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DECENTRALIZATION AND

PRIMARY HEALTH CARE IN

L E S O T H O

B Y

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POLITICAL AND ADMINISTRATIVE STUDIES

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Decentralisation and Primary Health Care in Lesotho

By Malcolm Wallis.

Introduction

In the 1960's there arose a growing awareness among those concerned with health in the less developed countries that existing programmes were doing little to improve the lives of the majority of the populations of these countries. The World Health Organisation (WHO) played a major role in this rethinking process, out of which the PHC concept emerged. At a WHO conference in 1977 a set of general principles were specified for application to the African region. Stress was placed on meeting "the real needs of the community", on integration of health with other aspects of rural life (e.g. agriculture, public works), on communication between communities and providers of services, and on cooperation with traditional medical systems.[1] Essentially, then, PHC means bringing health care closer to the majority of the population.

Putting PHC into practice is rather more difficult than stating a set of principles. For example, it is far from always easy to establish the nature of the "real needs of the community". This does not necessarily require high powered research teams going from village to village armed with tape recorders and Land Rovers. What is needed, however, are officials (at a variety of levels) who are aware of the nature of the communities being served and who possess the practical skills to draw realistic conclusions from such information as they may be able to gather. There are thus quite substantial implications for the kind of work to be done by medical staff posted to the rural areas. Secondly, integration of PHC into the national health system is not a simple matter. Here the problems centre on inequalities of access which often exist. The basic issue is that health systems tend to be biassed towards high costs and curative medicine, biasses which militate against the improvement of services for most people. This is, of course, not only a matter of economics but also concerns political influences on health policy.

PHC and Health Planning in Lesotho

The development of a PHC strategy in Lesotho is quite a new phenomenon. A network of influences have been at work over the last three or four years. In this connection, the role of various donors should be noted. In 1977 the Lesotho government signed an agreement with the United States Agency for International Development (USAID) to establish a "Rural Health Development Project".

At a subsequent "Workshop" at which possible strategies were examined, other donors (notably WHO) played a considerable role, which involved a strong advocacy of PHC. The donors have thus had the effect of strengthening the position of those within the Lesotho health system who support similar ideas. Also impotant in the formulation of strategy has been the mission sector (eight of the country's seventeen hospital are mission run). Over recent years, this sector has employed doctors (invariably expatriates) with sole responsibility for PHC (i.e. they have been expected to spend most of their time working in the clinics and villages away from the hospitals themselves). In 1975 the missions came together to form the Private Health Association of Lesotho (PHAL) and this developed into a lively pressue group. In 1977 PHAL produced a detailed report in which it argued that the "private" (i.e. mission) sector should play a major role in the evolution of the country's PHC programme.[2]

A 1978 workshop brought together a variety of elements in the health system with the purpose of contributing guidelines for the making of policy[3]. Out of a total of about 200 participants, some 27 came from PHAL institutions and 69 from the Ministry of Health. The balance came from a number of other ministries which undertake health related activities (e.g. Agriculture, Rural Development), from locally based non-government agencies (e.g. Catholic Relief Services) and from among the "traditional healers". The report of the workshop indicates a measure of consensus about future directions to be taken by the health system. Major objectives included reducing the incidence of the main communicable diseases (especially TB, Gastro-Enteritis, Polio and V.D.), increasing immunisation coverage, reducing infant and child mortality rates, increasing maternal and child Health coverage (MC), establishing a control programme for alcoholism and introducing a home follow up system for mental illness. To achieve these objectives other measures were thought to be required: improved coordination (both within and between ministries); improved linkages with traditional healers, improved planning and administrative capacity in the Ministry of Health; improved physical communication (e.g. radio, roads); improvements in staff welfare; standardisation of clinic staffing; more employment of Public Health Nurses and Health Inspectors; considerably intensified building of clinics; more emphasis on PHC in training health personnel, increases in community awareness of PHC, particularly through health education;

3/.... increased

increase nutrition; better water supply and sanitation; and the reduction of migrant labour by increasing employment opportunities[4]. This somewhat long and rambling list obviously contains some items not directly connected with PHC (e.g. labour migration), but presentation here does give some idea of the direction being taken.

