Final Country Report on Community-based Worker Systems in Lesotho

Khanya-African Institute
For Community-Driven Development & Lesotho CBW Steering Committee

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The report is available from www.khanya-aicdd.org

Contents

Glossary

ARV	Anti-retroviral treatment
AIDS	Acquired Immune Deficiency Syndrome
CBO	Community- Based Organisation
CBCD	Community-Based Contraceptive Distribution/ Distributors
CBW	Community-based worker
CHW	Community health worker
CHAL	Christian Health Association of Lesotho
DCI	Development Cooperation Ireland
DFID	Department for International Development, UK
DOTS	Direct Observation Therapy Short Course
FA	Facilitating Agent
FBO	Faith Based Organisation
FIDA	Federation of Women Lawyers
GoL	Government of Lesotho
HFA	Health For All
HIV	Human Immunodeficiency Virus
HBC	Home- based care
HSA	Health Service Area
HCBC	Home and Community- Based Community-based care
IFAD	International Fund for Agricultural Development
IPPA	International Planned Parenthood Association
LAPCA	Lesotho AIDS Programme Coordinating Authority
LPPA	Lesotho Planned Parenthood Association
M	Maluti (the currency of Lesotho; has same value as RSA rand)
MOHSW	Ministry of Health and Social Welfare
MLG	Ministry of Local Government
NAC	National Aids Commission
NGO	Non Governmental Organisation
NPO	Non-profit Organisation
NR	Natural Resources
OVC	Orphans and vulnerable children
PHC	Primary Health Care
PLWHA	People Living with HIV/AIDS
PRS	Poverty Reduction Strategy
PSIRP	Public Sector Improvement and Reform Programme
SC	Steering Committee
SHARP	Sexual Health and Rights Promotion Project
SP	Service Provider
SSRL	Institutional Support for Sustainable Rural Livelihoods
TB	Tuberculosis
TBA	Traditional Birth Attendant
VHW	Village Health Workers
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

EXECUTIVE SUMMARY

1 Introduction

1.1 With weak service delivery and an evident scarcity of resources, Lesotho, like many African states, faces daunting challenges in delivering services to its population, which is estimated at 2.1 million. In Lesotho, 58% of the total population live below the poverty line. Unemployment has increased with the retrenchment of thousands of workers from the mines in South Africa. The HIV/AIDS[1] pandemic has contributed to chronic and persistent vulnerability to hunger and poverty continues to prevail.

1.2 Khanya-African Institute for Community Driven Development (Khanya-aicdd) has been managing a 4-country action-research project on community-based worker (CBW) systems as a mechanism for pro-poor service delivery. This 3.5-year project was implemented in four countries, namely South Africa, Lesotho, Uganda and Kenya. The project is focusing on promoting dispersed, active and locally accountable community-based workers across various sectors, advocacy for policy and institutional support for community-based worker systems and strengthening linkages between community, government, facilitating agents and other stakeholders. The project purpose is that '*Organisations in South Africa, Uganda, Lesotho and Kenya have adapted and implemented a community-based worker system for service provision in the natural resource / HIV sectors, and policy makers and practitioners in the region have increased awareness of and interest in the use of CBW models for pro-poor service delivery*'.

1.3 CBWs are essentially volunteers, selected from the community in which they live, trained to render a specific task which may best be delivered at community level, supported and supervised by a facilitating agent (FA). CBWs are in some way accountable to the community or a specific group within the community and to the faciliating agent that they are affiliated to.

1.4 The CBW project is informed by earlier research work undertaken by Khanya-aicdd which identified that if people's livelihoods are to be improved, there is a need to strengthen linkages between the micro, meso and macro levels, both in terms of improving participatory governance and in terms of improving services (Khanya, 2001). The CBW project aimed to identify how services can be provided to all villages/communities in a cost-effective responsive and sustainable manner.

1.5 The Basotho have relied on and continue to rely on local service providers such as traditional birth attendants (TBAs), circumcision school tutors and traditional healers. In the 1970s and 1980s village health workers (VHWs) contributed to the effective functioning of the primary health care system. However, the beginning of the 1980s and early 1990s saw a fast rise in HIV/AIDS - focused CBWs, fuelled by the proliferation of donor funded community worker type projects within this sector. There has, however, been a decline in the number of CBWs in other health areas and in other sectors such as agriculture or paralegal services.

1.6 The four-country project started in January 2004 and ended in September 2007. The intended outputs were: **Good practice** in CBW systems **documented** and **shared**; **Common framework developed** with good practice; **Pilots designed** and **implemented**; Results of the **pilots mainstreamed**; and **policy implications** disseminated widely and de**bated in southern Africa and east Africa**. The process in Lesotho did not match that of the other three partner countries. The process has been slower partly because the project was only launched in June 2004, and partly because it attracted attention at national level and became a national process with a significant national symposium involving 450 participants in December 2006. A community animal health worker project also commenced in October 2006 and there are discussions

underway to extend this programme nationally which is a considerable achievement and commitment by the government of Lesotho.

