5+	0.6	4.8	45.6	46.2	2.7	78
Time since last pregnancy							
	<1 year	0.4	0.7	65.9	22.0	11.0	118
	1-2 years	0.9	2.3	69.7	14.4	12.6	355
	2-3 years	0.6	3.8	64.5	24.8	6.4	292
	>3 years	2.8	0.0	66.0	19.0	12.1	66
Educational level							
	Primary or less	1.1	4.7	64.8	22.3	7.0	474

	Secondary	0.6	1.0	71.5	15.4	11.4	302
	High school or more	0.4	0.0	70.1	12.0	17.5	105
Wealth quintile							
	1 st	0.3	3.7	68.3	19.5	8.2	219
	2 nd	0.3	4.5	64.1	20.8	10.3	181
	3 rd	2.4	1.2	68.9	15.9	11.7	161
	4 th	1.1	4.3	65.8	23.7	5.1	180
	5 th	0.2	0.1	71.7	14.6	13.3	153
Total		0.8	2.8	67.8	18.9	9.7	894

Table 2.4.1: Fertility preferences

3.6 percent of the sample wants another child soon (within less than two years) – this compares to 14.9 percent in LDHS2014. 67.8 percent of women want to wait more than 2 years compared to 25 percent in LDHS2014. In the sample, less than 20 percent do not want any more children whereas the level in LDHS2014 is 56 percent. It is likely that the younger IE sample explains much of the difference to the national level in LDHS2014.

Table 2.4.2: Contraceptives		Approve of contraceptives	Currently using any FP method	Currently using modern FP	Sample Size
District					
	Thaba-Tseka	93.3	73.2	70.5	276
	Mokhotlong	97.5	85.8	84.8	134
	Mafeteng	98.1	81.0	80.8	274
	Mohale's Hoek	96.5	77.6	77.6	210
Age Group					
	15-19	94.4	75.9	75.9	88
	20-24	95.5	76.8	75.9	298
	25-29	98.2	83.3	82.1	230
	30-34	98.2	81.3	80.5	147
	35-39	99.6	85.1	85.1	85
	40+	92.5	73.5	73.5	46
Educational Level					
	Primary or less	96.0	77.2	76.2	474
	Secondary	96.6	80.6	80.4	302
	High school or more	100.0	86.4	85.9	105
Wealth Quintile					
	1 st	95.2	75.8	75.8	219
	2 nd	96.5	81.6	80.4	181
	3 rd	95.6	75.4	74.1	161
	4 th	98.1	81.4	80.2	180
	5 th	98.7	84.9	84.9	153
Fertility Preferences					
	Would wait less than 2 years	84.2	80.5	78.4	37

Would wait more than 2 years	97.2	78.7	78.1	591
Would not have more children	97.7	81.7	81.7	173
Total	96.8	79.8	79.1	894

Table 2.4.2: Contraceptives

Figure 2-10 shows the current use of contraception by method. Injectables are the most commonly used method of contraception.

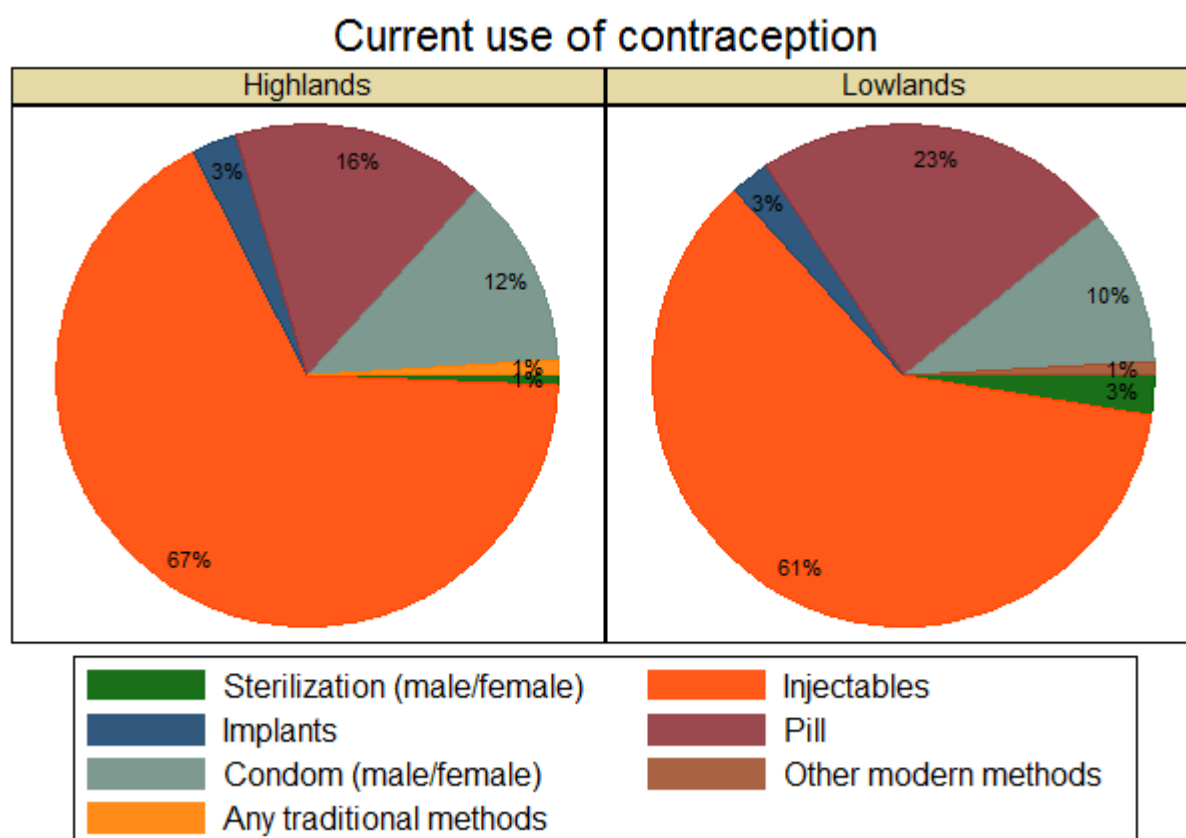


Figure 2-10: Current use of Contraception

Table 2.4.3 shows that among women who are currently not using any contraceptive methods, 4.4 percent report that they do not themselves approve of contraceptives, and 13.8 reports that their partner or other family members do not approve. Forty-four percent report that they did use contraceptive previously and 14.4 percent that they are about to start using contraceptives.

Table 2.4.3: Contraceptives (sample of women not currently using)		Ever used?	Why are you currently not using any method to delay or avoid getting pregnant? ¹								Sample Size
			Would like to get pregnant	Does not approve	Partner or family does not approve	Not available	Scared of side-effects	No knowledge of any method	No need ²	About to start	
District											
	Thaba-Tseka	42.8	1.1	8.3	24.7	1.7	5.4	2.7	34.9	13.9	79
	Mokhotlong	44.5	0.0	5.4	9.2	21.1	15.9	2.6	36.5	0.0	23
	Mafeteng	43.9	4.8	1.2	11.1	17.5	9.3	2.7	26.0	22.6	54
	Mohale's Hoek	44.9	1.2	5.3	10.2	3.4	5.5	0.0	50.4	9.9	41
Age Group											
	15-19	13.7	0.0	0.0	5.7	24.5	0.0	3.4	44.0	12.6	20
	20-24	43.4	0.8	4.6	12.3	17.2	7.7	1.5	33.4	16.9	62
	25-29	38.0	8.3	3.3	17.9	3.5	8.1	0.0	30.9	20.8	52
	30-34	62.9	0.0	1.1	20.0	3.1	13.1	0.9	44.3	5.2	28
	35+	60.1	2.2	15.1	10.4	0.0	12.8	7.0	31.0	8.8	35
Education											
	Primary or less	46.4	3.2	5.8	17.0	8.4	6.1	1.7	36.5	11.5	120
	Secondary or more	40.0	1.4	2.8	9.2	14.0	11.4	2.4	34.8	18.3	74
Wealth Quintile											
	1 st	44.4	1.2	7.6	16.1	5.9	9.8	0.6	36.4	13.8	63
	2 nd	42.8	1.4	5.8	17.7	12.1	4.2	4.3	38.6	13.0	36
	3 rd	40.3	0.0	0.0	13.3	26.7	6.4	0.0	38.5	15.2	37
	4 th	45.1	11.0	1.8	9.7	4.9	9.5	0.0	30.9	13.8	35
	5 th	49.3	0.0	6.8	10.1	0.0	12.4	6.6	31.9	16.3	26
Total		44.0	2.4	4.4	13.8	10.7	8.3	2.0	35.7	14.4	197

Table 2.4.3: Contraceptives (sample of women not currently using)

¹) Excluded category is labeled as other. ²) 'No need' includes reasons as lactational amenorrhea, hysterectomy, menopausal, infecund and lives apart.

2.5. Adolescent Fertility Preferences

There is an interest in reproductive health of adolescents, both from a health and social perspective. Although adolescents aged 10-19 years account for 11 percent of all births worldwide, they account for 23 percent of the overall burden of disease (disability-adjusted life years) due to pregnancy and childbirth (http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/). Fourteen percent of all unsafe abortions in low- and middle-income countries are among women aged 15–19 years, and adolescents are more seriously affected by complications than are older women. For example, stillbirths and death in the first week of life are 50 percent higher among babies born to mothers younger than 20 years than among babies born to mothers 20–29 years old. In addition, girls who become pregnant often leave school with potentially long-term implications for them as individuals, their families and communities. (http://www.who.int/maternal_child_adolescent/topics/maternal/adolescent_pregnancy/en/).

The sample of adolescents provides an opportunity to address their reproductive decisions and fertility preferences.

Table 2.5.1: Reproductive decisions		What age is a good age to have the first child?		Ideal number of children at age 50	According to you, in a couple, how should the number of children be decided? ¹			Sample Size
		Woman	Man		Woman	Man	Both	
District								
	Thaba-Tseka	20.2	22.7	3.2	23.8	36.4	39.8	224
	Mokhotlong	22.3	25.0	3.2	31.5	39.6	28.9	123
	Mafeteng	21.1	23.3	2.9	31.9	31.4	36.6	335
	Mohale's Hoek	21.6	23.6	2.7	39.1	34.6	26.3	290
Age Group								
	<15	21.1	23.5	3.0	32.6	36.6	30.7	376
	15	21.4	23.3	2.8	32.1	32.7	35.2	288
	>15	21.2	23.5	2.9	33.2	31.1	35.7	303
Education Level								
	Primary or less	21.2	23.4	3.0	33.4	37.7	28.9	545
	Secondary	21.4	23.5	2.8	32.8	29.6	37.6	383
	High school or more	20.5	23.2	3.1	24.4	28.1	47.5	41
Wealth Quantiles								
	1 st	20.7	23.1	3.2	29.6	44.6	25.7	182
	2 nd	21.0	23.3	2.9	32.8	31.9	35.3	201
	3 rd	21.7	23.9	2.9	28.6	33.4	38.0	197
	4 th	21.2	23.3	2.8	41.3	32.4	26.2	207
	5 th	21.3	23.4	2.8	29.1	30.2	40.7	185
Total		21.2	23.4	2.9	32.6	33.8	33.6	972

Table 2.5.1: Reproductive Decisions

¹) This variable contains 3 percent missing values

Note that 2.9 preferred number of children at age 50 is lower than the estimated total fertility rate in LDHS2014 of 3.3.

Table 2.5.2 shows that 56.3 percent of the adolescents would wait more than two years before the birth of their first child (38.8 percent have not decided). 98.3 percent say that it would be a big problem to be pregnant now (data not shown).

Table 2.5.2: Fertility preferences		If you could choose for yourself, how long would you wait from now until the birth of your first child? ¹					Sample Size
		Would not wait	Less than two years	More than two years	Does not want children	Have not decided	
District							
	Thaba-Tseka	1.0	7.9	52.3	0.5	37.5	197
	Mokhotlong	4.9	5.2	59.8	1.6	28.6	55
	Mafeteng	0.2	1.4	57.3	1.0	40.1	189
	Mohale's Hoek	0.7	2.8	56.8	0.0	39.6	134
Age Group							
	<15	0.5	2.4	61.7	0.3	35.1	232
	15	0.4	2.9	52.5	0.0	44.1	160
	>15	1.3	4.6	52.6	2.0	38.9	180
Education Level							
	Primary or less	1.2	4.1	53.8	0.2	40.5	321
	Secondary	0.4	2.7	58.5	1.2	37.0	227
	High school or more	0.0	0.0	59.0	1.8	39.3	25
Wealth Quantiles							
	1 st	1.4	6.0	59.8	0.0	32.3	123
	2 nd	1.2	2.9	52.5	0.6	42.9	109
	3 rd	0.0	6.9	46.0	0.6	46.1	106
	4 th	0.5	0.8	58.5	0.0	40.2	122
	5 th	0.9	1.6	62.0	2.1	33.4	115
Total		0.8	3.2	56.3	0.8	38.8	575

Table 2.5.2: Fertility preferences

1) This variable includes 35 percent missing values. This is due to a misunderstood skip pattern in the questionnaire.

Table 2.5.3 shows if the adolescents have received information about family planning methods by selected categories. 53 percent of the sample does not mention to have talked to either a health worker, LPPA, a village health worker, friends or family, or a teacher about family planning methods. 87 percent of the sample report to approve of family planning methods.

Table 2.5.3: Family planning	Have any of the following ever talked to you about family planning methods?					Approves of FP methods	Sample Size
	Health worker	LPPA	Village health worker	Friends or family	Teacher ¹		
District							

	Thaba-Tseka	6.2	2.8	2.8	8.2	0.5	88.6	224
	Mokhotlong	6.6	5.0	6.2	14.2	0.0	87.9	123
	Mafeteng	8.9	6.3	8.1	22.0	16.3	88.3	335
	Mohale's Hoek	8.2	4.8	3.5	14.9	8.1	84.4	290
Age Group								
	<15	5.6	3.0	2.4	13.9	9.1	87.6	376
	15	8.9	7.7	7.0	19.1	5.0	86.8	288
	>15	10.7	6.0	9.5	20.0	17.3	87.1	303
Educational Level								
	Primary or less	6.1	3.6	5.2	15.3	4.5	86.4	545
	Secondary	9.0	6.4	5.7	17.7	16.1	88.4	383
	High school or more	20.7	13.0	14.8	35.3	21.7	85.5	41
Wealth Quantiles								
	1 st	5.3	2.9	2.8	7.4	2.7	84.8	182
	2 nd	6.6	3.8	2.7	15.4	10.6	87.7	201
	3 rd	6.1	2.1	7.8	15.8	11.3	86.8	197
	4 th	7.5	5.7	8.6	18.8	7.0	85.9	207
	5 th	13.5	10.3	6.5	25.4	17.0	90.2	185
Total		8.1	5.3	5.9	17.3	10.4	87.2	972

Table 2.5.3: Family Planning (adolescents)

¹⁾ In the questionnaire it is not specifically asked whether a teacher provided the information. The adolescent has to explicitly mention this in order to have the information recorded.

The adolescent questionnaire included a section on knowledge assessment. One of the questions was '*Which are effective methods of contraception?*' Figure 2-11 shows the answers provided by the adolescents. The questionnaire only allows for a yes or no answer and it is therefore possible that missing observations could be interpreted as *don't know*. The height of the bar in figure 2-11 shows the level of answers for each option. Conditional on an answer provided, the orange bar indicates the level who answered yes.

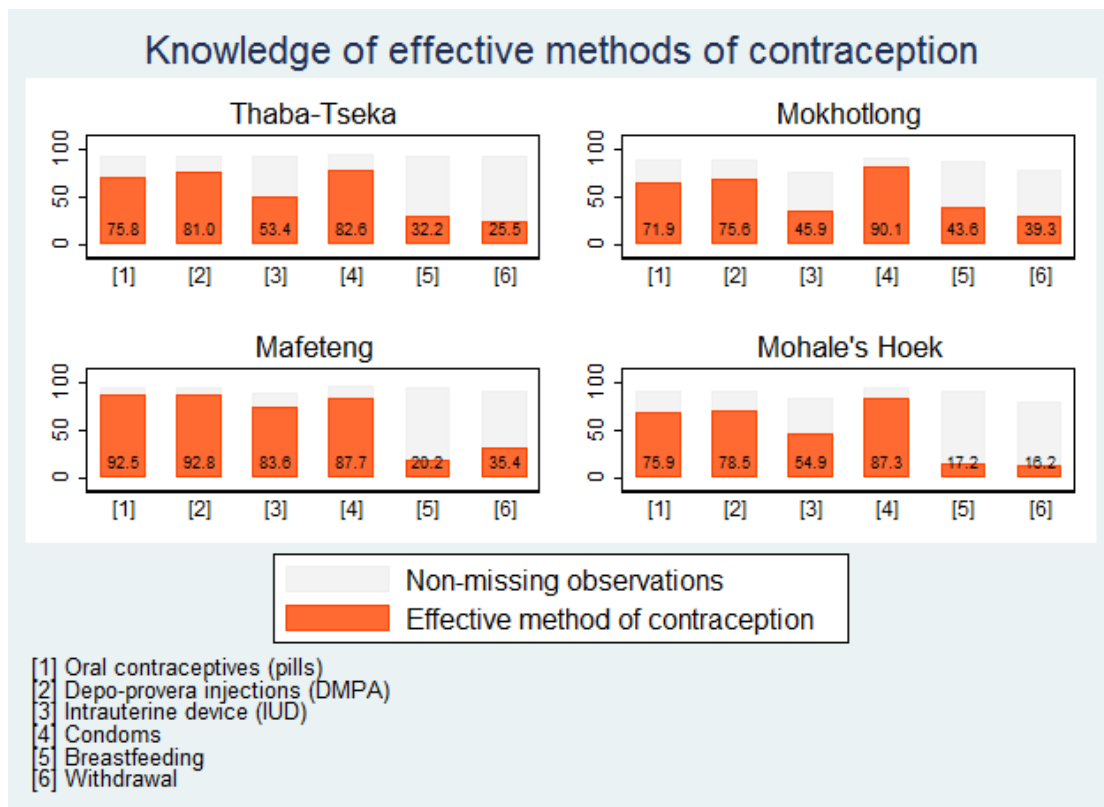


Figure 2-11: Knowledge of effective methods of contraception

Overall, 85 percent of adolescents recognize oral contraceptives, injections, and condoms as effective methods of contraceptives. The level is lower for IUD (68 percent). Twenty-three percent report breastfeeding to be effective and 30 percent says that withdrawal is an effective method of contraceptive.