Decentralisation

There are a number of ways in which the adoption of the PHC strategy implies the taking of measures to decentralise government operations. Prior to a discussion of this point, two general issues should be noted. First, the distinction between deconcentration (decentralisation of administrative or bureaucratic powers) and devolution (decentralisation of some legislative powers for example to local councils)should be borne in mind. PHC does not necessarily imply the adoption of both these approaches, and indeed in Lesotho there is no devolution at all, the district councils having been abolished soon after independence. Thus, decentralisation in the Lesotho case is likely to be much more a matter of deconcentration rather than devolution. The most that is likely to occur is the creation of various channels of community participation of an advisory kind; and this has a slight relation to devolution. Secondly, in decentralisation perhaps the most difficult exercise concerns finance. It seems to be particularly difficult to establish the right balance between central government policy and the free play of local initiative as far as finacne is concerned. The nature of the relationship between the centre and the district can easily lead to budgetary disaster. Decision makers involved in planning for decentralisation may be haunted by the fear that this kind of catastrophe will happen. It thus becomes of some importance to work out the most appropriate balance, always bearing in mind the various constraints which exist.

These rather general having been made, we can turn to a detailed analysis of the various ways in which PHC implies decentralisation. There is no doubt that influential (if not decivive) decision-makers in Lesotho's health sector are agreed that PHC is not possible without some move towards decentralisation.

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A few interviews may be referred to in order to bear this out. One doctor at a mission hospital argued that it was vital that there be "real decentralisation"; even if this meant "mismanagement here and there" it would still be preferable to the present system. Officials in the Ministry of Health, both professionals and administrators, took the view that the present system was "over-centralised" and that PHC implied decentralisation, more or less by definition.

Such general statements may be made more concrete by reference to a number of examples. First, PHC implies a close knowledge of the conditions under which communities actually live. This certainly means more than knowing something about the "cases" which find their way to the district hospital. PHC suggests a much more preventive emphasis than this, implying much more community work than is usually the case in western medicine[5]. It is difficult to see how this kind of work can be done if expertise is concentrated in a central place and not brought into closer working knowledge of the needs and problems of rural communities. For example, to draw up district health plans without considerable knowledge of the various communities in the districts can only be a highly superficial exercise. Thus, PHC suggests a shift in the location of expertise within a country - another way of saying that some form of deconcentration is needed.

Secondly, it seems clear that the power to spend needs to be decentralised to some extent for PHC to work. It is not realistic to expect administrators in the capital city to have the detailed knowledge to enable them to make optimal decisions affecting people in the districts. Provided that suitably qualified personnel can be placed away from the centre, it is certainly advantageous for some financial decisions to be taken in the districts (or whatever). Decentralisation may also ease the frustration associated with slowness in releasing funds by the centre.

Thirdly, PHC has to utilise personnel in such a way that the villages are adequately covered, highlighting the role of "auxiliaries" or "paraprofessionals" and /or village level workers, who may not necessarily be paid at all. Personnel of this kind require supervision and this, in effect, suggests the necessity of a measure of deconcentration. It may be said that adequate supervision by, say, a district medical officer should both motivate and

5/.... control

control personnel. This is virtually impossible if central control prevents the exercise of discretion by the supervising officer. It would seem that for PHC to succed the administrative styles and structures have to be of a kind to encourage the exercise of discretion in supervising subordinates. The encouragement of initiative on the part of lower level workers in the health hierarchy is in itself an important dimension of decentralisation, and is linked to PHC. The exercise of this initiative cannot normally be encouraged within a highly centralised administrative system.

Finally, PHC implies a measure of community participation. It is hard to see how PHC can succed as a strategy otherwise because (a) it is supposed to be based upon needs expressed by communities theselves and (b) it may require a substantial element of self help on the part of communities (e.g. in the selection of one of them to become a volunteer health worker or in the building and / or maintenance of a clinic). If everything is dependent on decisions emanating from a remote central bureaucracy success seems most unlikely.

Enough has now been said to establish that PHC is (whether implicitly or explicitly) a strategy involving a decentralised approach to health care. Expressed somewhat rhetorically, PHC means taking improved health care to the villages. For this to be done effectively, some sort of administrative reorganisation is required and this seem to suggest among other things - a move in the direction of decentralisation.