1.7 This report summarises the development and results of the CBW project in Lesotho over the past three years and highlights some of the key learnings of the project.

2 Government policies, systems and structures in service delivery

2.1 Lesotho's Vision 2020 and the national Poverty Reduction Strategy (PRS) emphasise public participation in the planning and implementation of development programmes. The PRS has three interconnected goals: (i) to create jobs through the establishment of an environment that facilitates private sector-led economic growth; (ii) empower the poor and the vulnerable and improve their access to health care and education; and (iii) deepen democracy and improve public sector performance.

As the health services are overwhelmed by the HIV/AIDS pandemic, part of the strategy involves training additional village health workers and introducing incentives for them, establishing training for traditional healers to complement health delivery and emphasising health education to prevent disease transmission.[2]

Lesotho held its first local government elections on the 30th April 2005. This event was a major move towards institutionalising grassroots democracy by involving the local population with their own development. The key objective, is to bring services closer to the people.

2.2 The PRS revealed a high level of dissatisfaction with the poor levels of service delivery and communities felt that government bottlenecks in this regard made it difficult to for them to improve their livelihoods. So while there were positive policy changes developing, the situation at the start of the CBW project was a situation of dire poverty, high unemployment, an HIV/AIDS pandemic and little being done to rectify the situation on the micro level.

3 A review of case studies of community-based worker systems in Lesotho

3.1 An in-country review of CBW systems was conducted to draw out 'best practice' and a number of case studies from Lesotho are reviewed.

3.2 The Federation of Women Lawyers (FIDA) Lesotho was established in 1988 and was a registered non-governmental organisation. FIDA designed and implemented a **paralegal** programme aimed at training Basotho about human rights and about the law of their country and its impact on their lives. Recruitment and selection of paralegals was done at the district level. The community had the selection criteria explained to them and then individuals were invited to volunteer. Volunteers had to be approved by the community and local leaders. They then underwent training and sat an examination. Once recruited, paralegals formed district paralegal associations for organisational purposes.

FIDA and the Ministry of Justice, Human Rights Law and Rehabilitation and Constitutional Affairs designed the training programme for the paralegals. Refresher courses were undertaken by the FA every six months. Due to lack of funding it was very difficult to monitor and to supervise the work of paralegals and this has had a knock on effect on training and evaluation components of the programme. FIDA used radio programmes (Seboping) and written material to inform the public about its activities.

[2] http://www.lesotho.gov.ls/articles/2005/chapter_8.pdf

The paralegals charged a small fee for their work. At the end of every month, the paralegals would submit a written report detailing the cases they had handled, the user fees they had charged and their investment plan.

FIDA also undertook routine monitoring and inspection trips. The paralegals themselves were expected to account to their communities but this was not legislated for and therefore depended on the willingness of the paralegals which was one of the weaknesses of the paralegal programme. The programme has now closed as funding was not sustained.

3.3 The Village Health Worker programme started in 1975. The Ministry of Health established a cadre of village health workers (VHWs) to complement services provided at hospitals, clinics and health centres within the Health Service Areas (HSA). Later when the Traditional Birth Attendants (TBAs) were brought into the health system, it was discovered that the Village Health Worker (VHW) was the same person as the TBA. Therefore the roles of the TBA and VHW were combined in the **community health worker** (CHW).

CHWs are nominated by the communities living within the jurisdiction of the HSAs. This process is facilitated by the chief and health workers who present criteria for recruitment and selection to the community in an open public meeting. Basic literacy in Sesotho and minimal English, willingness to serve without expectation of remuneration. and permanent residence in the community are three of the criteria. CHWs sign a contract and take an oath of allegiance in front of the community.

The work of the CBWs includes management of minor ailments, health education, pre-, intra- and postnatal care, family planning, supervision of patients on chronic medication, monitoring and caring for chronically ill patients and collection of health statistics. CHWs work closely with the traditional chiefs as well as the health services. They have not yet been linked into the local government structures.

The training of the CHWs is done by the FA, which is usually the Health Centre. Initially CBWs are inducted and trained for two weeks. VHWs are tested to assess their readiness at the end of this induction phase and those who score above a certain pre-determined standard are recruited as CHWs.

The local Chief has a monitoring role. Supervision is the responsibility of the Health Centres but they have not been effective in this due to a lack of budgetary support. For example, when UNICEF pulled out as the financier of the VHW programme in 1988, the whole supervision and training programme collapsed. Recently some donors have come in to support the work of CHWs such as Irish Aid and the World Health Organisation.

Free medical treatment for CHWs and their families was an incentive in the past but didn't work due to a lack of definition of the term. For instance, there was no clarity as to whether this was restricted solely to primary care or included hospitalisation. Lack of adequate supervision and concrete data make it difficult to assess the impact of CHWs. However, it can be argued that CHWs have been the backbone of the community-based health services for a long period since the inception of the PHC concept in Lesotho. Recently, failure to support CHWs is causing frustration among them and increased drop out rates. Many are transferring to HIV/AIDS peer educator programmes or HIV home-based care programmes run by better-financed donor-funded organisations.