3. Descriptive Statistics - Facility Survey

This chapter starts with an overview section that follows the structure of the health center quarterly quality checklist used in the context of the Performance-Based Financing pilot. This section is followed by a more in-depth analysis of the baseline data from the 53 surveyed health centers; this includes data from the health provider interviews. The last section looks into patient reports from the exit interview.

3.1. Quality indicators

The following indicators are chosen based on the quarterly quality checklist for health centers (from November 2015) and adapted to the baseline survey questionnaire.

Part A: General Services

Part A: General Services		By type		By district				All
		MOH	CHAL	TT	MOK	MAF	MH	
Staff is correctly managed								
	Staff meeting is conducted monthly	83.3	86.4	80.0	75.0	93.8	84.6	84.6
	All staff have written job descriptions	38.7	45.5	43.8	0.0	43.8	61.5	41.5
	Staff performance has been assessed internally in past year	46.4	38.1	46.7	62.5	31.3	40.0	42.9
Health center has access to improved water source		96.8	100.0	100.0	100.0	100.0	92.3	98.1
Health center has access to official phone line		93.5	100.0	100.0	87.5	93.8	100.0	96.2
Consultation room								
	Equipped with a safety box	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Posted procedures of decontamination	41.9	31.8	56.3	87.5	18.8	7.7	37.7
	Water source and soap	83.9	100.0	87.5	100.0	93.8	84.6	90.6
The health center did <u>not</u> ran out of disinfectants (in past 30 days)		90.3	95.5	75.0	100.0	100.0	100.0	92.5
Patient Safety								
	Medical waste is disposed according to standards ¹	67.7	59.1	75.0	75.0	56.3	53.8	64.2
	Sterilization is done according to standards ²	86.7	90.9	81.3	87.5	93.8	91.7	88.5
	Posted procedures	3.3	4.5	0.0	0.0	6.3	7.7	3.8
Patients have access to functioning toilet facility		86.7	95.5	93.3	100.0	100.0	69.2	90.4
Sample Size		31	22	16	8	16	13	53

Table 3.1.1: General Services

¹⁾ Burned and outsourced are accepted as appropriate standards. ²⁾ Dry-heat sterilization, autoclaving, steam sterilization, chemical method and outsources are accepted as appropriate standards.

Part B: Primary Care Services

Part B: Primary Care Services		By type		By district				All
		MOH	CHAL	TT	MOK	MAF	MH	
Patient amenities								
	There is a reception and a waiting room	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	There is a room with privacy for patients	100.0	86.4	100.0	100.0	81.3	100.0	94.2
	There is a room for minor surgery	36.7	31.8	46.7	37.5	43.8	7.7	34.6
Service availability								
	ANC	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Delivery	90.0	71.4	78.6	75.0	93.8	76.9	82.4
	PNC	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Family planning	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Immunization	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Growth monitoring & nutritional advice	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Tuberculosis, STI & HIV	100.0	100.0	100.0	100.0	100.0	100.0	100.0
	Laboratory services	100.0	85.7	86.7	100.0	93.8	100.0	94.1
Equipment is available and functional ¹								
	General equipment	85.5	86.8	82.5	92.5	86.3	86.2	86.0
	ANC	99.4	100.0	100.0	100.0	100.0	98.5	99.6
	Delivery	80.0	83.0	75.2	98.2	75.9	84.5	81.2
	Delivery (intensive care)	53.4	51.9	48.5	65.9	55.1	46.5	52.8
	PNC and Newborn care	78.6	76.2	70.0	78.1	79.7	84.1	77.6
Stock of drugs and contraceptives are adequate ²								
	General drugs	81.5	80.4	74.3	92.1	76.2	88.3	81.0
	Vaccines	82.0	86.5	60.9	78.5	96.9	93.9	83.9
	Contraceptives	78.2	79.5	77.5	85.0	83.6	71.5	78.6
National guidelines are available								
	IMCI	93.3	81.8	86.7	87.5	100.0	76.9	88.5
	Graphs for growth monitoring	100.0	90.9	100.0	100.0	100.0	84.6	96.2
	Vaccination	96.7	86.4	86.7	100.0	93.8	92.3	92.3
	Family planning	93.3	68.2	100.0	100.0	68.8	69.2	82.7
	ANC	96.7	95.5	93.3	100.0	100.0	92.3	96.2
	Delivery	96.7	90.9	93.3	87.5	100.0	92.3	94.2
	PNC	83.3	72.7	93.3	75.0	75.0	69.2	78.8

Newborn care	76.7	77.3	100.0	75.0	62.5	69.2	76.9
National health strategy	10.0	18.2	0.0	0.0	31.3	15.4	13.5
Immunization processes are in order							
Vaccines are stored appropriately in fridge	100.0	95.5	100.0	100.0	93.8	100.0	98.1
Temperature in vaccination fridge is within standard range	93.3	86.4	86.7	87.5	93.8	92.3	90.4
Sample Size	31	22	16	8	16	13	53

Table 3.1.2: Primary Care Services

¹⁾ The indicators are defined as the average availability of functional equipment across the selected items shown in figure 3-12, 3-13, 3-14, 3-15, and table 3.7.1, respectively.

²⁾ Stock of drugs and contraceptives are defined as adequate if the items have not been out of stock in the past 30 days. The indicators are defined as the average across items shown in figure 3-9, 3-10, and 3-11.

Part C: Community Services

Part C: Community Services	By type			By district			All
	MOH	CHAL	TT	MOK	MAF	MH	
Health center has an estimate of the size of the catchment area	80.6	80.0	60.0	71.4	93.8	92.3	80.4
Village Health Workers							
At least one visit a month	36.7	52.4	42.9	12.5	50.0	53.8	43.1
Specially assigned village health supervisor	80.6	68.2	81.3	75.0	50.0	100.0	75.5
There is a Health Center Executive Committee	96.8	86.4	100.0	87.5	87.5	92.3	92.5
Representative of VHC	93.3	100.0	100.0	85.7	92.9	100.0	95.9
Representative of community	96.7	100.0	100.0	85.7	100.0	100.0	98.0
A least one meeting a month	64.3	40.0	61.5	50.0	25.0	83.3	55.8
Written records of meetings	96.7	77.8	100.0	85.7	76.9	91.7	89.6
Sample Size	31	22	16	8	16	13	53

Table 3.1.3: Community Services

3.2. General information

66 percent of MOH health centers have had a major investment in infrastructure in either 2013 or 2014. Overall health facilities in Lesotho provide services round-the-clock with the only exception of one health center in Mafeteng.

At some point in the seven days preceding the survey, 17 percent of the health centers had experienced disconnection from the water system, 28 percent had an electric power outage and 37 percent had a lack of telephone services. Most of the health centers in Thaba-Tseka and Mohale's Hoek have a functioning computer whereas it is only one in four of the health centers in Mokhotlong and one in three of the health centers in Mafeteng.

Table 3.2.1: General information	By District				Missing obs
	Thaba-Tseka	Mokhotlong	Mafeteng	Mohale’s Hoek	
Last major investment in infrastructure (2013/14)	61.5	83.3	69.2	63.6	10
24 hours services	100.0	100.0	93.8	100.0	0
Any time in last 7 days with no water	12.5	12.5	31.3	8.3	1
Electric power outage in the last 7 days	56.3	25.0	6.3	23.1	0
No telephone services in past 7 days	56.3	14.3	20.0	46.2	2
Access to a functioning computer	86.7	25.0	33.3	100.0	2
Access to functioning transportation	37.5	12.5	43.8	46.2	0
Sample Size	16	8	16	13	
General information	By Type				Missing obs
	MOH	CHAL	All		
Last major investment in infrastructure (2013/14)	65.5	71.4	67.4		10
24 hours services	100.0	96.0	98.1		0
Any time in last 7 days with no water	10.0	27.3	17.3		1
Electric power outage in the last 7 days	29.0	27.3	28.3		0
No telephone services in past 7 days	41.4	31.8	37.3		2
Access to a functioning computer	60.0	71.4	64.7		2
Access to functioning transportation	35.5	40.9	37.7		0
Sample Size	31	22	53		

Table 3.2.1: General information

All health centers report referring patients to other facilities. Figure 3-1 shows some selected services that are referred. Only 38 percent of the health centers have access to functioning transportation that can be used to transport patients to a referral facility.

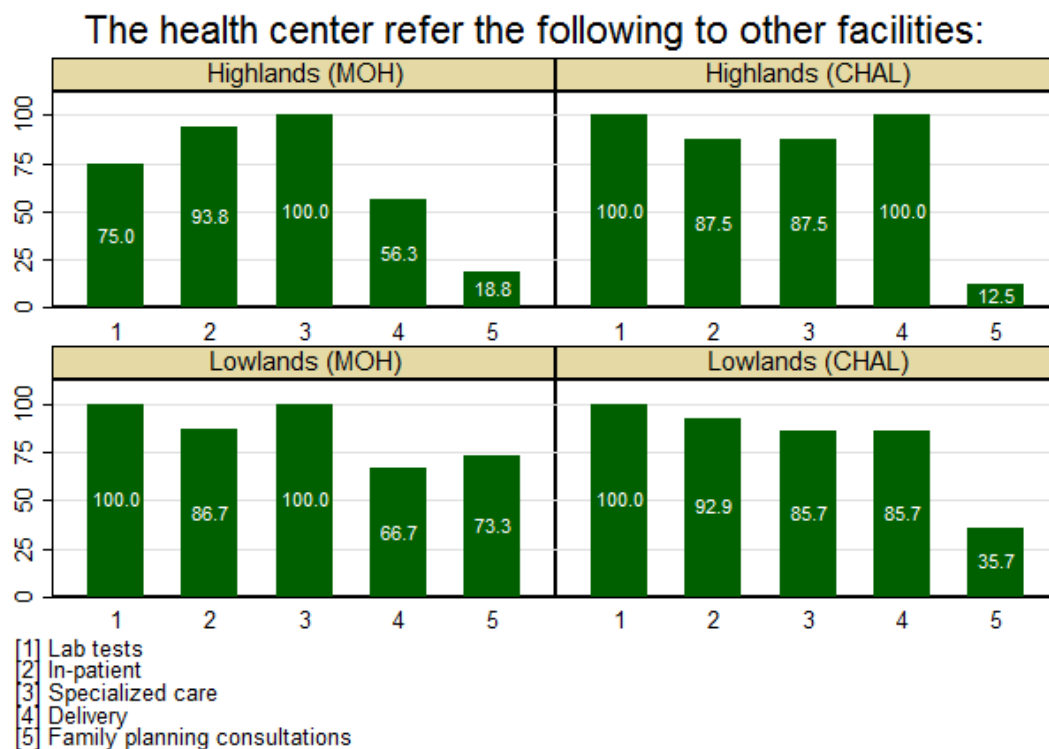


Figure 3-1: The Health Center refer the following to other facilities

Most of the health centers report to have a reception and waiting room, room with privacy for patients, and heating during the winter. Only around one-in-three of the health centers report to have a room for minor surgery.

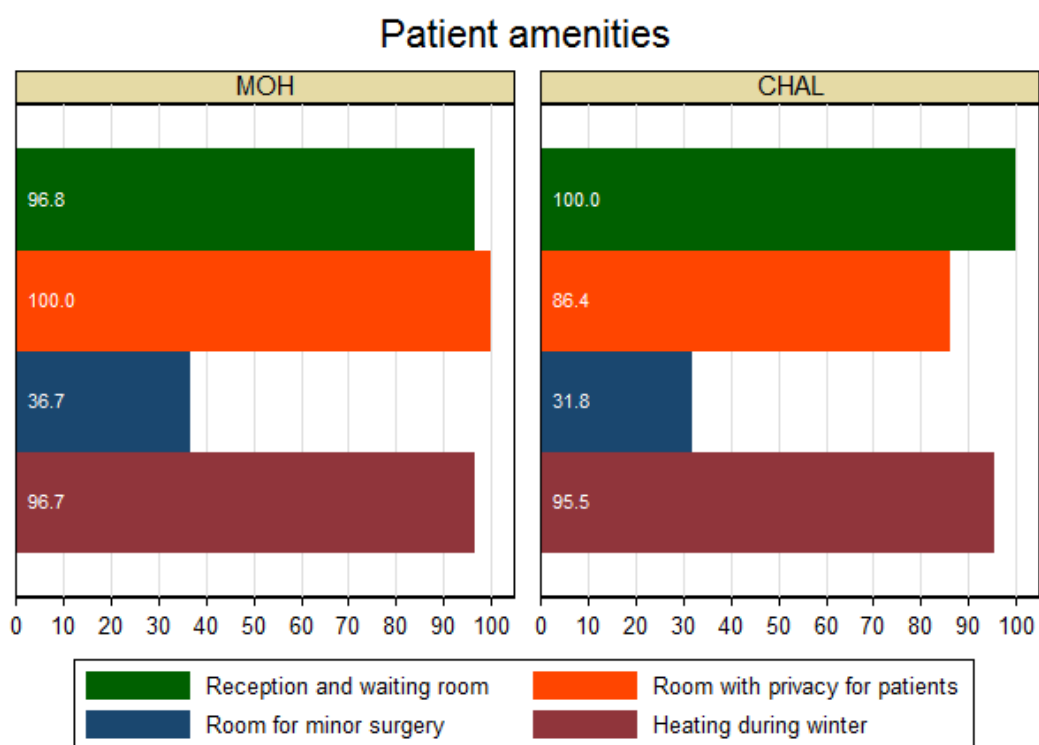


Figure 3-2: Patient amenities

Figure 3.3 shows the level of health centers that report to have information for patients publicly posted.

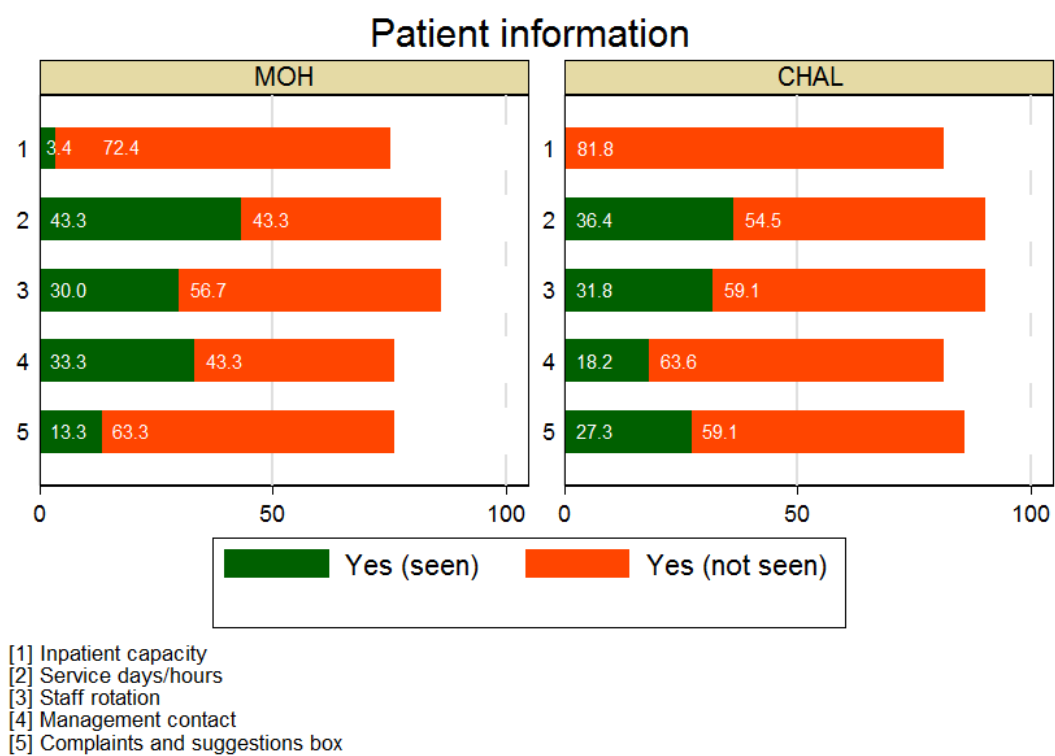


Figure 3-3: Patient Information

3.3. Services



Figure 3-2: Services Offered

Overall, the facilities are likely to offer all main MCH services except for delivery services (see figure 3-2). In CHAL facilities in the districts of Thaba-Tseka and Mokhotlong (highlands districts) only 43 percent of the facilities provide delivery services. In the districts of Mphahle's Hoek and Mafeteng (lowlands districts) the level is around 85 percent for both MOH and CHAL facilities.

We now turn to tables that describe in more detail what is included in the different services provided. These tables are divided according to the following MCH services: child health including immunization, family planning, and maternal health including ANC, PNC, and deliveries. Included is also a section on laboratory services.