Existing administrative arrangements

We have already indicated that the delivery of health care is by no means exclusively a state activity. The majority of the rural clinics are run by various private organisations, of which the main ones are the Roman Catholic and Lesotho Evangelical Churches. This fact has, of course, considerable consequences for planning since it means that historically the allocation of facilities has not been purely a matter of health factors but also a function of the often competing interests of the two main churches in the country. Because of considerations such as these, our discussion of present arrangements must pay some attention to the mission (or " private ") sector.

6/.... State

State responsibility for health care is vested in a Ministry of Health, headed by a Minister who represents the Ministry in Cabinet and in the National Assembly. The senior civil servant in the Ministry is its Permanent Secretary. Until recently a large number of officials reported directly to him (one consultant estimated that there were eighteen). Among them were the deputy P.S, the Chief Matron, two senior medical officers of health (one for public health, one in charge of the central hospital in Maseru), and the district medical officers (all of whom are doctors). Most of these officers have responsibilities linked to the decentralisation to health care. The deputy P.S, for example, has authority delegated to him to control the ministry's finances. He thus is responsible for making decisions which affect the level of resources available to the different districts. If districts require to incur expenditure on anything except food they must apply to the deputy P.S - a clear sign of overcentralisation. The chief matron has overall responsibility for the nursing services provided by the Ministry. Decisions over such matters as disciplinary proceedings affecting nurses in the districts are the concern of her office.

In addition, mention should be made of the Ministry's Planning Unit. This provides a direct link with donors such as USAID. It is only quite a recent creation having been established in 1976. Prior to that date, all planning for health had taken place in the Central Planning and Development Office, which liaised directly with the Permanent Secretary. This arrangement had not allowed the ministry to make a sufficiently concentrated planning effort, hence the idea of a planning unit. For the past two years, USAID has funded specialists in various fields to assist in building up the ministry's planning capability, with special reference to rural health development[6]. These technical assistance personnel have played a particularly influential role in the steps currently being taken to reorganise the ministry.

In the districts, the key figures are the District Medical Officers (DMOS). Most of them find it difficult to give as much time as they would to the primary health care dimension because of the amount of work to be done at the hospitals where they are based. Communication difficulties also arise in the mountain districts, where some clinics may be a full day's drive (or horseback ride) from the hospital.

7/.... It is only

It is only where a district has more than one doctor that work in the remote areas is possible. However, staffing presents problems here. The Ministry is heavily dependent on expatriate personnel for work in the districts. As of late 1980, very few Basotho doctors were working in the district hospitals and the future supply of foreigners was uncertain. As a result of this unstable staffing position, it is not unknown for districts to be without DMOS for extended periods. For most of 1979, for example, there was no doctor in Mokhotlong, the most remote mountain district. The DMOS are assisted by Matrons and hospital secretaries (only introduced in 1980, to the accompaniment of resistance by some matrons, who felt their positions to be threatened).

Below the level of the government district there is a complex pattern of health provision. Most of the districts contain mission hospitals, some of which are larger than the government facilities. But historically the missions have been less hospital oriented than the government. The vast majority of rural clinics were established by the missions with the R.C. church playing a particularly prominent role. There are also a few run by the Red Cross and by the communities themselves. It is clear that the contribution of the private health providers to PHC can be signficant but in recent years severe financial problems have lowered the quality of service, especially in the clinics. It appears that the exercise of private initiative has not always been very effective, especially as far as the supervision of rural clinics is concerned.

Village Health Workers

Turning to the penetration of the health system below the clinic level, we now examine the village. From 1975 onwards a number of Village Health Workers (VHW) programmes were established, both by government institutions and by the missions. There are now between 250 - 300 VHWS working in various parts of Lesotho;their role in PHC is likely to be crucial. Hitherto, VHWS have operated on an ad hoc basic with little central government direction or planning. For the most part VHW programmes have arisen as a result of uncoordinated local initiatives. An example is the Quthing district where the DMO took the initiative. The programme there began in 1975 with the objective being "to provide preventive services and to increase contact between the health services, i.e. hospital, and the consumer. 7

8/.... Elaboration of

Elaboration of this generalised objective followed and in 1977 the district health team reported more specifically:

" 1) Selection, training and follow up of a volunteer VHW in a village. This volunteer is responsible for case finding, referral and follow up of patients.

2) The VHW is responsible for health education in the village.

3) The VHW is to act as a liaison between the village and the hospital.

4) The VHW is to assess the villages' attitude towards health care and the quality of health services."8

Subsequently, the VHWs in Quthing were introduced to simple curative care (first-aid, T.B. referral and follow up)

The programe was internally evaluated in 1976. One of the main findings was that some difficulties had arisen in the selection of VHWs. The more bureaucratically they were selected the less effective they tended to be. Thus it was felt to be preferable that they be selected by a meeting of villagers rather than by the DMO or Public health Nurse. Secondly, the evaluation noted the importance of devising training courses appropriate to the level of health knowledge of the VHWs. To improve on this adequately meant increasing the duration of the present normal two weeks training course. By and large, the conclusion drawn by the evaluation was that the programme had made a positive impact in the district primarily because the VHWs filled a gap in the existing health service. It should also be noted that the VHW idea was welcomed by the villagers and at least by some of the local chiefs. Encouraged by the promising start made in Quthing, a number of other VHW programmes sprang up, included one associated with the flying doctor service. A consensus seems to have emerged from discussions with a number of health personnel that the VHW idea has a lot to offer Lesotho's health system.

Lest the account given so far appear to be a somewhat glowing one, it should also be noted that there exist quite significant problem areas which have certainly muted the impact of VHW programmes. One of the main difficulties has been finance. So far central government has not provided very much by way of financial support, other than allocating funds to enable central government experts, such as the health educator, to contribute to VHW courses Since the districts do not have funds of their own to allocate for this

9/.... purpose

the DMOS have not found it easy to launch effective VHW activity. As already noted, the missions too have financial difficulties and these limit considerably what they can contribute to the effort.

The financial constraint has produced three main consequences. First, it has limited the amount of training that can be given to VHWS because of the difficulty of meeting the various costs involved (e.g. transport, accomodation). Secondly, it has meant that generally VHWS are not paid. In the Quthing case, they were given a small monthly payment (about $ 6) to cover expenses, the funds being raised by imposing higher charges at the MCH clinics and through donation from the Lesotho Family Planning Association. This is an unusual case. A third consequence has been that the VHWS have not always been given adequate equipment to carry out their tasks (at least some sort of first aid kit seems to be essential).

Thus, the financial side has been problematic. Attempts to raise money from within communities have been abandoned because of poor responses. In some cases, private organisations overseas have given donations which have assisted somewhat. In this way some VHWS have been provided with first aid kits. But it has even been necessary at times for staff at the hospitals to contribute out of their own pockets. In such circumstances, it is hard to see the VHW concept fulfilling the various expectations that have been attached to it. A number of drop outs from the VHW programme have occurred through the problem of remuneration. In some areas VHWS are willing to continue but morale among them is not what it might be.[9]

A second gap in the existing arrangements concerns supervision. In the course of the fieldwork it was repeatedly stressed that the workers have to be fairly closely supervised, especially in the early stages when they lack experience. Often, however, the VHWS are left in isolation from the rest of the health service. This also leads to loss of morale. The question arises of who should do the supervising. Generally speaking, it is impossible for the hospital based staff to do the job for a whole district of 300,000 people and often there is only a single nurse based at a clinic. The problem of supervision remains to be solved.

Thirdly, there is the sphere of training. For reasons already given it has not been possible to finance courses of longer than two weeks duration .

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This has let to some scepticism about the usefulness of VHWs since, it is argued, not much medical knowledge can be put across to them in such a short period. The answer would seem to lie in longer courses or a scheme of refresher training (or a combination of the two).

A fourth factor which has proved problematic for VHW programmes concerns the chiefs[10]. In some areas they have played an important role in the recruitment of VHWs and in other ways. Some interviewees considered that chiefs were an indispensable element. However, it was recognised by other health professionals that the chiefs could not always be relied upon. Many of them were said to be apathetic and completely unwilling to contribute any real effort. It was also claimed that they tended to be excessively involved in village factionalism. For these reasons, it was stressed by some interviewees that it had proved necessary to operate without the help of the chiefs. This, however, leaves open the question of which alternative channels to use if such assistance is not to be counted upon. Again, this is a problem which remains for the planners of the VHW programme to solve.

Finally, there is the issue of public support for the VHW idea. There have been suggestions in some areas that communities have been sceptical because they are dominated by the idea that medical treatment can only be administered by doctors. This questioning of the validity of the concept (which can be encouraged by politicians) is potentially damaging. In the course of 1980, it appeared that the problem was being solved, in view of the positive reports coming in. It remains to be seen, however, whether political support can be extended to embrace a fuller allocation of central government financial resources to back up the VHWs.