Data on service availability are collected in two separate main sections in the facility assessment. The main part of the following tables are oral reports from the head of facility (or most informed staff) in combination with utilization coverage from the HMIS system. The interviewer asked the head of facility if the service is offered (in-facility or as outreach) and then verified the number of patients per service from the HMIS. This section provides information on a more detailed level. For example, for delivery it is not asked in general if delivery services are provided, it is asked specifically if the health center offers a) Spontaneous vaginal delivery, b) Assisted delivery, c) Home delivery, d) C-section.

In addition, we have oral reports from the facility head from a general section about services. This section asks questions in general terms about services. For example, are delivery services offered in the health center? Figure 3-2 reports the level based on this general information

whereas the following is mainly based on the detailed information from HMIS - whenever data is from the general section it will be marked with a * and when inconsistencies are found this will be mentioned in the text.

Child Health

All health centers offer in-facility growth monitoring and nutritional advice. The outreach availability varies across districts and type of facility: 100 percent outreach availability in Mohale's Hoek and only 43 percent of facilities in Mokhotlong – and 83 percent versus 75 percent for MOH facilities and CHAL facilities.

All facilities also report in-facility immunization services and around 70 percent report immunization outreach activities. Again, Mokhotlong has the lowest outreach activity with less than 20 percent of MOH facilities and none of CHAL reporting immunization done outside the facilities. However, 63 percent of facilities in Mokhotlong have outreach work plans. Service availability does not vary noticeable by vaccine (see figure 3-3). 98 percent of all health centers provide a Bukana with an immunization schedule.

Table 3.3.1: Available Services – Child Health		By District				Missing obs
		Thaba-Tseka	Mokhotlong	Mafeteng	Mohale’s Hoek	
Growth monitoring & nutritional advice						
	In-facility availability	100.0	100.0	100.0	100.0	4
	Outreach availability	92.9	42.9	66.7	100.0	4
	Days per week	4.5	5.0	2.9	3.2	5
Immunization						
	In-facility availability	100.0	100.0	100.0	100.0	5
	Outreach availability	83.3	12.5	66.7	100.0	5
	Days per week	3.0	3.3	1.1	2.0	6
	Outreach work plan*	73.3	62.5	6.3	30.8	1
	Bukana*	100.0	87.5	100.0	100.0	1
Sample Size		16	8	16	13	
Available Services – Child Health		By Type				Missing obs
		MOH	CHAL	All		
Growth monitoring & nutritional advice						
	In-facility availability	100.0	100.0	100.0		4
	Outreach availability	82.8	75.0	79.6		4
	Days per week	4.0	3.3	3.7		5
Immunization						
	In-facility availability	100.0	100.0	100.0		5
	Outreach availability	71.4	70.0	70.8		5
	Days per week	2.2	2.0	2.1		6
	Outreach work plan*	53.3	22.7	40.4		1
	Bukana*	96.7	100.0	98.1		1

Sample Size	31	22	53	
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Table 3.3.1: Available Services – Child Health

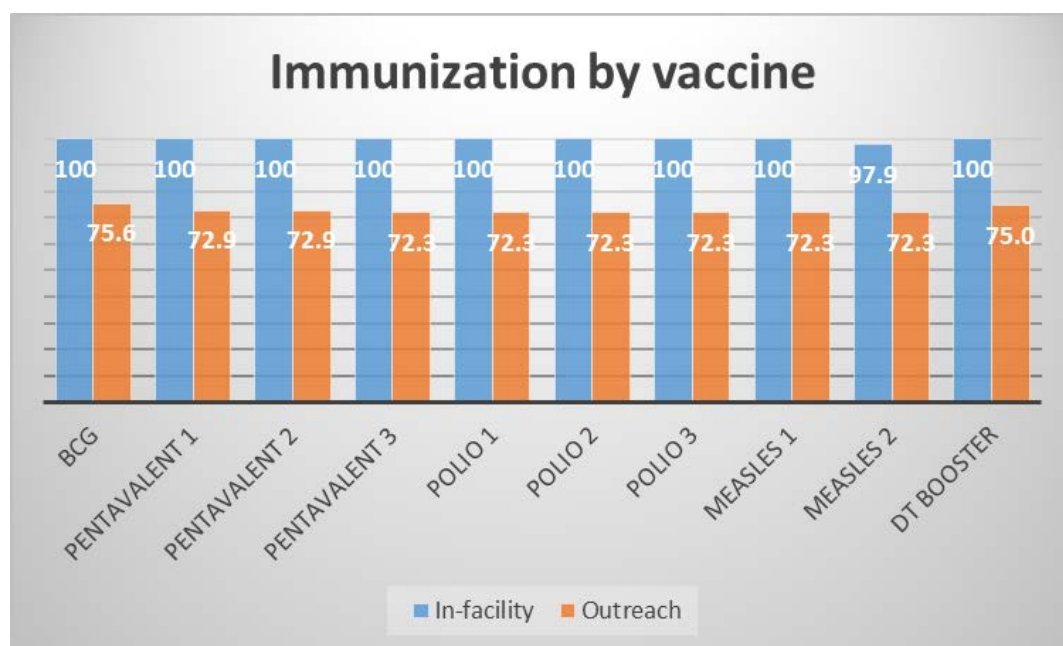


Figure 3-3: Immunization by vaccine

Family Planning

The level of family planning services is only conducted for the MOH health centers. All MOH health centers report offering family planning services; in particular, all health centers provide contraceptive pills, injections and male condoms as an in-facility services. The outreach availability for these methods is around 80 percent, with Mokhotlong showing the lowest level of activity. The availability for implant insertion is a little lower, with in-facility availability around 90 percent and 50 percent as an outreach service. IUD is provided in a little less than 60 percent of the health centers, and sterilization is a very uncommon service.

Table 3.3.2: Available Services - Contraceptives		MOH Health Centers					Missing obs
		Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	All	
In-facility							
	Contraceptive pill	100.0	100.0	100.0	100.0	100	2
	Injection	100.0	100.0	100.0	100.0	100	3
	Implant insertion	90.0	100.0	50.0	100.0	89.3	3
	Male condoms	100.0	100.0	100.0	100.0	100	3
	IUD	50.0	20.0	50.0	88.9	57.1	3
	Female sterilization	0.0	0.0	0.0	11.1	3.6	3
	Male sterilization	0.0	0.0	0.0	0.0	0.0	3
Outreach							
	Contraceptive pill	90.0	40.0	80.0	100.0	82.8	2
	Injection	88.9	40.0	80.0	100.0	81.5	4
	Implant insertion	55.6	0.0	50.0	75.0	50.0	5
	Male condoms	80.0	40.0	80.0	100.0	78.6	3
Days per week							

Sample Size	10	6	6	9	31	
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Table 3.3.2: Available Services - Contraceptives

Maternal Health

All health centers report providing antenatal care services in the general section. The following table shows service availability divided by in-facility and outreach. In Mohale's Hoek only 83.3 percent of the health centers report ANC as an in-facility service, however the outreach level is reported to be 91 percent. Ninety-two percent of the health centers prescribe iron and folate routinely (78 percent is verified by records) and all health centers provide a Bukana with a section on pregnancy.

All MOH health centers offer spontaneous vaginal delivery services while the level for CHAL health centers is 86 percent. Only one of the health centers reports having the capacity to manage emergency caesarian sections and none of the facilities offer home delivery services. Note that the general level in figure 3-2 for deliveries is lower. I.e. when asked if the health center offers delivery services some health centers answers no, although they do have spontaneous vaginal deliveries at the facility.

All health centers report to offer postpartum services. However, as for ANC some facilities in Mohale's Hoek report to offer this exclusively as an outreach service.

Table 3.3.3: Available Services – Maternal Health		By District				Missing
		Thaba-Tseka	Mokhotlong	Mafeteng	Mohale’s Hoek	
Antenatal Care						
	In-facility availability	100.0	100.0	100.0	83.3	4
	Outreach availability	86.7	33.3	64.3	90.9	7
	Days per week	4.3	2.3	3.1	2.9	9
	Iron and folate* (verified by records)	92.9 (64.3)	87.5 (62.5)	93.8 (93.8)	92.3 (84.6)	2
	Bukana*	100.0	100.0	100.0	100.0	2
Postnatal Care						
	In-facility availability	100.0	100.0	100.0	91.7	3
	Outreach availability	66.7	14.3	69.2	80.0	7
	Days per week	4.9	4.7	4.4	3.8	10
Delivery						
	Spontaneous vaginal delivery	100.0	85.7	93.8	91.7	2
	Assisted delivery	12.5	0.0	0.0	0.0	4
	Home delivery	0.0	0.0	0.0	0.0	7
	C-section	6.3	0.0	0.0	0.0	4
Sample Size		16	8	16	13	
Available Services – Maternal Health		By Type			Missing	
		MOH	CHAL	All		
Antenatal Care						
	In-facility availability	96.6	95.0	95.9	4	
	Outreach availability	77.8	68.4	73.9	7	

	Days per week	3.5	3.1	3.3	9
	Iron and folate* (verified by records)	96.7 (80.0)	85.7 (76.2)	92.1 (78.4)	2
	Bukana*	100.0	100.0	100.0	2
Postnatal Care					
	In-facility availability	100.0	95.2	98.0	3
	Outreach availability	63.0	61.1	62.2	7
	Days per week	4.9	4.0	4.6	10
Delivery					
	Spontaneous vaginal delivery	100.0	85.7	94.1	2
	Assisted delivery	3.3	5.3	4.1	4
	Home delivery	0.0	0.0	0.0	7
	C-section	0.0	5.3	2.0	4
Sample Size		31	22	53	

Table 3.3.3: Available Services – Maternal Health

Laboratory

All MOH health centers report providing laboratory services as well as 86 percent of the CHAL health centers. The following figure shows for the facilities with laboratory services, the percentages of facilities that are able to do a specific test today or in the past 3 months. The number in the figure refers to the following tests:

- 1: White cell and red cell counts
- 2: Hemoglobin estimation
- 3: Blood type and cross match
- 4: Tuberculosis
- 5: Gram stains
- 6: HIV testing
- 7: CD4 count
- 8: Hepatitis B testing
- 9: Hepatitis C testing
- 10: Syphilis testing
- 11: Urine protein and glucose test
- 12: Pregnancy test
- 13: Blood sugar test
- 14: Stool tests for parasites
- 15: Stool tests for occult blood
- 16: Liver functioning testing

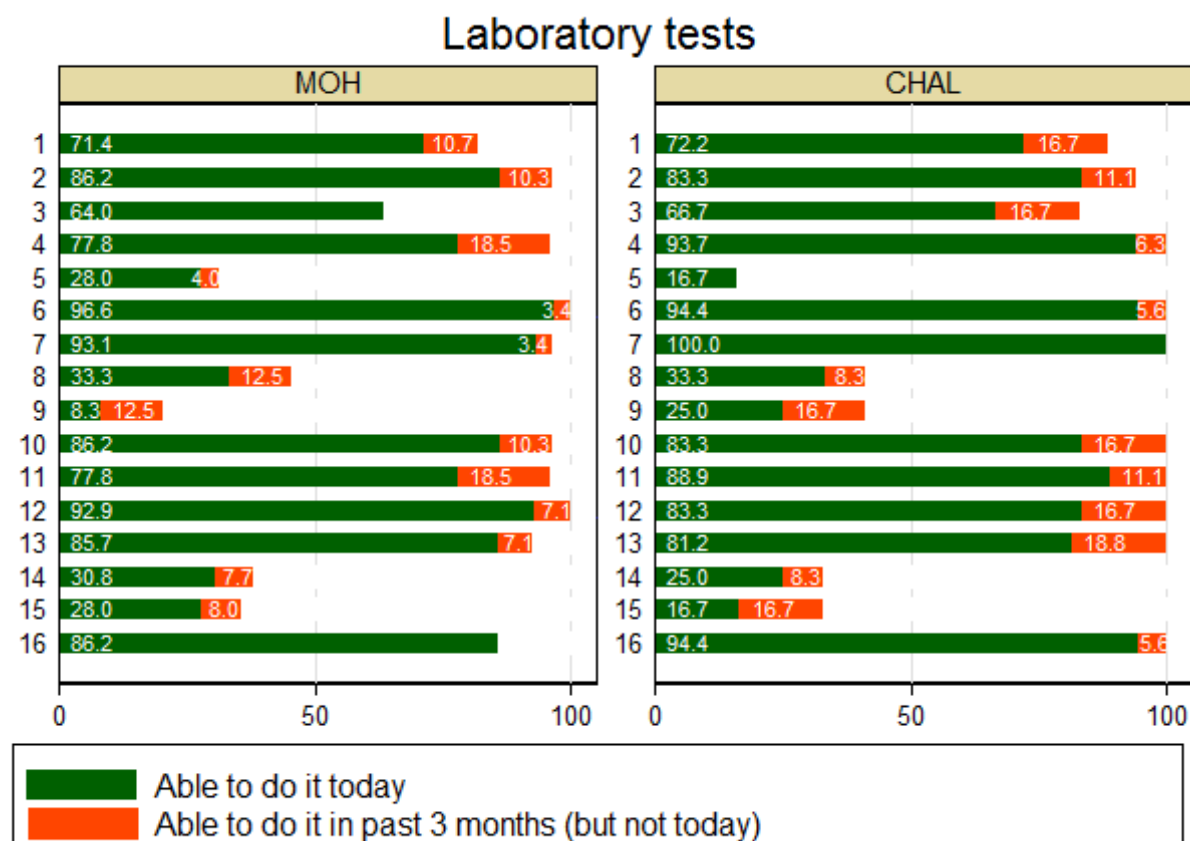


Figure 3-4: Laboratory tests

3.4. Administration and Management

Table 3.4.1 shows some selected indicators for the administration and management in the health centers. 77 percent of the health centers have a facility work plan for the current financial year. Of these facilities, 80 percent identifies ANC as a priority for the fiscal year, 85 identifies deliveries as a priority, 72 percent identifies PNC, 54 percent identifies family planning, 77 percent identifies integrated management of child illness, and 82 percent identifies immunization as a priority. On average the health centers had 5 staff meetings in the past 3 months and in 42 percent of the health centers, all staff members have a written job description.

72 percent of the health centers had their overall performance assessed externally in the past year, while staff performance has been assessed externally in 46 percent of the health centers.

Table 3.4.1: Administration and management	By district				Missing
	Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	
Facility work plan (verified)	75.0 (37.5)	62.5 (37.5)	81.2 (68.8)	84.6 (61.5)	0
Priority health-related activities (conditional sample)					

	ANC	91.7	75.0	75.0	72.7	2
	Delivery	100.0	75.0	75.0	81.8	2
	PNC	83.3	75.0	50.0	81.8	2
	Family planning	58.3	75.0	41.7	54.5	2
	IMCI	91.7	75.0	75.0	63.6	2
	Immunization	91.7	75.0	83.3	72.7	2
Number of facility staff meetings in past 3 months		6.2	4.8	4.3	4.5	1
All staff have written job descriptions		43.8	0.0	43.8	61.5	0
Supervisions in past 3 months by:						
	Hospital representative	62.5	62.5	6.3	38.5	0
	DHMT representative	40.0	100.0	80.0	76.9	2
Performance of facility assessed externally (in past year)		80.0	85.7	60.0	69.2	3
Staff performance assessment (in past year)						
	Internally	46.7	62.5	31.3	40.0	4
	Externally	56.3	37.5	46.7	38.5	1
Sample Size		16	8	16	13	
Administration and management		By type				Missing
		MOH	CHAL	All		
Facility work plan (verified)		77.4 (51.6)	77.3 (54.5)	77.4 (52.8)		0
Priority health-related activities (conditional sample)						
	ANC	79.2	80.0	79.5		2
	Delivery	83.3	86.7	84.6		2
	PNC	70.8	73.3	71.8		2
	Family planning	66.7	33.3	53.8		2
	IMCI	75.0	80.0	76.9		2
	Immunization	79.2	86.7	82.1		2
Number of facility staff meetings in past 3 months		5.3	4.6	5.0		1
All staff have written job descriptions		38.7	45.5	41.5		0
Supervisions in past 3 months by:						
	Hospital representative	45.2	31.8	39.6		0
	DHMT representative	74.2	65.0	70.6		2
Performance of facility assessed externally (in past year)		80.0	60.0	72.0		3

Staff performance assessment (in past year)				
Internally	46 . 4	38 . 1	42 . 9	4
Externally	56 . 7	31 . 8	46 . 2	1
Sample Size	31	22	53	

Table 3.4.1: Administration and management

97 percent of MOH health centers and 86 percent of CHAL health centers have executive committees. Figure 3-5 shows the composition of these committees. Most committees have a Village Health Worker representative and a community leader representative. Rarely is there a representative from the ministry of health, from CHAL or the district health management team.