Proposed Reforms

Our discussion thus far suggests three main points. First, there has been a recognition of the inadequacy of Lesotho's existing health service, especially as far as delivery to the rural areas is concerned. This recognition is shared by some decision-makers within government. Secondly, PHC has achieved gradual acceptance within influential circles in the health sector.

11/.... Thirdly, most

Thirdly, most of the steps taken thus far have been of a rather ad hoc, unplanned nature and have had limited and patchy impact. In the context of these three points we now wish to turn to a consideration of the reorganisation effort now underway, in which the Ministry's Planning Unit is playing a leading role.

A variety of proposals have been made, about which final decisions are still in the process of being taken. Firm central government commitment has yet to be obtained, for reasons which will be discussed later. One of the most important proposals is the formation of health service areas (HSAs). Although opinions differ as towhat is entailed in establishing these areas, there are basically two elements. The first is the creation of a level of health administration below that of the government district. The boundaries of these areas will not coincide with those of any other government organisation. The second element is the partial integration of the government and private/mission sectors. The assumption behind HSAs is that they will provide a basis for running a much more forceful PHC programme than was previously possible. What seems likely to happen is that each hospital in the country will be made the center of an HSA. Thus, the mission hospitals will be included. In each HSA the controlling hospital will have the task of supervising such extra- hospital matters as clinics and VHWs. Among other things, this will mean that goverment hospitals will have responsibility for the supervision of non-government clinics and that non-government hospitals will supervise government clinics. In this way, itis hoped to fill the "supervision gap" existing in the rural health services. A

Accompanying this re-organisation, steps are being taken to strengthen staffing especially at the clinic level where major problems concerning both the quantity and quality of personnel have arisen in the past. Recently efforts have been made to recruit "nurse clinicians" who will be expected to not only run clinics but also supervise VHWs. Much of the outcome of Lesotho's HSA effort seems to rest on whether this particular position in the hierarchy is filled successfully.

As far as community participation is concerned, it has been suggested that a variety of bodies be established at district, hospitals and village level. Details of membership, powers etc remain to be worked out but it is expected that there will be some community involvement. Thus far, the "Public Voice" has been largely absent from the health system. How far the proposed system of

 participation

participation will be representational remains to be seen; the question of whether members should be elected, nominated or a combination of the two is a matter of political sensitivity which remains to be decided. It is also not yet clear what kind of input these structures for participation will make. Here, there seem to be two issues to weigh up: the need for communities to feel they can make effective decisions so as to encourage them to be active; and the need to preserve certain matters for decision by professionals who have the requisite technical knowledge. The balancing of these two considerations is an important task. There is, of course, a danger of "participation" degenerating into tokenism, provoking cynicism rather than authentic community involvement in health planning.

As far as more bureaucratic matters are concerned, there appears to be a reasonable case for allocating some discretion for finance and personnel to the districts. There is a measure of agreement that the health system is over-centralised and that this causes delay and demoralisation. But decentralisation involves broad questions of government policy which go beyond the Ministry of Health. This means that such powerful branches of government as the Treasury and Cabinet Office (which is in charge of personnel) are likely to play an important role in deciding the formula to adopt. Administration Reforms usually involve an element of risk, and decentralisation may perhaps involve more than most, particularly under Lesotho's conditions of scarcity and political division. Yet the case for some form of decentralisation remains strong. A balance has to be struck between the normal concern of the centre with control and the need for HSAs (and other field units) to exercise some measure of discretion so as to become vehicles for the implementation of PHC.

A major financial problem concerns the role of the mission hospitals. As previously noted, they are expected to play a major role in PHC and especially in the new HSA framework. The issue worrying planners is that all the mission hospitals are in some degree of financial difficulty. Even now, this puts them in the somewhat invidious position of charging higher fees than the government institutions, whilst at the same time paying staff lower wages. One of the aims of HSA planners is to bring about equality between the two sectors. This will, however, involve a significant subsidy element which will presumably have to come out of the government's recurrent budget.

13/.... A step such as this

A step such as this will involve the Treasury, where the oosts may well be regarded as prohibitive in the light of the other competing interests within the bureaucrecy. This is currently a matter of negotiation between the parties involved; precise figures for money involved are not available.

The personnel factor also requires some consideration. Although PHC is almost by definition an approach to medical care which reduces the relative importance of the highly qualified professional, there is still a significant role for the doctor to play. It is important that posts in the field be occupied by personnel with an orientation towards PHC. This has implications in the spheres of recruitment and training. Most of the doctors now working outside of Maseru are expatriates, an arrangement which is unlikely to continue indefinitely It will then become vital to ensure that Basotho doctors are found to occupy such posts. Part of the problem here has been how to persuade doctors to remain in government service rather than enter private practice. However, the recent salary increases(of the order of 50%) may reduce the extent of "leakage" of this kind. But there is still pressure to remain in the capital, even if in government service. This may be a problem associated with training, and we would here echo the views of Frankenberg and Leeson:-

" A solution cannot be acheeved by creating fully trained doctors in the Western Style. In the first place, the training of such doctors is not appropriate to the conditions in which they would be required to work; secondly, economic resources are not sufficient to train enough; thirdly, the few that are trained are likely to remain in, or move to, either towns, or worse still, metropolitian countries like the United States and the United Kingdom"[11].

Certainly doctors in Lesotho have a heavy preference for living and working in the capital city, even if out-migration from the country is not a significant problem. The present allocation of local manpower has a strong urban bias. If the present talk of PHC is to descend from the realm of rhetoric, this issue will need attention.

There are two further categories of personnel which require mention. First, the Village Health Workers. It is estimated that to provide adequate coverage

14/.....something like 1,000

something like 1,000 VHWs are needed, on the basis of the assumption that there are that many villages in Lesotho. This is a long run aim, which will perhaps only be accomplished over a period of twenty years. Details of how this will be implemented are now being gone into, the fact that the goal is such a modest one is an indication of government awareness of considerable administrative problems. In the meantime, work is being done on the development of a suitable curriculum for VHWs, based upon a recently drawm up " task list" which strongly emphasises their preventive public health role[12]. It is hoped that the steady and controlled development of the VHW programme will assist in plugging the rural health education gap which appears to exist at the moment[13]. Also of considerable importance for rural health improvement will be the corps of "nurse clinicians".

We have already discussed something of their role. A detailed job analysis recently drawn up shows that this job is a key one for the whole PHC strategy. Nurse Clinicians will not only be required to play a major curative role (diagnosis etc) but will also be the trainers of VHWs and managers of PHC in their areas. The disincentives of hard working conditions, isolation etc. will perhaps be overcome by recently improved salary scales, which are now considerably better than those of Staff Nurses in the hospitals. It remains, however, to be seen if this will solve one of the greatest problems in Lesotho's health system: the tendency of qualified personnel to resist posting to the rural areas.

Resource Allocation and Access

It is unlikely that the PHC strategy will do very much to bridge the gap between those with relatively high access to health care and those without it. Precise figures are not available, but there are signs that the gap may even widen somewhat. In the third plan period (1979 - 1984) the focus will be on the improvement and expansion of existing rural clinics rather than on building of new ones. Only five clinics are proposed for construction in the period. The official assumption, therefore, seems to be that the existing provision of clinics is broadly adequate but that quite a bit can be done to improve the quality of what exists. At the same time, srong demands exist in the rural areas for the provision of more hospitals and clinics. Analysis of the figures for public investment in health during the next plan period

15/... shows that "Health Clinics"

shows that "Health Clinics" are expected to take up about 6% of the total for the Ministry (about 2.m). This contrasts with a figure of $15m in for the proposed development of a national referral hospital, about 60% of the total.[14] This difference of provision flies in the face of the ideas held by the advocates of primary health care. For example, in addressing the workshop in Lesotho in 1978, Dr. David Morley is reported to have argued "that these so-called" disease palaces" (i.e hospitals) are reputed to act as referral centres, but experience has shown that most of their patients come from within a 5 - mile radius". He argued that what should be done instead is spend the money on smaller hospitals and health centres in the rural areas.[15] A similar point has been made by Oscar Gish in his study of the health sector in Tanzania:-

"Because the provision of additional hospital beds of the conventional type must produce more inpatients and thereby make more difficult the allocation of more resources for the preventive and rural health services it is necessary to avoid the extension of conventional hospital service except in the most desperate circumstances"[16].