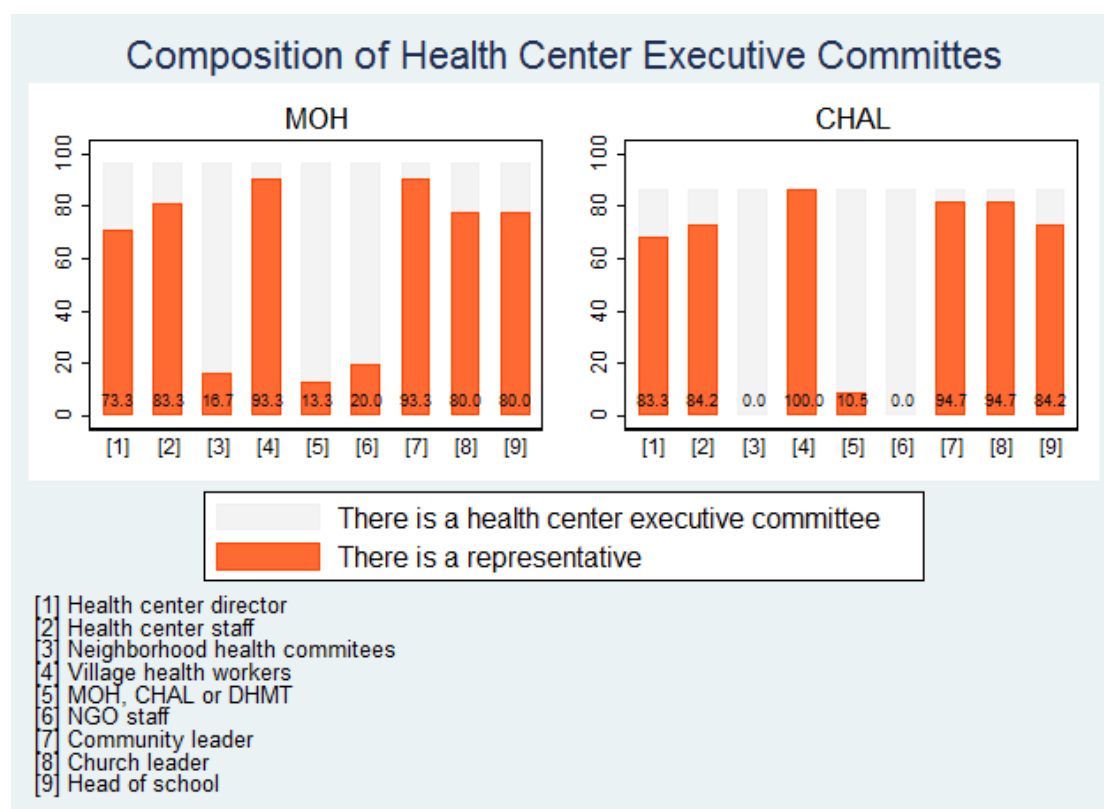


Figure 3-5: Representatives in Health Center Executive Committees

3.5. Hygiene and patient safety

Table 3.5.1 shows that almost all facilities surveyed has access to improved water source at the health center. Only one health center reports using a village tap. Overall, 17 percent of the health centers report that there was a time in the preceding seven days with no water availability. Table 3.5.1 further shows access to functioning toilets, separated by gender. 90 percent of the health centers have functioning toilets.

Table 3.5.1: Water source and toilet facilities	By Type		By District				All
	MOH	CHAL	TT	MOK	MAF	MH	
Access to improved water source (piped into facility/plot)	96 . 8	100 . 0	100 . 0	100 . 0	100 . 0	92 . 3	98 . 1

Any time with no available water (in past 7 days)	10.0	27.3	12.5	12.5	31.3	8.3	17.3
Access to functioning toilet facility (separated for male and female)	86.7	95.5	93.3	100.0	100.0	69.2	90.4
Sample Size	30	22	15	8	16	13	52

Table 3.5.1: Water source and toilet facilities

All health centers report having consultation rooms. The following figure shows the percentages for [1] having a safety box or closed container for disposal of used sharps, [2] having posted procedures for decontamination, and [3] having a basin with a water source and soap.

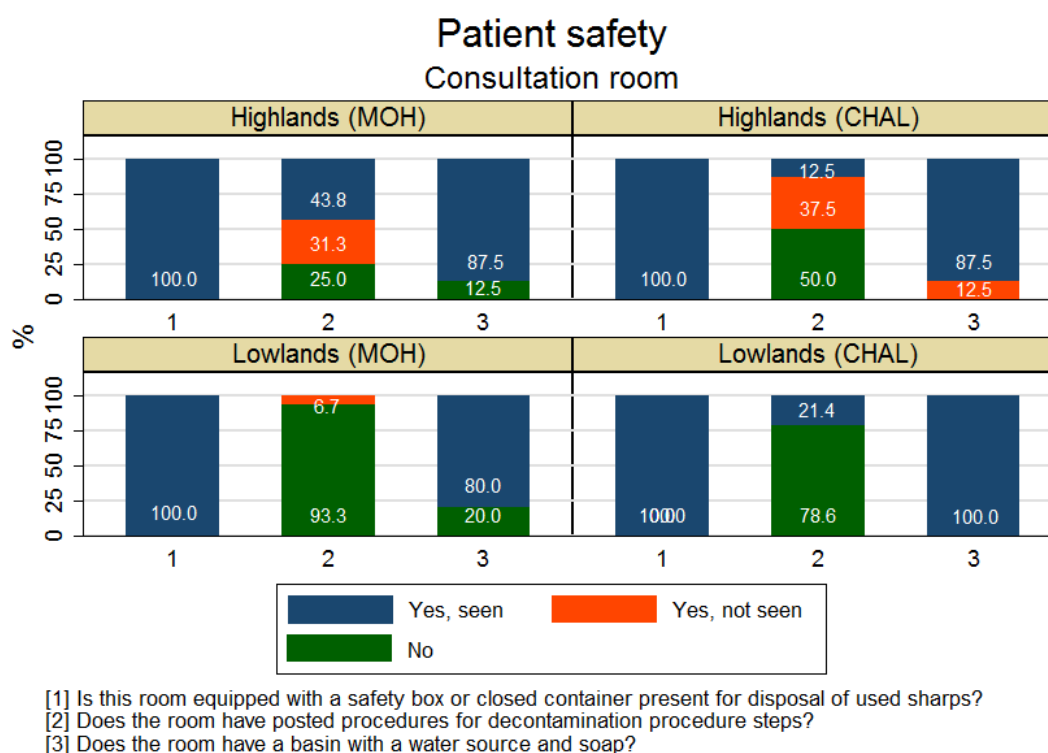


Figure 3-6: Patient Safety – Consultation Room

Four health centers in the sample ran out of disinfectants in the past 30 days and had no disinfectants for 30 out of these 30 days.

The following figure shows what kind of sterilization methods are used by the health centers. Boiling is not recommended for sterilization.

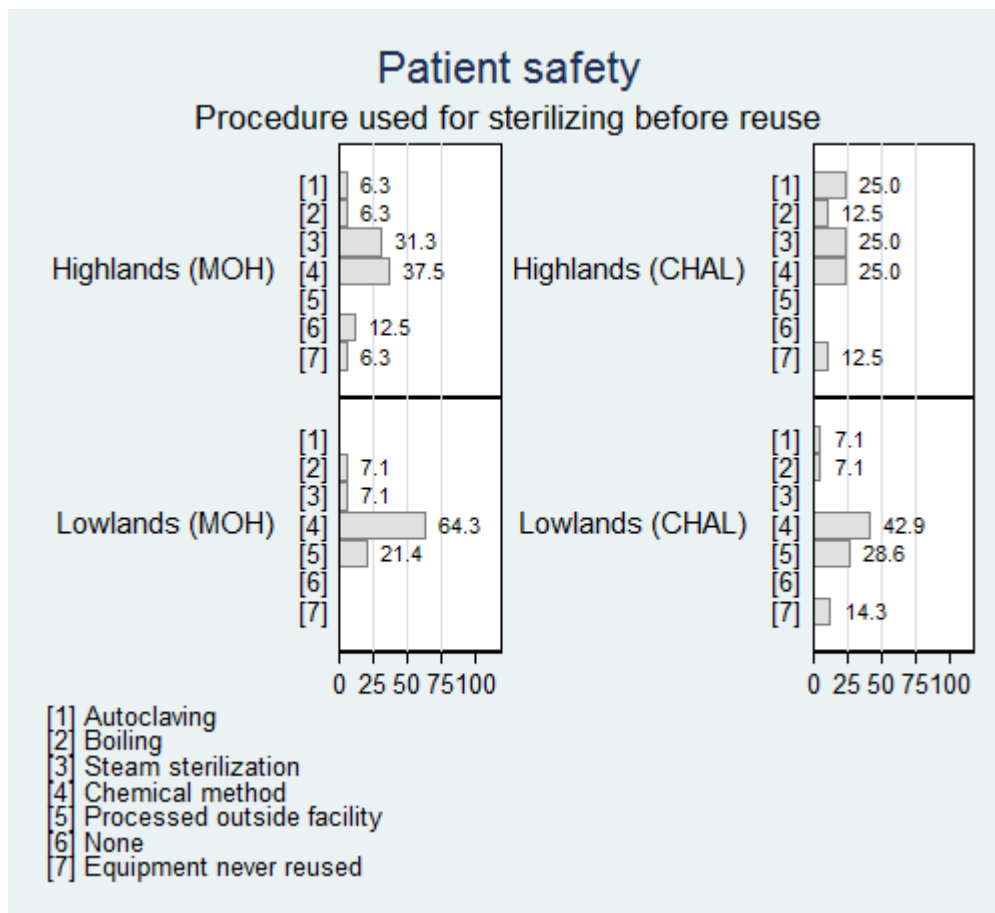


Figure 3-7: Patient Safety – Procedure used for Sterilizing before Reuse

3.6. Drugs, contraceptives and supplies

The following table shows how drugs are stored at the health centers. All MOH health centers and 82 percent of CHAL health centers store drugs in separate rooms. However, only one in four of the health centers uses an area that looks clean and dry with protection from sunlight. More than 90 percent of the facilities have maintained stock registers.

Table 3.6.1: Drug storage		By Type			Missing
		MOH	CHAL	All	
	Separate room only used for drugs with doors and windows that can be locked	100.0	81.8	92.2	2
	Area looks clean and dry and windows can be covered to keep sunlight out	25.0	27.3	26.0	3
	Drugs kept on an elevated platform	100.0	100.0	100.0	2
	Stock register maintained	96.3	90.9	93.9	4
Sample Size		31	22	53	

Table 3.6.1: Drug Storage

Figure 3-8 shows the storage method that the health centers report to have.

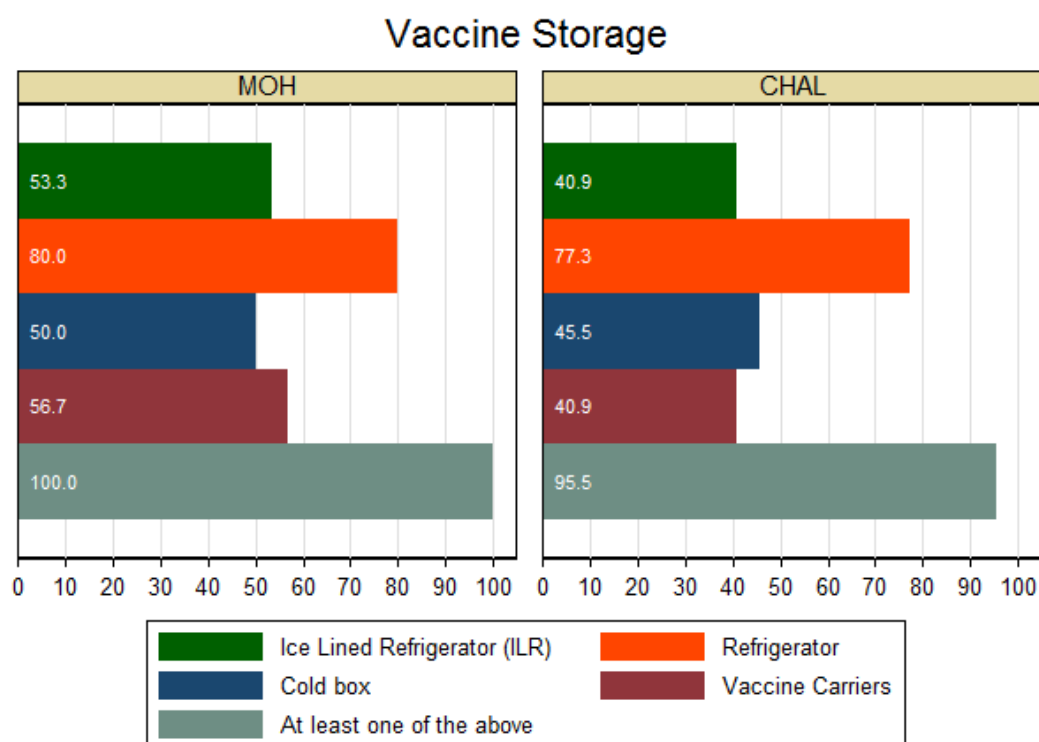


Figure 3-8: Vaccine Storage

Ninety-seven percent of health centers logged the temperature twice a day for the past week and 92 percent of the observation were in the range of 2-8 degrees Celsius.

The following figures show the availability of (1) selected general drugs, (2) selected vaccines and (3) selected family planning methods. The height of the bar indicates the level of non-missing observations. The percentages within the bars indicate the level of health centers that have been out of stock in the past 30 days for the selected item.

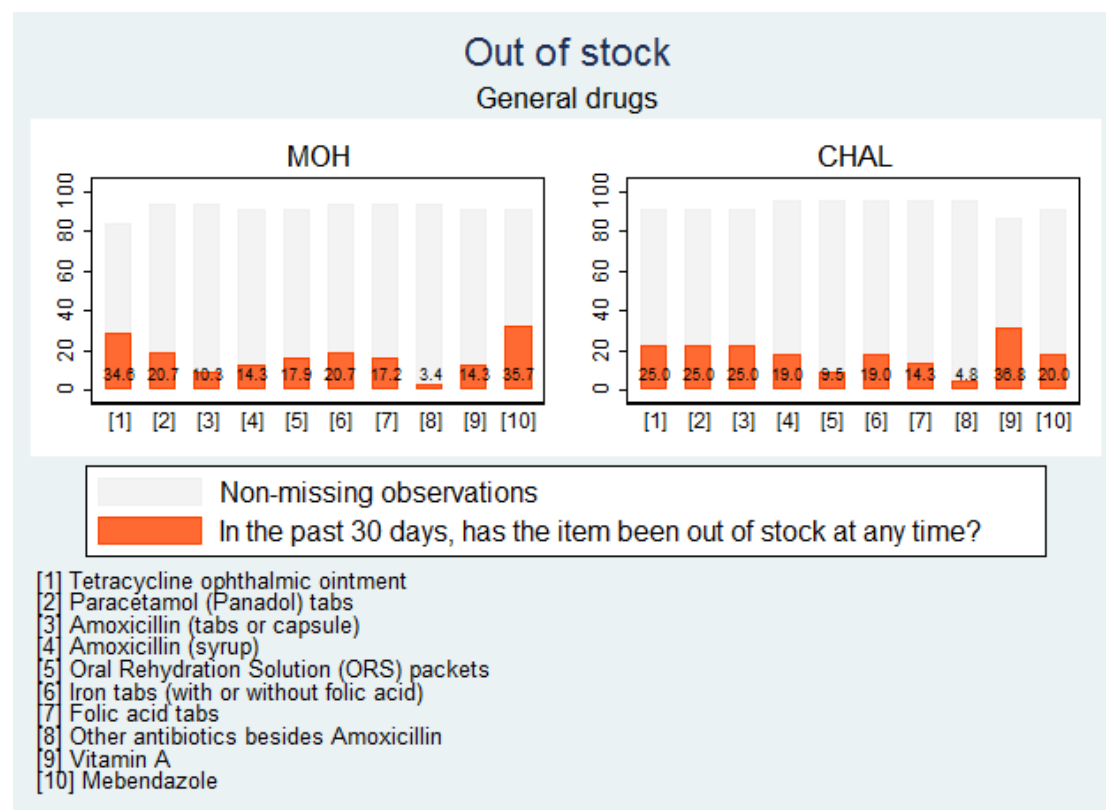


Figure 3-9: Out of Stock – General drugs

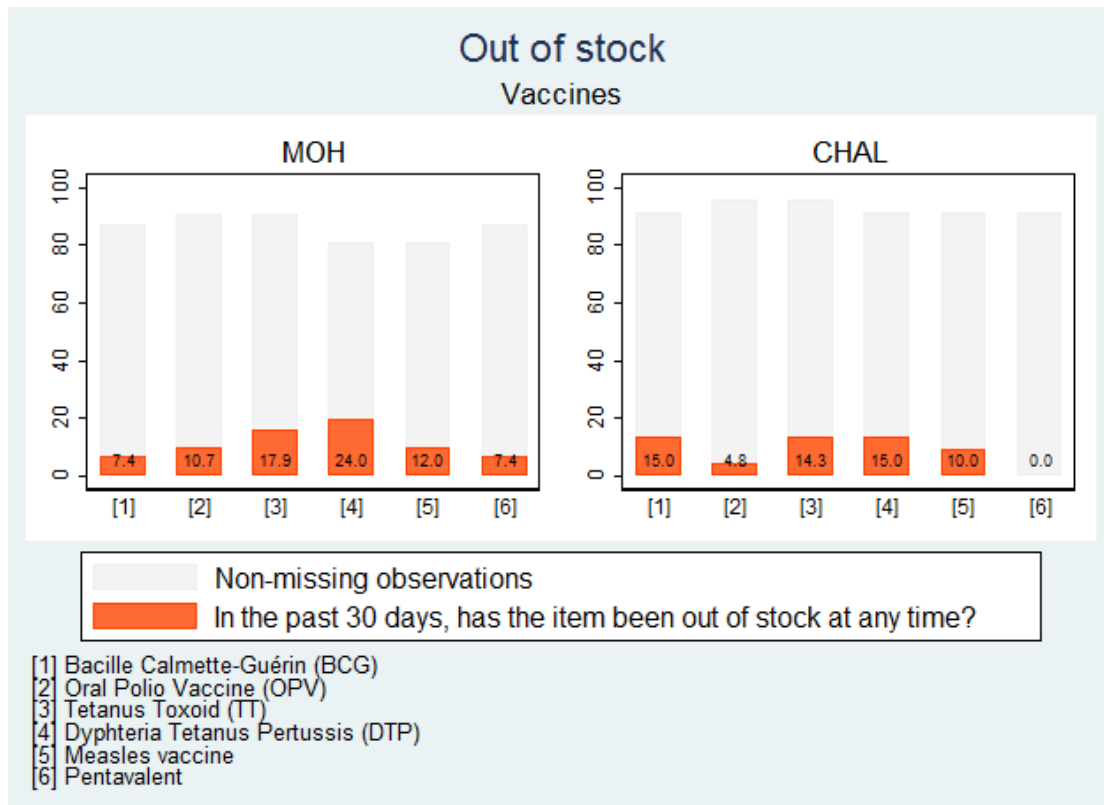


Figure 3-10: Out of stock - Vaccines

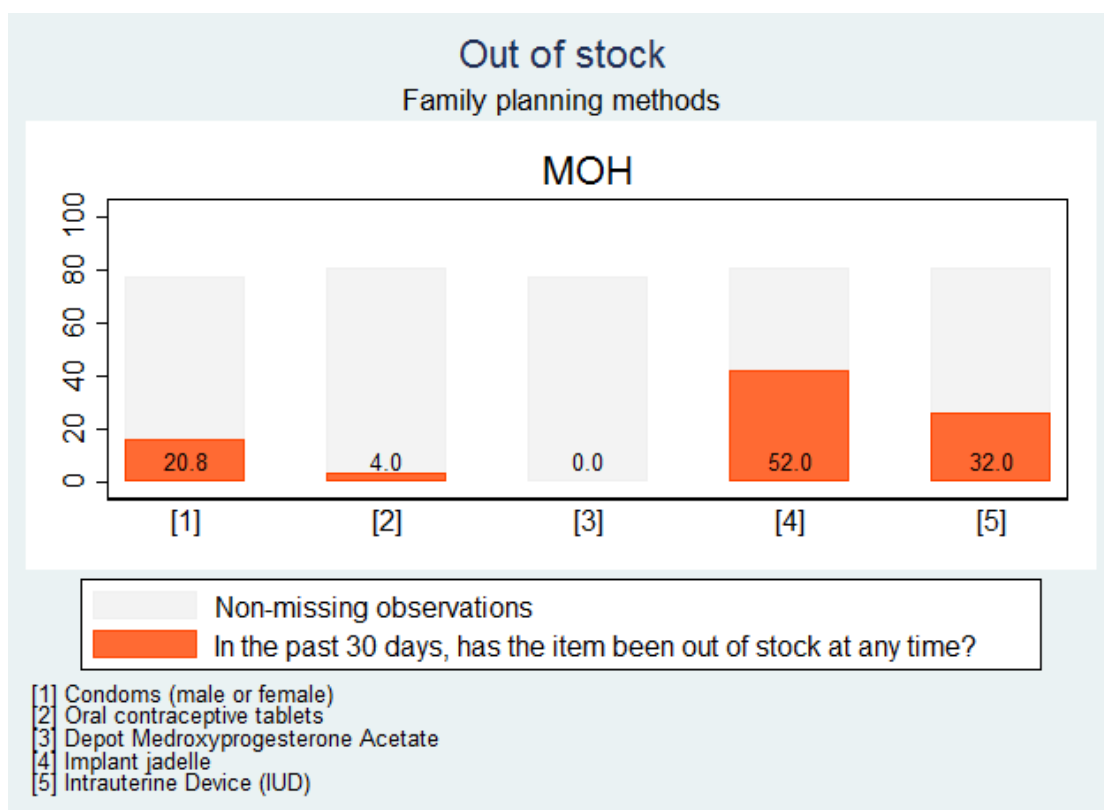


Figure 3-11: Out of Stock – Family Planning Methods

3.7. Equipment

This section shows the level of available and functioning equipment for 1) selected general equipment, 2) selected equipment for ANC, 3) selected equipment for delivery, 4) selected equipment for delivery (intensive care), 5) selected equipment for PNC and newborn care.

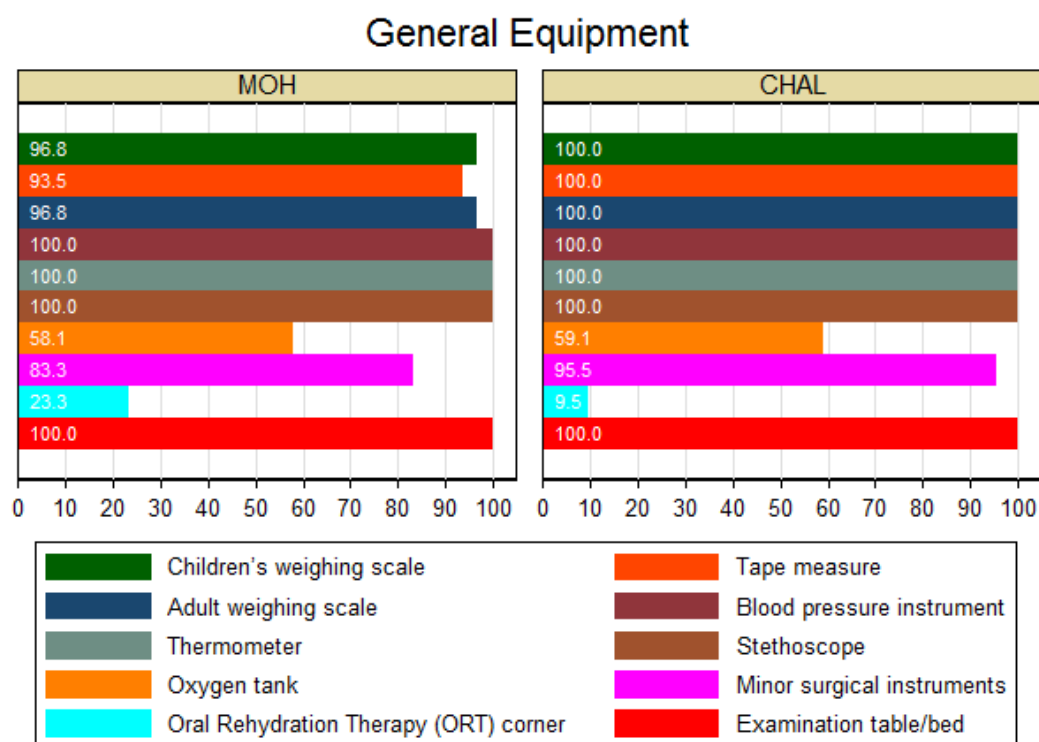


Figure 3-12: General Equipment

Table 3.7.1: Equipment and diagnostic kits - Antenatal Care	MOH	CHAL	All	Missing
Equipment:				
Examination table/bed	100.0	100.0	100.0	0
Fetoscope	100.0	100.0	100.0	0
Blood pressure instrument	100.0	100.0	100.0	0
Tape measure	100.0	100.0	100.0	0
Adult weighing scale	96.8	100.0	98.1	0
Diagnostic kits: Out of stock in past 30 days				
HIV testing kit	39.3	36.4	38.0	3
Pregnancy testing kit	26.9	22.7	25.0	5
Rapid plasma reagin (RPR) test	54.5	55.0	54.8	11
Urine protein & glucose testing kit	36.0	23.8	30.4	7
Sample Size	31	22	53	

Table 3.7.1: Equipment and diagnostic kits - Antenatal Care

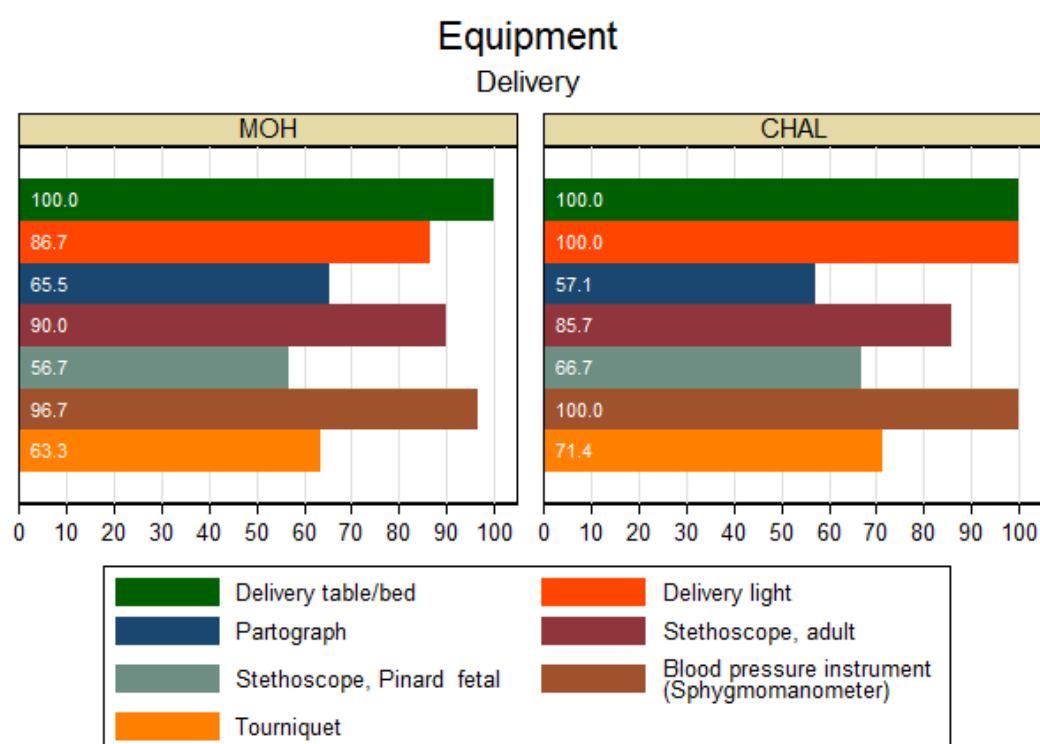


Figure 3-13: Equipment - Delivery

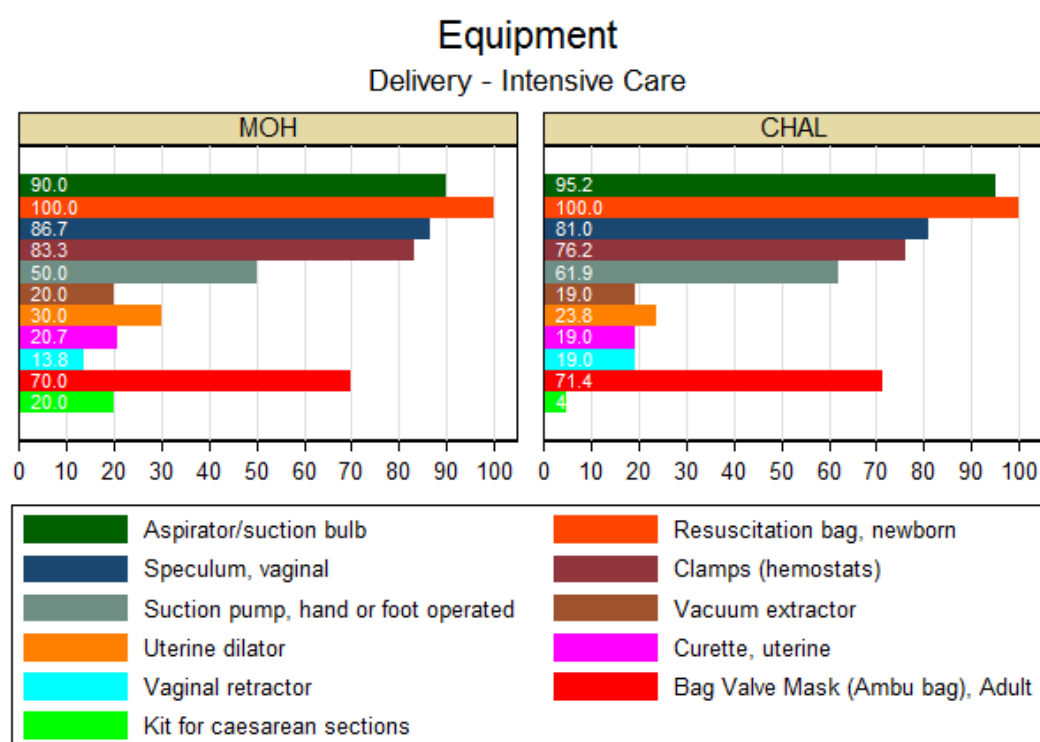


Figure 3-14: Equipment – Delivery (Intensive Care)

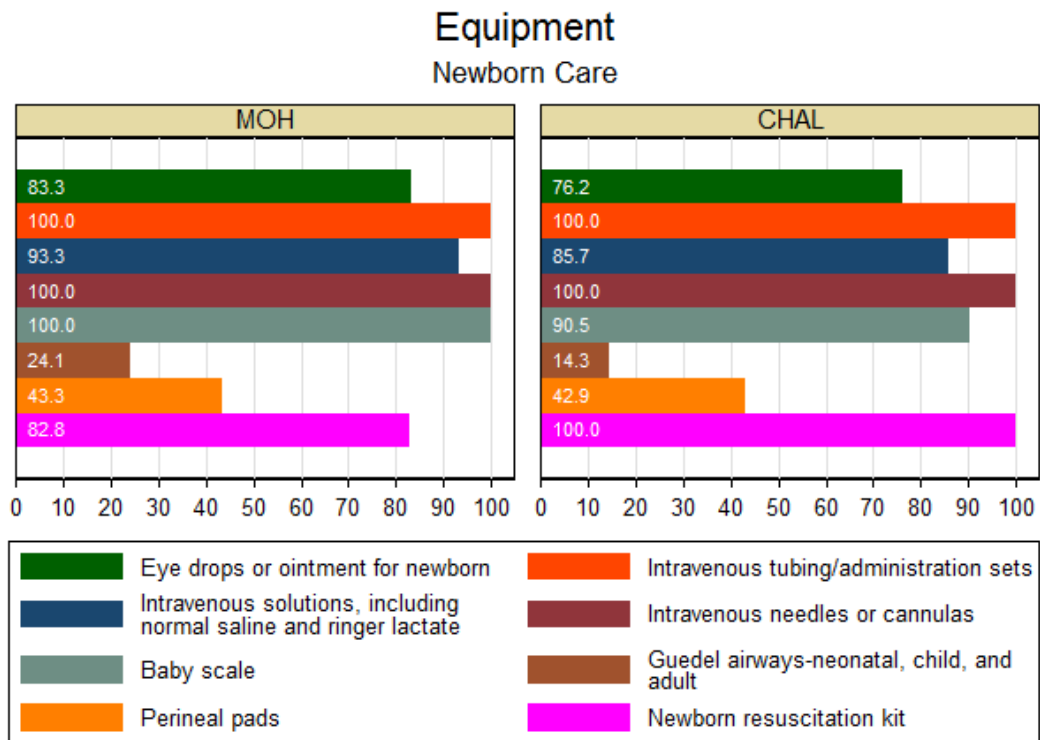


Figure 3-15: Equipment – Newborn Care

3.8. Health Providers

On average, the health centers report having 7.3 authorized positions and 6.5 filled positions. The following figure shows the level by health provider category. Few health centers report having more filled positions than authorized positions for some categories.

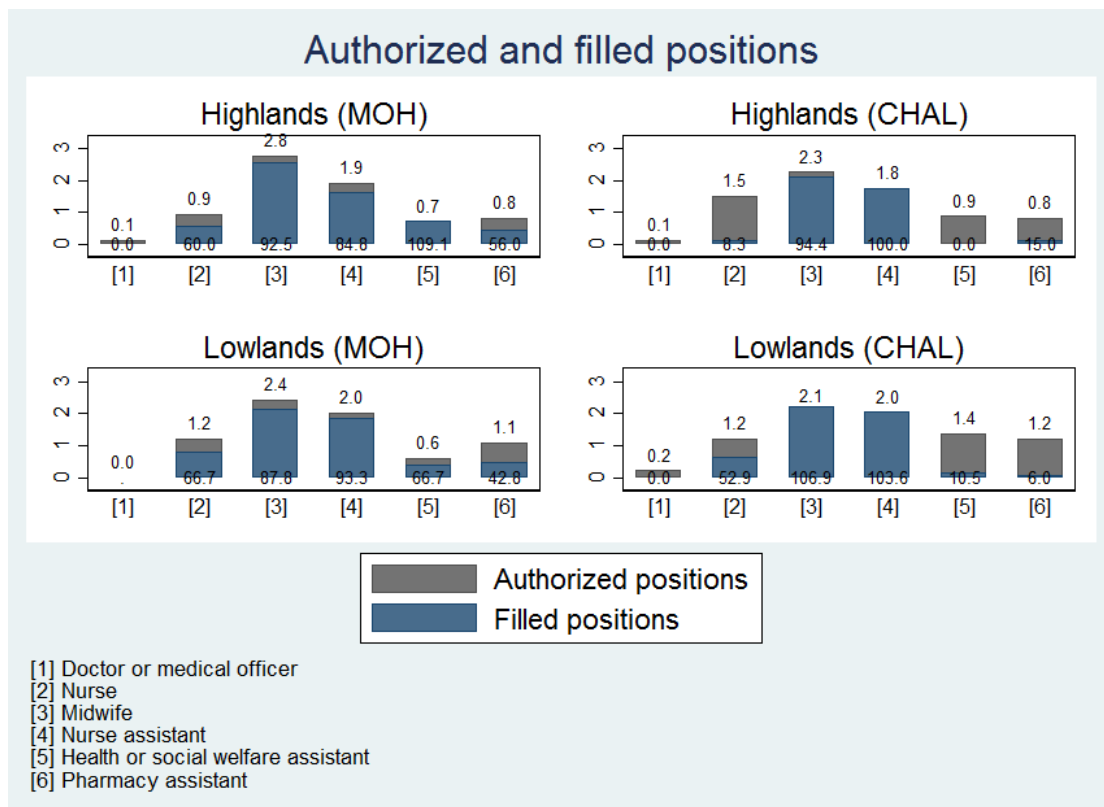


Figure 3-16: Authorized and Filled Position

For each health center, the baseline survey included up to three health provider interviews. Forty-seven percent of these interviews are with a trained nurse or midwife and the remaining 53 percent with a nurse assistant. Based on information from the health provider interviews, the following figure shows the percentages of health providers who have provided (1) curative consultation for children, 2) family planning consultation, 3) ANC, 4) PNC and 5) deliveries in the past 3 months.