The difficulty in applying this argument fully to Lesotho is geo-political. The inadequacy of present facilities within the country means the referral of patients periodically to hospitals in neighbouring South Africa. It is partly because this arrangement is regarded as objectionable that this attempt is being made to upgrade facilities in Maseru. This does, however, have implications for primary health care because such allocation of resources is distorted in favour of those who are already relatively privileged. In this sense, inequality of access to health facilities seems likely to remain.

Health and Decentralisation

What has so far been portrayed in this article are the elements making up the administrative factor in Lesotho's health system and we have highlighted a variety of problems in this connection. The assumption throughout has been that outcomes of proposals for health improvement hinge on this factor as well as on more directly medical matters. It is clear that the Ministry of Health has started - albeit rather tentatively-along the road of administrative reform. Among health planners, administrators and some professionals there is broad agreement on the desirability of bringing about change.

16/....But it is not

But it is not yet clear whether a situation has been attained which Dror has described as "explicit and cerefully considered strategy determination".[17] What remains to be seen is whether commitment will be forthcoming at the highest levels of the hierar - (the network of Permanent Secretaries, Cabinet Ministers etc).

One of the main dimensions to be taken into account in analysing proposals for administrative reform is risk acceptability. The main point here is that the strategy being proposed by the health planners and their allies (both inside and outside the bureaucracy) involves increased public expenditure. Noone can say with confidence at this stage what weights should be attached to the various costs and benefits involved. Of particular importance is the finance required to subsidise the mission hospitals so that they can play the roles assigned them in the new strategy. Understandably, caution is being exercised by those in financial authority (primarily the Treasury) until it has been satisfactorily proved that the benefits will adequately compensate for the costs, bearing in mind the conditions of scarcity under which the Lesotho Government operates especially as far as recurrent expenditure is concerned. The question of risk acceptability also arises when we consider the granting of discretion on financial matters to the field. Decisions still have to be taken on the difficult issue of what might reasonably be included within a district budget. A formula has to be found which will allow districts to spend in cases where it is desirable, whilst other matters remain reserved for central government approval. Also to be considered is the question of accountability. If government expenditure is to be decentralised, then accountability is inevitably diffused. Not surprisingly, this sort of change is not regarded with much confidence by those who are aware of the problem of obtaining suitable staff for the districts. Recent strengthening of the quality of health administration in the districts may make this a less significant problem, but it undoubtedly exists at present.

How fast a government can go in the reform direction depends a lot on the quality of personnel available. For planning, the U.S.A.I.D. has supplied some technical assistance and has thus made a substantial impact, certainly as far as advocacy of PHC is concerned. The development of local expertise in this area is underway, albeit hesitantly. More critical, however, is the situation in the field. Here there are three main levels at which problems may be identified. First, at district level there are major difficulties in rercuiting doctors. Even if PHC reduces dependence on this level of professionalism, the tendency of Basotho doctors to resist rural postings is a major difficulty. Secondly, there is urgency attached to the recruitment of nurse clinicians.

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Some would say that they are more important in the new strategy than doctors. Much has been done to ensure that they fit into their roles as smoothly as possible but it is not possible to feel confident that sufficient will be recruited, given the difficult working conditions confronted in many of the places where the clinics are situated. And this can be said even if the salaries offered to them are extremely high by Lesotho standards. A great deal of the difficulty concerns the intangibles of attitude and commitment. Training may assist them in gearing them to the tasks required in an isolated rural environment, but it may not be enough. This point also applies, of course, to doctors. The third level is the Village Health Worker. Impressionistic evaluation is on the whole positive, but at least two key issues have to be resolved. Perhaps the main one is supervision . Poor supervision (or its complete absence) will result in many VHWs greatly reducing their levels of commitment; they often simply drop out. A second issue is payment. That VHWs are not paid anything is likely to prove a significant difficulty, especially in areas of the country where mercenary considerations tend to be to the fore (i.e in the more densely populated areas close to the towns).

Another matter still to be resolved is community participation. Most administrators and planners would agree with Uphoff and his colleagues, when they recently argued:-

"A participatory approach to providing health care will necessitate some organisation of the local clientele. We see three major functions for such organisations. First collective action by rural people may be necessary to get health programs underway and to make their responsive to local needs. Second, local organisations can be effective mechanisms for learning about community health perceptions, and for disseminating information on nutrition, family planning, and other health matters. Third, since many health problems affect entre communities and cannot be resolved by individual effort, organisations are needed to significantly raise health levels in many rural areas." 18.