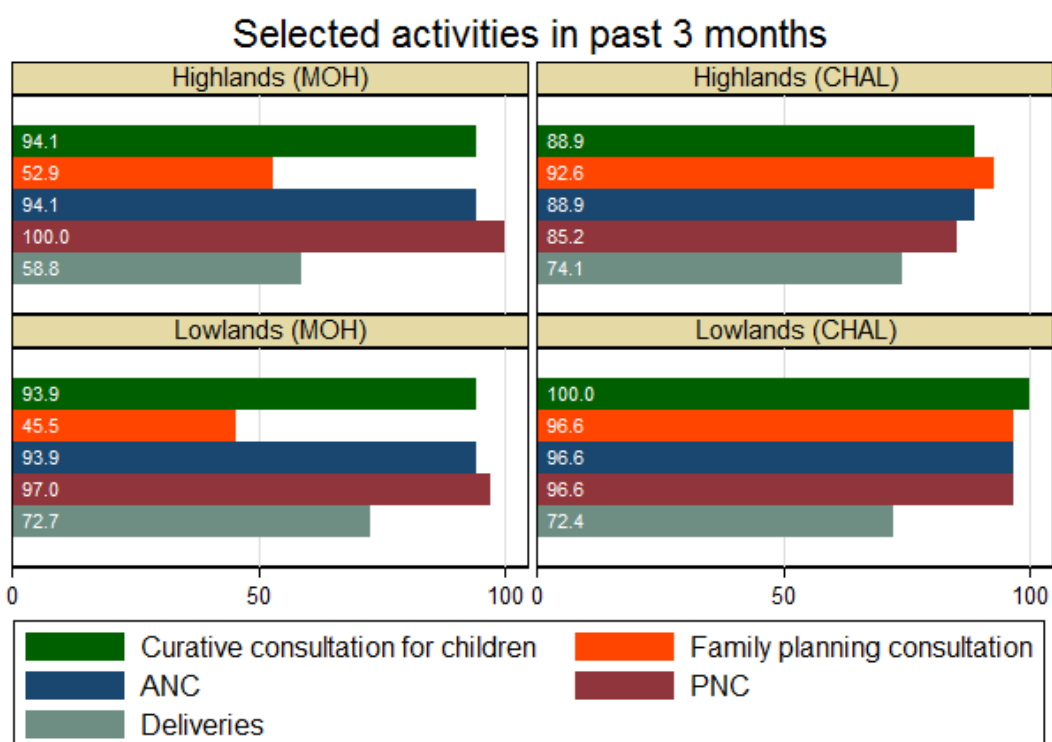


Figure 3-17: Selected Activities in past 3 months

The following figure shows for selected subjects, the most recent time the health provider received in-service training. This training only includes training received after undergoing professional education. The selected subjects are the following; 1) IMCI, 2) Family planning, 3) ANC, 4) Deliveries, 5) Newborn care, 6) PNC, 7) Nutrition and growth monitoring, 8) Immunization.

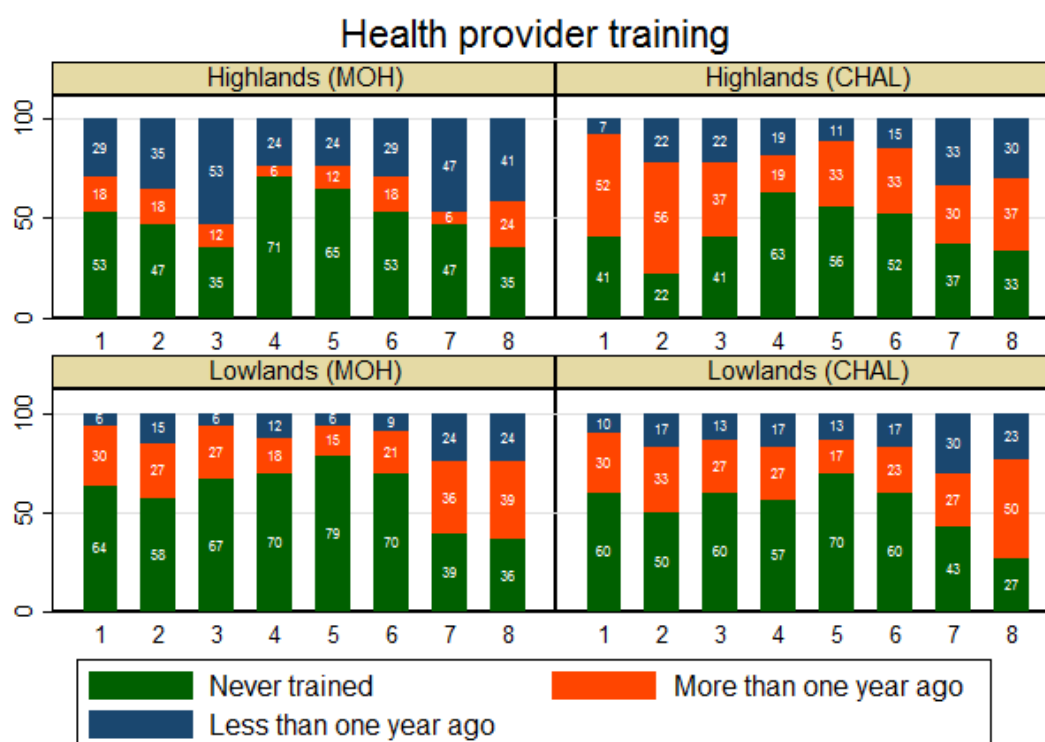


Figure 3-18: Health Provider Training

Staff knowledge:

For the purpose of the health provider knowledge assessment, this report presents four case scenarios; the first three cases assess the health providers' knowledge related to IMCI guidelines in high HIV prevalence settings and case 4 is an ANC scenario. The case scenarios do not ask for the specific diagnosis but for actions and recommendations that the health provider would take in these cases.

In the first scenario the health provider is informed that a 25 months old child with diarrhea and fever has not eaten/drunk since yesterday and has two of the danger signs; she is lethargic and a skin pinch goes back very slowly. The health provider is explicitly told that it is a low malaria area and there is no cholera. In Thaba-Tseka and Mokhotlong, around half of the health providers mention urgent referral to hospital. The level is lower in the districts of Mafeteng and Mohale's Hoek (around 30 percent). Seventy percent of CHAL health providers in the lowlands districts and 81 percent of MOH health providers would start IV treatment. This level is lower in the highlands district. In the Lowlands CHAL health centers, 87 percent of the health providers would initiate oral rehydration salts (ORS) at the facility, followed by 66 percent in Lowlands MOH facilities, 53 percent in Highlands MOH facilities, and 37 percent in highlands CHAL facilities. A little more than 70 percent of health providers in the lowlands prescribe ORS for home treatment, the level in highlands is less than 50 percent.

Case Scenario #1

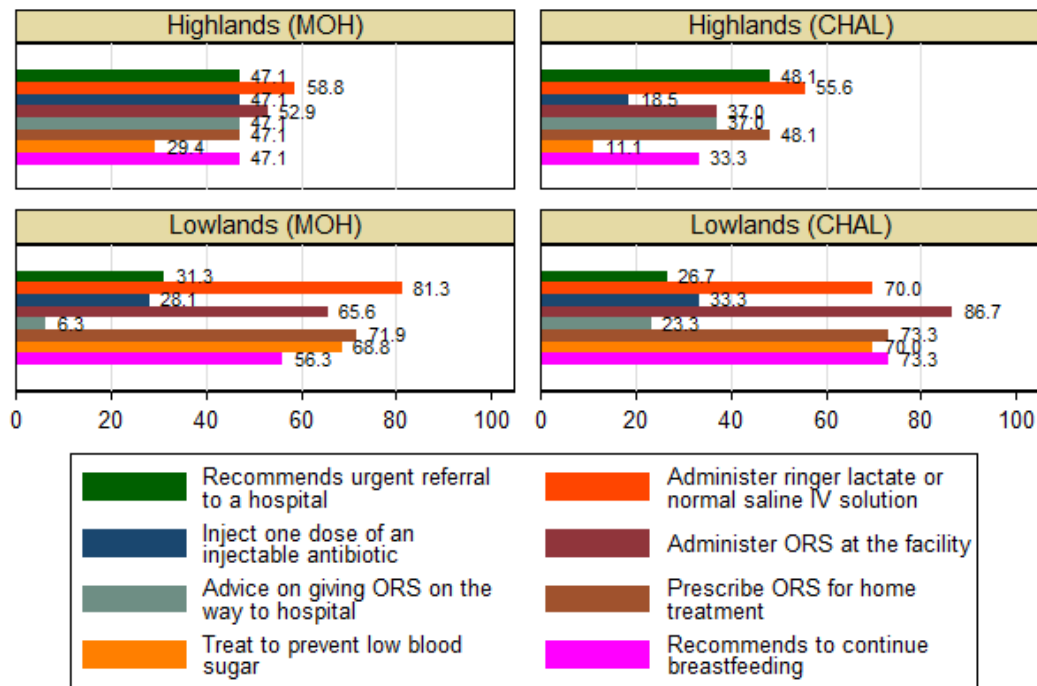


Figure 3-16: Case Scenario #1

The level of health providers that would inject one dose of an injectable antibiotic varies from around 20 percent in CHAL health centers in Thaba-Tseka and Mokhotlong to around 50 percent in MOH health centers in the same districts. . Less than 30 percent of health providers in Thaba-Tseka and Mokhotlong mention to treat to prevent low blood sugar whereas around 70 percent of the health providers in Mafeteng and Mohale's Hoek do that. Health providers who mention that they would recommend continuing breastfeeding is also higher in Mafeteng and Mohale's Hoek compared to Thaba-Tseka and Mokhotlong.

The second case presented is of a 29 months old with fever and ear discharge. There is no other symptom or malaria in the area. Assessment of the child confirms the fever and reveals a stiff neck and an area of tenderness behind the right ear. More than 90 percent of health providers in MOH and around 85 percent of health providers in CHAL prescribe or administer antibiotic. Overall, 44 percent would refer urgently to a hospital.

Case Scenario #2

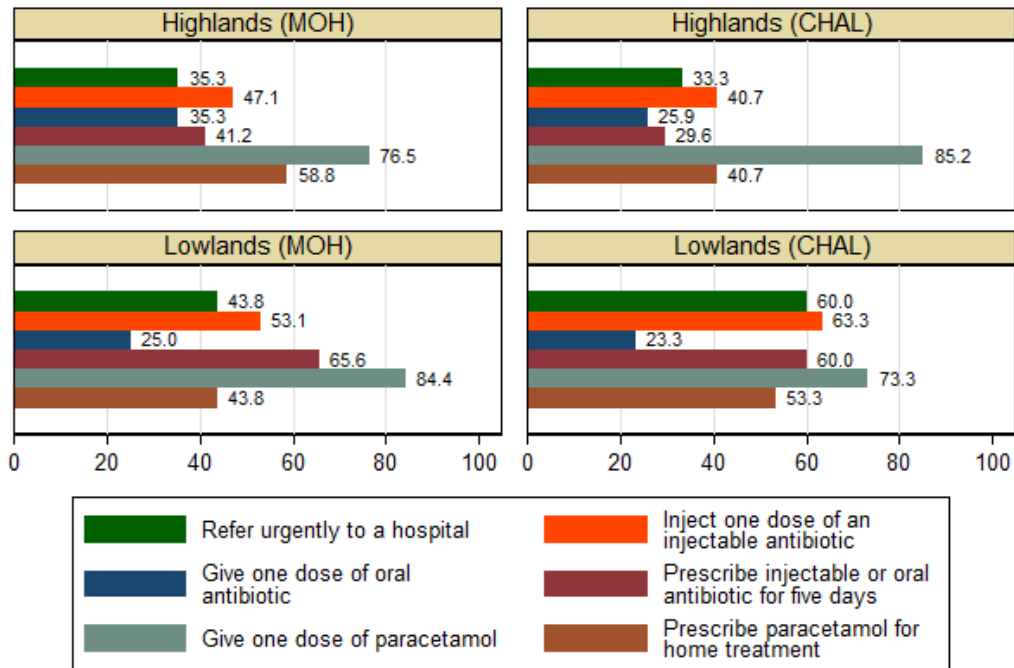


Figure 3-17 Case Scenario #2

In the third case, the health provider are informed that a 13 months old child has been coughing for 5 days (no stridor or wheezing) and had fever since last night. The assessment confirm 38.8°C and shows fast breathing and chest in-drawing.

Case Scenario #3

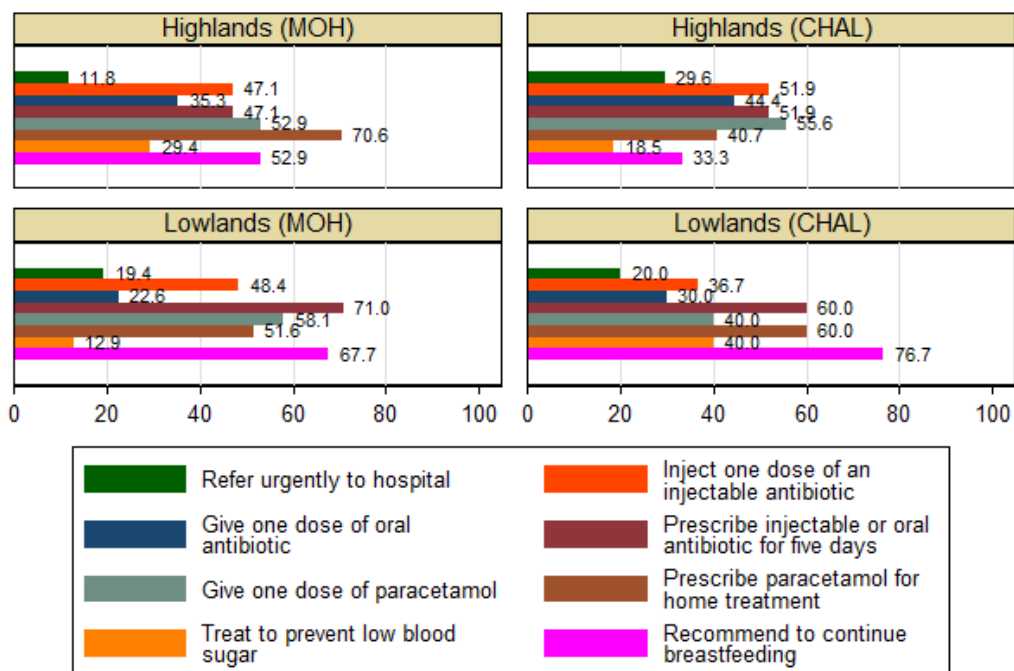


Figure 3-18: Case Scenario #3

The ANC case scenario is a 30-week pregnant woman who has attended the antenatal clinic three times. All findings were within normal limits until her last antenatal visit in the prior week. At that visit, it was found that her blood pressure was 130/90 mm Hg., her urine was negative for protein. The fetal heart sounds were normal, the fetus was active and uterine size was consistent with duration of the pregnancy. She has come to the clinic, as requested, for follow-up.

The following figure shows the danger signs mentioned by the health provider that requires the woman to go immediately to the hospital or health center. The majority of the health providers recognize vaginal bleeding, severe headache, blurred vision, lightheadness, dizziness, and blackouts as a danger sign. In Mafeteng and Mohale's Hoek convulsions is also mentioned as a danger sign by 75 percent of health providers in MOH health centers and 67 percent of CHAL health centers. Convulsion is only mentioned by around 40 percent of the health providers in Thaba-Tseka and Mokhotlong, which is fewer than providers mentioning abdominal pain or to feel ill as a danger sign.

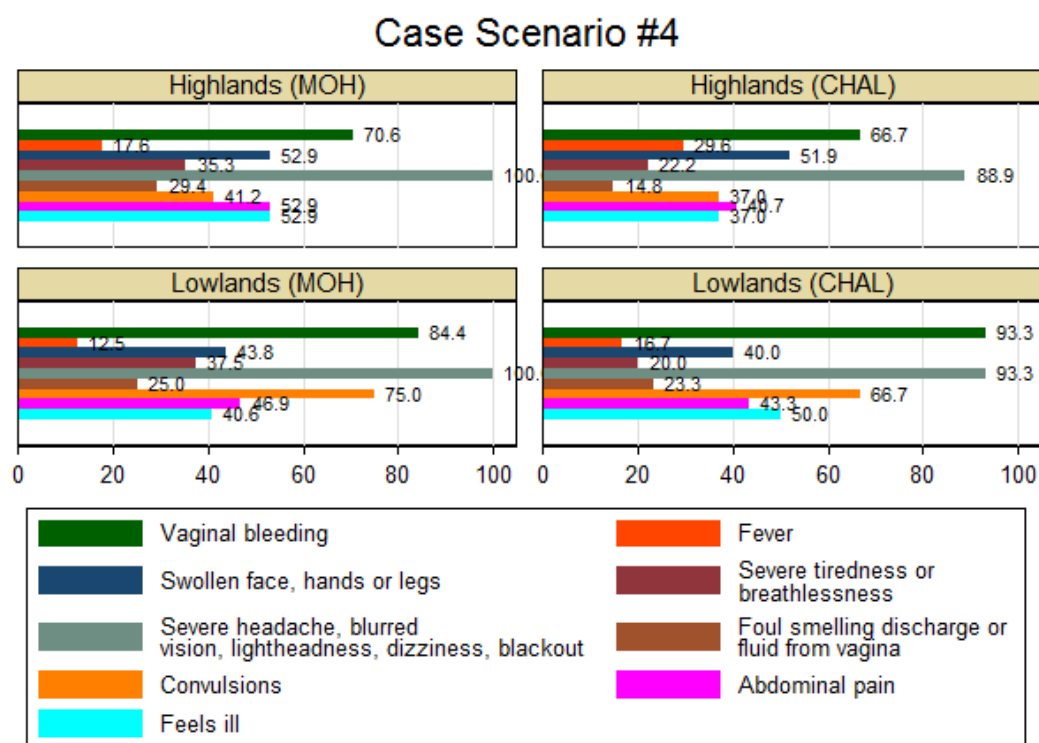


Figure 3-19: Case Scenario #4

3.9. Exit Interviews

For each health center, the baseline survey included two exit interviews with women who went for ANC and two exit interviews with caregivers of children less than 5 who visited the health center at the day of interview. Half of the ANC sample is a first time visit while 1 out of 3 children is a first time visit for that particular illness. In 91 percent of the child sample, the mother took the child to the health center. All interviewed women and caregivers report to have their or their children's Bukana with them to the health center (98 percent is confirmed by the interviewer).

ANC:

The Tetanus Toxoid (TT) vaccine is given during the pregnancy to prevent the risk of tetanus for mother and baby. According to the Bukana, 50 percent of the women has a record of one tetanus injection and 47.1 percent has a record of two or more injections. This leaves 2.9 percent with no record, with the highest level of no injection in Mokhotlong (5.9 percent) and the lowest level in Mafeteng where all women have at least one record of an injection. When the women are asked about TT injections, 7.6 percent report that they never had an injections and 34 percent report that the health provider did not ask about TT injections. Only 34 percent of the Bukana mention the women's blood group.

The following figure shows some indicators for content of care for ANC as reported by the women in the exit interview. Most women report to have their weight and height measured and to have their blood pressure measured. Few women were asked about their blood type, however most women gave a blood sample.

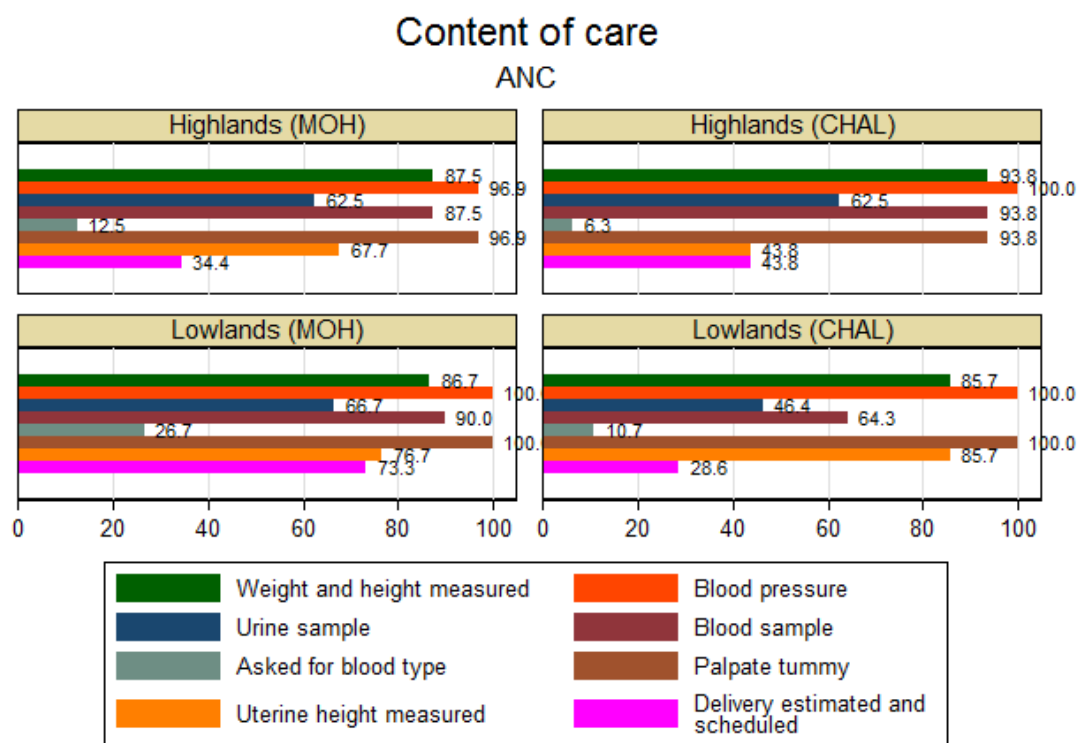


Figure 3-20: Content of Care - ANC

The exit interview also asks the women if the health provider talked with them about danger signs for the pregnancy. 30 percent of the women report that a health provider did not inform about danger sign, neither at this visit nor at previous visits. The exit interview also asks the women to mention the danger signs that they know of. The following figure shows the level of awareness of danger signs in pregnancies. Vaginal bleeding is the most commonly cited danger sign with 64 percent of the women mentioning it.

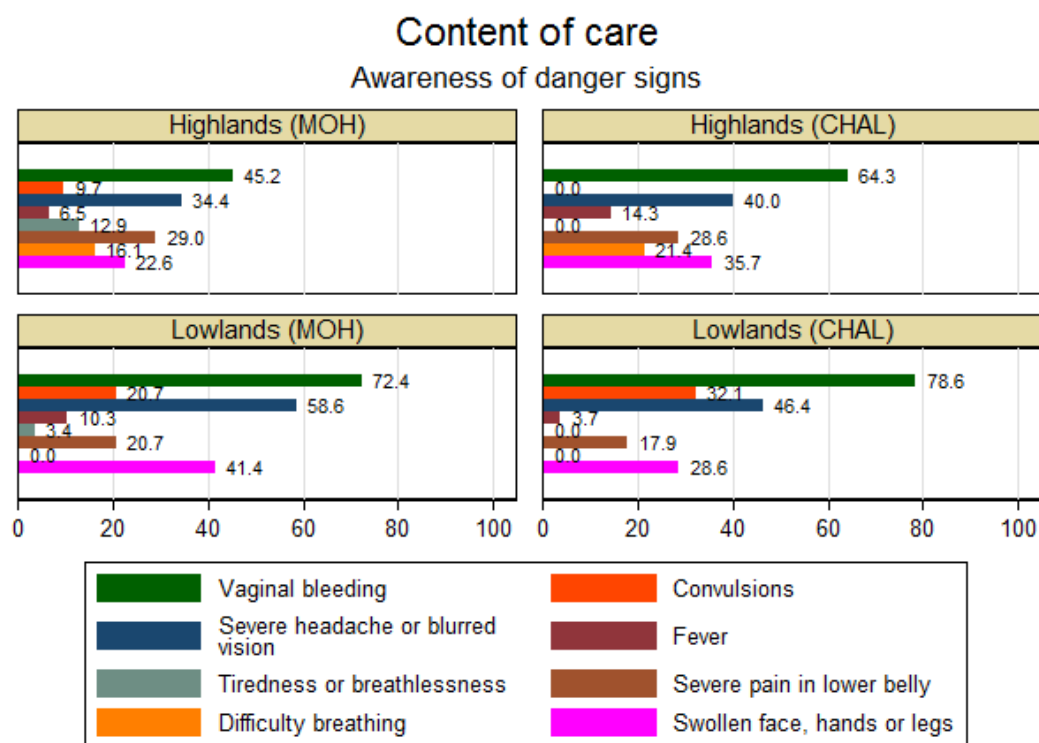


Figure 3-21: Content of Care – Awareness of danger signs

Overall, 57 percent of the women discussed family planning methods with the health provider during their ANC visit. The following figure shows the family planning methods discussed where the numbers refer to; [1] Sterilization (male or female), [2] Injectables, [3] Implants, [4] Contraceptives pill, [5] Condoms (male or female), [6] other modern method, and [7] any traditional method.

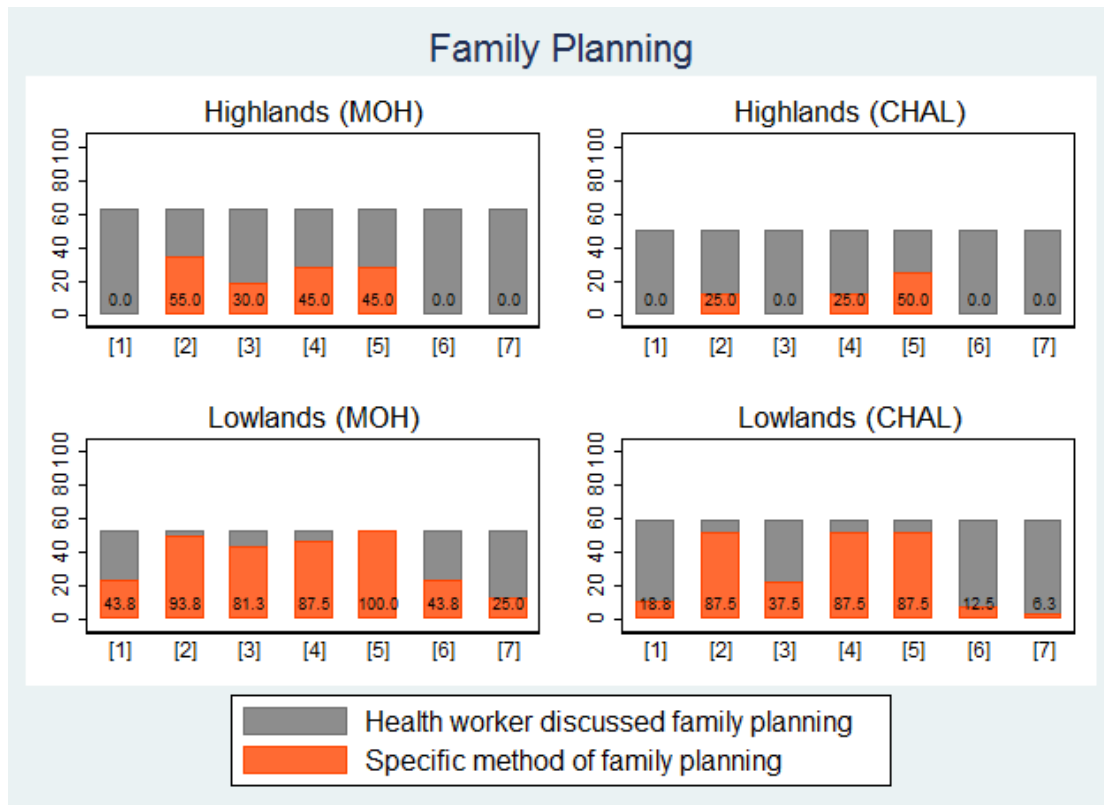


Figure 3-22: Family Planning

Child Care:

The following figure shows some indicators for content of care for the child sample as reported by the caregiver in the exit interview. 72 percent of the children were weighed whereas only 41 percent had their height measured. 70 percent of the children either had their weight or height compared against a growth chart.

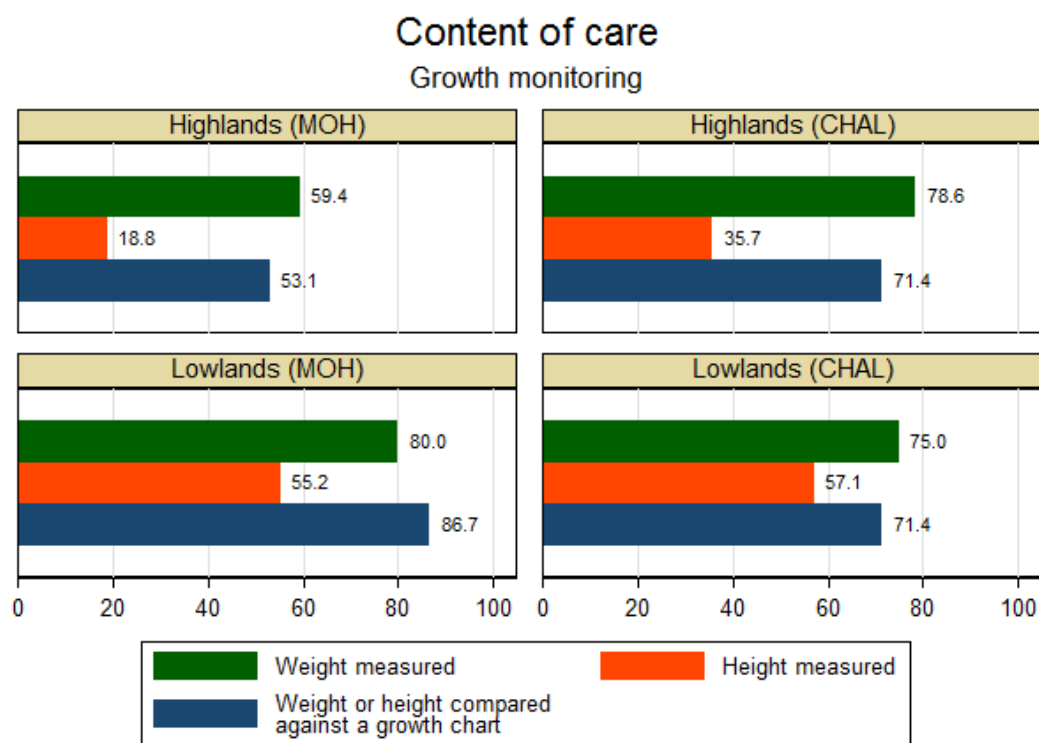


Figure 3-23: Content of care – growth monitoring'

The exit interviews includes 24 children aged 12-23months. According to the Bukana, they all received the BCG vaccine, Polio 0, and 3 doses of pentavalent.

Time and satisfaction:

The most time consuming aspect of visiting the health center is the transportation. On average, the patients that participated in the exit interview spent one hour and 40 minutes on transportation. The worst situation is in Mokhotlong where the patients spent more than 2 hours on average to get to the health facility. 88.6 percent walked to the health center and 6.6 percent took a public bus. On average, the waiting time at the health center was one hour and 20 minutes. The longest waiting time is in Mafeteng where patients waited on average two hours for their consultation. Despite the long waiting time in Mafeteng, the consultation time was on average less than 10 minutes. In Mohale's Hoek that has the shortest waiting time (one hour) the consultation took the longest (17 minutes).

On average, patients spent more than half an hour longer to get to a MOH health center compared to CHAL, and the waiting time was also around 10 min longer. Average consultation time is 13 minutes for both types of facilities.

In the interview, the patients/caregivers were asked if they thought the waiting time was too long. Forty percent agreed with this statement (data not shown).

Table 3.9.1		By type		By district				All
		MOH	CHAL	Thaba-Tseka	Mokhotlong	Mafeteng	Mohale's Hoek	
Time								
	Transportation time	114	78	109	160	58	86	100
	Waiting time	86	77	67	103	122	66	83
	Consultation time	13	13	12	10	9	17	13
Important reasons to choose this health center								
	Location close to home	84.7	97.6	89.1	73.3	96.8	92.3	90.0
	Trust in providers / high quality of care	26.6	27.1	10.9	26.7	41.3	28.8	26.8
	Availability of drugs	5.6	5.9	1.6	3.3	11.1	5.8	5.7
	Other	6.5	2.4	4.7	13.3	0.0	5.8	4.8
Sample Size				64	31	64	52	211

Table 3.9.1: Time and satisfaction

Despite the long transportation time, 90 percent of the patients / caregivers mention location close to home as one of the two most important reason for choosing the health center. This is by far the most common reason provided. A little more than one out of four mentioned trust in providers or high quality of care. The third most common reason is availability of drugs. However, this is only mentioned by 6 percent of the interviewed.