This is fine in principle; putting it into practice is another matter. Bearing in mind that public acceptance is critical, a few points can be raised.

First, there is the question of the chiefs. Should a participation strategy be devised with their cooperation or should they be ignored ? On the one hand, it has sometimes been found useful to involve chiefs in, for example, setting up VHW programmes. However, there are numerous cases of apathetic chiefs whose contribution has been minimal and can only be expected to remain that way. In the circumstances, it may not be judicious to assume that they will necessarily play a key role.

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That assumption can lead to a situation where some communities have vigorous primary health care, whilst others are deprived. Exactly how to deal with this issue within a strategy of community participation remains to be resolved.

Secondly, there is the question of the institutions for community participation. There may be a temptation to make whatever bodies are established purely advisory. Previous experience - both in Lesotho and elsewhere - suggests that such bodies play a purely formal and legitimising role, without leading to any shift of power within the system. A further, and related, doubt concerns the manner of recruitment to these bodies. In the country's present political climate it is likely that any elected representatives will very much be in the minority. If these doubts are confirmed as valid, there is not likely to be a high level of public acceptance and participation.

Finally we have raised the question of access to health care. In Lesotho's case, at least, it appears that PHC will not bring greater equality but may serve as an adjunct to an inceasingly unequal health system. The building of large referral hospitals elsewhere in Africa has had this sort of effect. Lesotho's experience may be different, but it is unlikely. At the same time, it has to be recognised that the country's geopolitical position vis a vis South Africa creates somewhat exceptional circumstances. The question, however, is whether such considerations justify urban biassed allocation of public expenditure envisaged in the third plan period.

NOTES

1. WHO, Primary Health Care (Brazzaville, 1977), P6

2. Private Health Association of Lesotho, A program to Improve Primary Health Care Organisation and Services in Lesotho (Maseru, 1977)

3. Ministry of Health and Social Welfare, Primary Health Care in Lesotho: Report of a Seminar and Workshop (Maseru, 1978). On strategies, see also Nick Devas, 'A strategy to Achieve the objectives of Primary Health Care in Lesotho,' DAGOccesional paper 9 (University of Birmingham, 1980).

4. Ministry of Health and Social Welfare, opcit, PP.54 - 56.

5. As suggested in Norman. I. Uphoff, John. M. Cohen, Arthur. A. Goldsmith. Feasibility and Application of Rural Development Participation A State of the Aet Paper (Cornell University Rural Development Committee, 1979), PP.

6. These personnel have contracts with the University of Hawaii which, in turn has a contract with USAID.

7. Ministry of Health and Social Welfare, The Village Health Worker in Lesotho (Maseru, 1977), P.42

8. Ibid, P.42

9. Interview, staff of Butha-Buthe hospital (11/3/80

10. The position of chief is hereditary.

11. Ronald Frankenberg and Joyce Leeson, "Health Dilemmas in the Post-Colonial World: Intermediate Technology and Medical Care in Zambia, Zaire, and China" in Emanual de Kadt and Gavin Williams (eds), Sociology and Development (London: Tavistock, 1974), P. 275.

12. Ministry of Health and Social Welfare, Curriculum Adaptation Workshop (Maseru: 1980), PP.10-11.

13. For a discussion in connection with the use of potable water, see Richard Feachem et al, Water Health and Development (London: Trimed, 1978), P. 179.

14. Kingdom of Lesotho, Third Five year Development Plan. (Maseru, 1979), PP.339 - 340.

15. Ministry of Health and Social Welfare, Primary Health Care., P.6.

16. Oscar Gish, Planning the Health Sector (London: Croom Helm, 1975), P. 104.

17. Yehezekel Dror, "Strategies for Administrative Reform" in Development and Change (Vol 11, 1970-71, no.2), P.21.

18. Uphoff, Cohen, Goldsmith, Feasibility and Application of Rural Development Participation P.250. see also J. Dainbridge and S. Sapirie, Health Project Management: A Manual of Procedures for Formulating and Implementing Health Projects (Geneva: WHO, 1974), P.153.