Appendix

Table A.1: Catchment population

District	Catchment area	MOH/CHAL	Catchment Population (HHs) ¹	Estimated HHs w. recent birth ²	Estimated HHs w. an adolescent ³
Thaba-Tseka	Auray HC	CHAL HC	820	132	102
	Bobete HC	MOH HC	3313	900	695
	Ha Lephoi HC	CHAL HC	1130	197	131
	Ha Mokoto HC	MOH HC	1112	215	74
	Ha Popa	CHAL HC	661	141	149
	Katse HC	MOH HC	328	78	53
	Khohlo-Ntso HC	MOH HC	928	78	49
	Linakeng HC	MOH HC	979	204	87
	Manamaneng HC	MOH HC	1179	191	247
	Methalaneng HC	MOH HC	1530	353	176
	Mohlanapeng HC	CHAL HC	1495	316	173
	Montmartre HC	CHAL HC	1662	496	248
	Sehong-Hong	MOH HC	1158	269	181
	Semenayane	MOH HC	1571	321	304
	St Theresa HC	CHAL HC	1696	484	142
	Thaba-Tseka HC	MOH HC	1459	267	222
	All		21,021	4642	3033
Mokhotlong	Libibing HC	MOH HC	1740	427	333
	Linakaneng HC	MOH HC	1077	375	351

	Malefiloane HC	MOH HC	2470	582	456
	Mapholaneng HC	CHAL HC	4434	1338	1029
	Moeketsane HC	MOH HC	1133	217	190
	Molikaliko HC	MOH HC	3010	1060	721
	St James HC	CHAL HC	1498	786	504
	St Martin HC	CHAL HC	1014	206	192
	Tlhanyaku HC	MOH HC	2787	876	617
	All		19,163	5867	4393
Mafeteng	Emmaus HC	CHAL HC	3141	906	509
	Kole HC	CHAL HC	2645	684	476
	Leco-op HC	MOH HC	6152	1483	989
	Litsoeneng HC	MOH HC	4832	1232	900
	Malea-Lea HC	MOH HC	685	174	98
	Masemouse HC	CHAL HC	1088	422	218
	Matelile HC	CHAL HC	2813	414	301
	Motsekuoa HC	CHAL HC	2514	735	580
	Mount Olivet HC	CHAL HC	1515	585	210
	Mount Tabor HC	CHAL HC	1394	449	272
	Ribaneng	CHAL HC	1217	416	223
	Samaria HC	CHAL HC	4513	2310	1075
	Sekameng HC	MOH HC	1869	578	372
	St Andrew HC	CHAL HC	960	323	333
	Thaba Tsoeu HC	MOH HC	1874	457	571
	Thabana-Morena	MOH HC	2073	777	379
	Tsakholo HC	MOH HC	3851	1180	870
	All		43,136	13125	8376
Mohale's Hoek	Bethel HC	CHAL HC	507	152	65
	Holy Cross HC	CHAL HC	2873	613	473

	Kuebunyane HC	MOH HC	2017	431	327
	Liphiring HC	MOH HC	689	139	67
	Lithipeng HC	MOH HC	2863	404	439
	Mofumahali Oa	MOH HC	3287	430	635
	Mohalinyane HC	MOH HC	1253	485	260
	Mootsinyane HC	MOH HC	1199	179	217
	Morifi HC	MOH HC	2356	424	224
	Mpharane HC	MOH HC	4087	719	474
	Nkau HC	MOH HC	3166	881	441
	Nohana HC	MOH HC	5243	921	1121
	Phamong HC	MOH HC	1282	210	234
	Ha Tsepo HC	CHAL HC	3444	964	827
	All		34,266	6952	5804
Total			117,586	30,586	21,606

Table A.1: Catchment population

1) Catchment population calculated from 2006 population census. 2) Estimated number of households with recent birth is calculated as number of households times the estimated share of households with recent birth (information from listing). 3) Estimated number of households with an adolescent is calculated as number of households times the estimated share of households with an adolescent (information from listing).

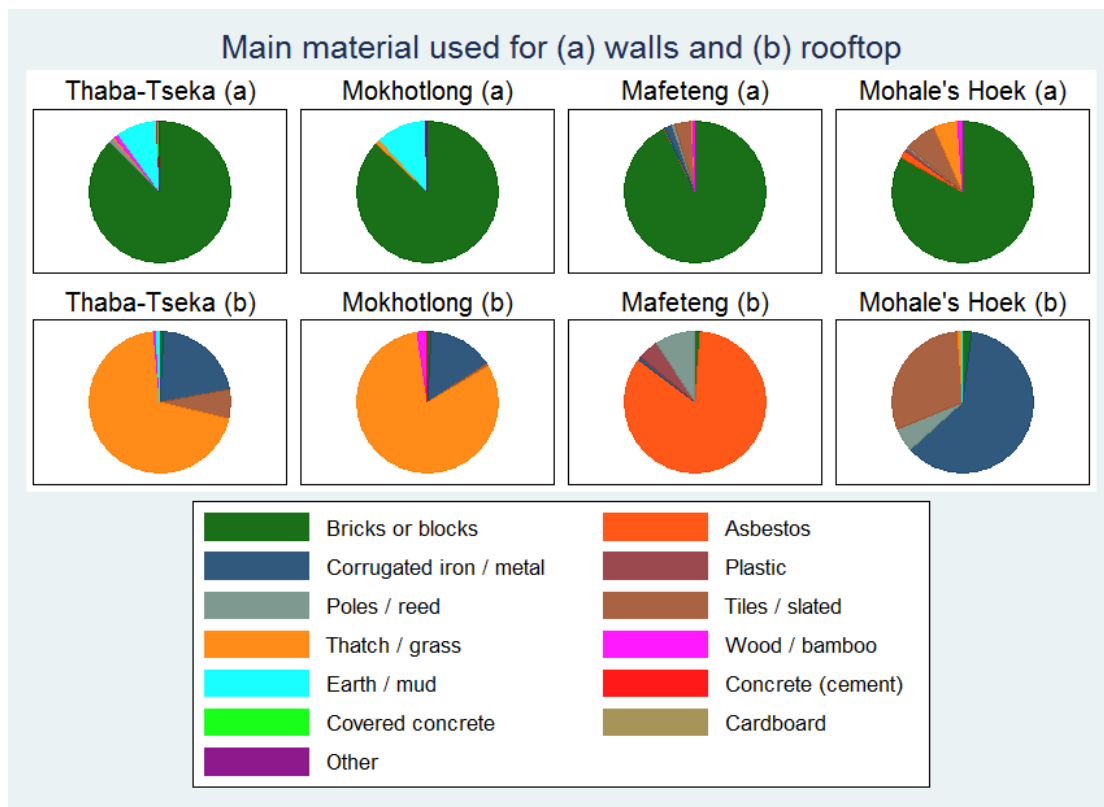


Figure A-0-1: Main material used for (a) Walls and (b) Rooftop

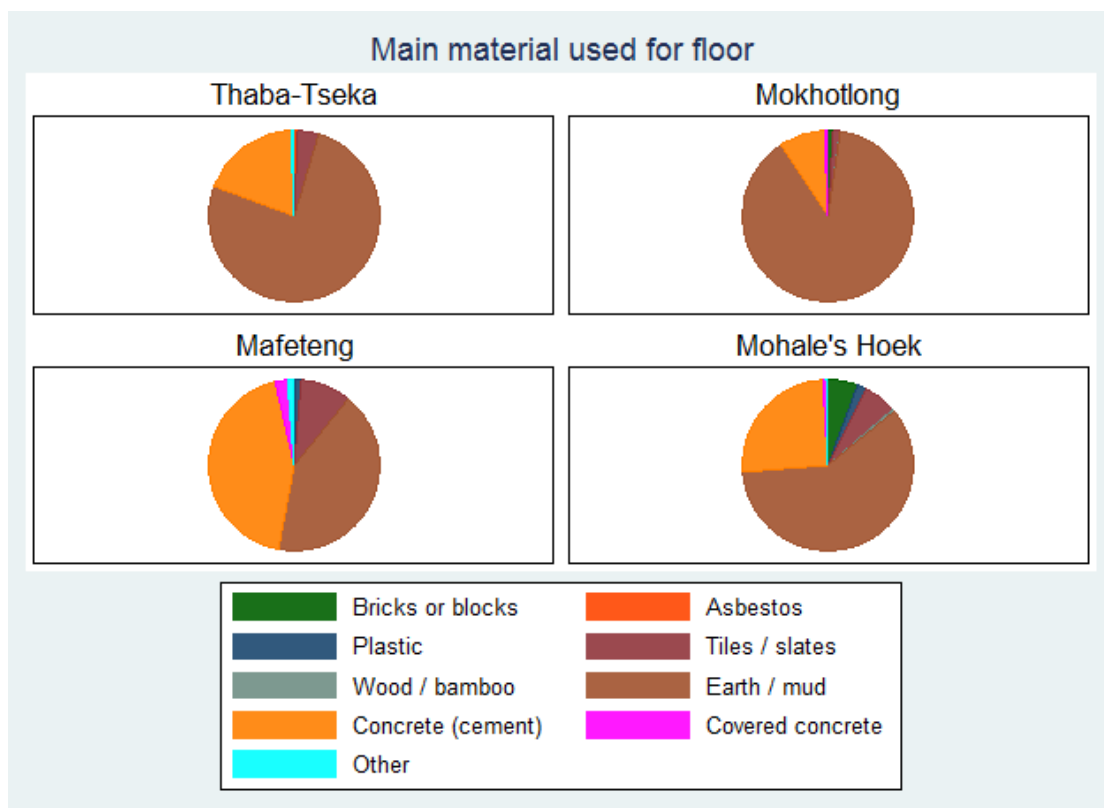


Figure A-0-2: Main material used for Floor

Table A.2: Housing characteristics across Wealth Quintiles		1 st	2 nd	3 rd	4 th	5 th
Type of dwelling						
	Traditional hut	27.0	15.1	12.5	7.1	1.6
	Improved traditional hut	4.7	4.5	4.0	3.9	1.5
	Rondavel	41.5	40.3	21.5	11.9	6.0
	Modern house	21.2	34.5	52.9	68.1	84.5
Water source						
	Non-improved and more than 10 min away	9.6	6.5	6.2	8.9	6.2
	Non-improved and within 10 min	8.2	6.1	4.4	2.8	1.8
	Improved and more than 10 min away	24.8	23.9	28.7	23.6	20.3
	Improved and within 10 min	57.3	63.4	60.8	64.8	71.7
Sanitation						
	Non-improved and shared	0.6	2.5	2.7	2.0	4.3
	Non-improved and not shared	1.0	2.4	3.2	5.8	5.3
	Improved and shared	8.5	9.6	11.7	11.5	15.8
	Improved and not shared	89.8	85.4	82.4	80.7	74.5
Material (floor)						
	Bricks or blocks	0.9	1.3	2.2	1.2	2.8
	Tiles / slates	0.0	0.5	1.8	6.1	23.7
	Earth / mud	93.6	84.7	65.7	41.4	14.5
	Concrete	4.7	12.7	27.9	44.8	53.8
Material (roof)						
	Corrugated iron	26.8	42.5	63.4	75.9	73.7
	Tiles / slates	0.5	0.6	2.0	2.9	16.0
	Thatch / grass	71.0	54.3	31.9	19.4	6.2
Material (walls)						
	Bricks or blocks	78.7	88.3	89.6	91.3	94.9
	Wood	4.6	3.5	2.4	0.7	0.3
	Earth / mud	13.2	6.4	6.6	3.9	1.5
Energy (cooking)						
	Kerosene/ paraffin, gas, electricity, diesel	0.6	2.6	12.9	23.8	37.9
	Wood, charcoal	94.1	90.1	74.5	65.0	48.8
	Animal dung, agricultural waste, shrubs/ straws	5.3	7.3	12.5	11.2	13.3
Energy (lighting)						
	Kerosene/ paraffin, gas, electricity, diesel	0.4	0.9	6.9	15.4	30.3
	Wood, charcoal	89.2	87.9	77.1	65.5	50.3
	Animal dung, agricultural waste, shrubs/ straws	10.5	11.2	16.0	19.2	18.3
Selected durable goods						
	Television	0.2	0.3	2.4	15.0	68.0
	Electric stove	0.0	0.5	1.5	5.5	16.6

Bed	21.6	74.7	87.7	97.5	99.1
Refrigerator / freezer	0.0	0.0	0.3	1.9	34.1
Mobile	45.9	65.0	79.1	89.6	96.4
Truck or car	0.0	0.0	0.8	1.2	19.1
Trailer	0.2	0.6	0.8	8.3	27.8
Sample Size	480	448	415	418	359

Table A.2: Housing Characteristics across Wealth Quintiles

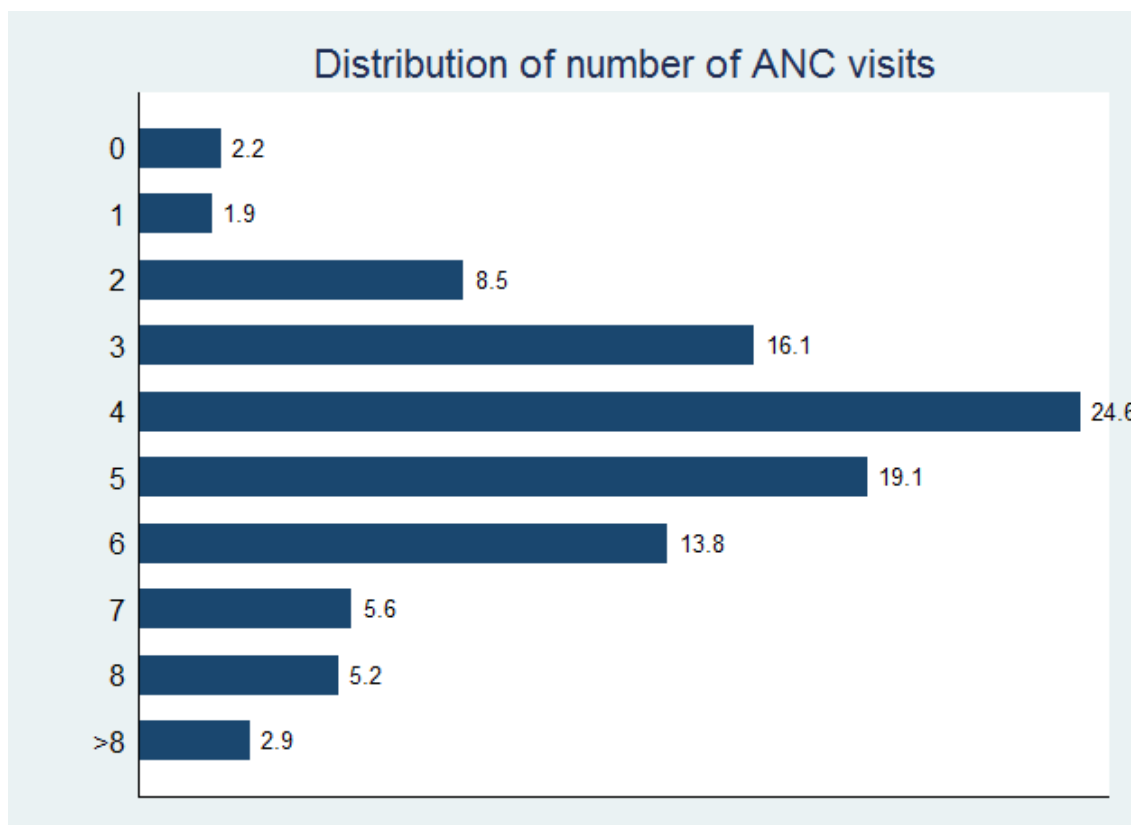


Figure A-0-3: Distribution of number of ANC visits

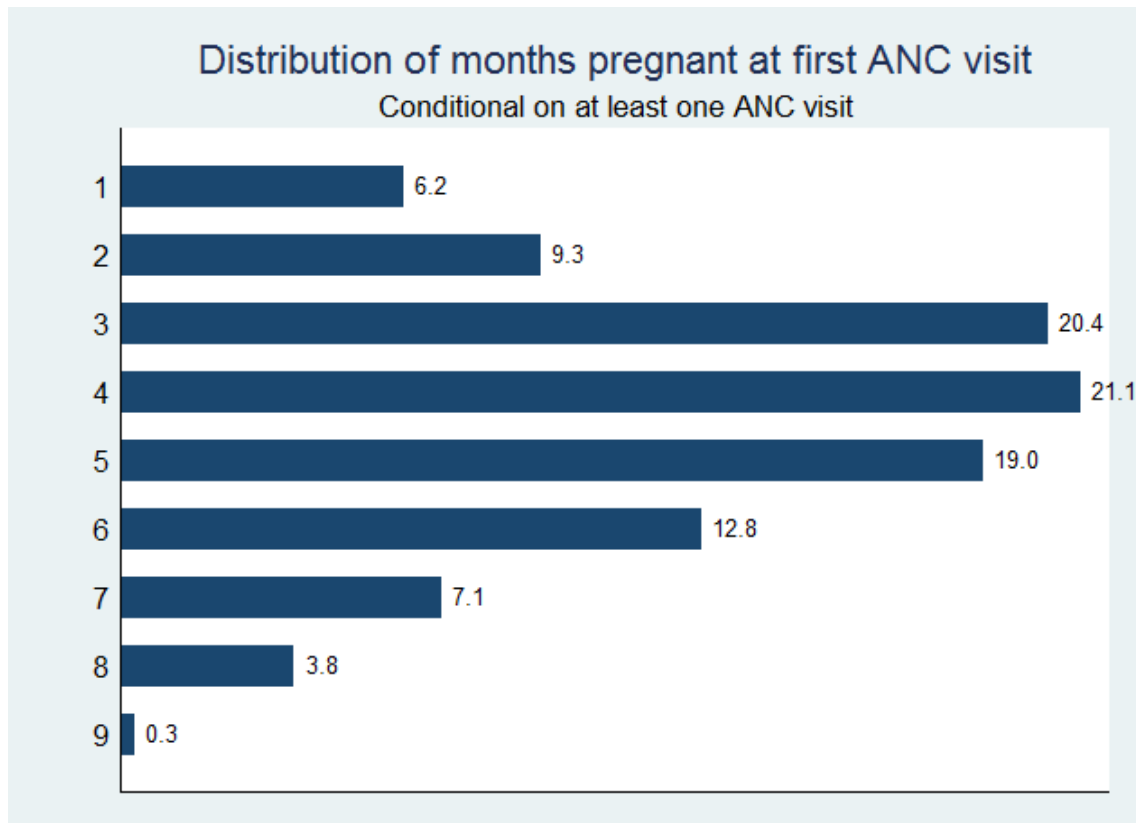


Figure A-0-4: Distribution of months pregnant at first ANC visit