3.4 In 1987, the Lesotho Planned Parenthood Association (LPPA) developed a **community-based contraceptive distribution** (CBCD) project as it was clear that the government services alone would not be able to meet the targets of the International Planned Parenthood Association in terms of child spacing and reduced child mortality. The community-based contraceptive

distributors were nominated by communities in a process facilitated by field educators who were recruited by LPPA. One criterion was that community-based contraceptive distributors (CBCD)s needed to be able to read and write to qualify. The training of CBCDs was designed and commissioned by LPPA through nurses stationed at LPPA clinics. No test was administered at the end of the first training. The LLPA did not forge strong links with other organisations or the communities. The programme suffered strong criticism and folded in 1997.

3.5 **CARE South Africa-Lesotho Sexual Health and Rights Promotion Project (SHARP)** is a cross border community HIV/AIDS initiative. The goal of the project is to facilitate, influence and promote positive sustainable behavioural change in high risk communities that are infected/affected by HIV/AIDS. The priority target groups are commercial sex workers, transporters and taxi drivers and low income women. A second aim is to increase the quality of care and treatment at community level. The programme extends its reach into the community through the use of community volunteers, counsellor and community workers. For instance, 120 peer educators work to promote safer practices among their priority target group. Other volunteers provide psychosocial support to people living with HIV and AIDS (PLWHA). Over 24 support groups have also been started.

4 Findings from the case studies reviewed

4.1 Judging by results from organizations using CBWs to provide services, albeit that some of the case studies are no longer operational, the CBW system is a very relevant approach/mechanism to pro-poor service delivery in Lesotho.

4.2 In the HIV/AIDS sector the study identified that the CBW systems had created a better understanding of the plight of people living with HIV/AIDS and a noticeable increase in the number of people who joined the campaign against HIV/AIDS whilst negative attitudes towards PLWHA appeared to have changed.

4.3 Since the CBW process is community driven, its potential for sustainability is stronger. However, much of the actual impact and sustainability will depend on how identified weaknesses are managed and supported by other stakeholders such as government and the private sector. All aspects of the system have to be attended to for the system to work.

4.4 HIV/AIDS, improved agricultural production and then literacy were the order of priority for programmes as identified by communities as part of research in developing the national Poverty Reduction Strategy.

4.5 Financing of community-based worker projects remains a major challenge. Although several initiatives are encouraging communities to raise funds among themselves to finance their projects there is still a need for external assistance from either government or donors. Money is needed to run the programme and also to pay stipends as stipends have been found to encourage commitment and effectiveness. Interviews with CBWs reveal that they often use their own resources to do their work e.g. in transport costs to reach clients.

4.6 CBW programmes should report to local community structures which should provide coordination of all the programmes in the area and monitor and support them.

4.7 The review found that there are no uniform criteria applied for selection of community-based workers by service providers. While community structures are involved in selection of community-based workers, there is too much dependence on the FA. Communities have not taken up the responsibility and ownership of the process and this weakens accountability and sustainability.

4.8 Community-based workers are considered part of the community. They play a very key role in terms of linkages within the community and between the community and other service providers.

4.9 Concerning day to day operational issues, CBWs are usually accountable to and supervised by the chief of the village development council while professional matters, replenishment of supplies, training and supervision are the responsibility of FA structures. There is a successful collaborative arrangement between CARE and the Lesotho Ministries of Agriculture and Health. Peer Educators and community facilitators are accountable to CARE while Village Health Workers are accountable to the Ministry of Health and Social Welfare and chiefs. VHW programmes are totally donor supported.

4.10 Despite pronouncements made in favour of CBW systems, official policies on CBW systems are under-developed. Consequently, approaches and standards are determined independently by the various FAs. There is a need for coherent policy development.

4.11 Community-based worker systems are a useful and viable model which should be widely implemented in Lesotho. For a more successful system that will widely spread community development, there is a need for a national policy framework for CBWs driven by a collective consortium of service providers. There is also a need for a radical examination of all the factors that limit impact and that are risk factors in terms of sustainability.

4.12 CBW systems reduce the pressure on scarce resources, because they bring services to people in a cost-effective manner. This point is supported by research conducted by Khanya (2002) into the cost effectiveness of farmer to farmer community-based worker systems in Lesotho which found that CBW systems, in this sector, are more efficient in terms of service delivery. However, to be effective, they have to be well run.

4.13 CBWS are most effective when they work with existing community structures to mobilise community involvement and resources and receive strong support from the facilitating agent.

5 Key Learnings

Given the scarcity of resources and the critical shortage of service providers, community-based worker systems are probably the best means of ensuring equitable and sustainable distribution of resources and services. There is also political willingness to champion the work of CBWs. Lesotho has an abundance of human resources which could be trained to provide services. Despite the existence of a common vision for 2020, development initiatives are still sectoral and not integrated. This must be addressed urgently at a policy level. Funding is critical. Procedures for accessing funds must be simplified and NGOs must develop accountability systems.

6 Recommendations

The following recommendations are largely drawn from a national symposium on community-based worker systems organised by the CBW Steering Committee and which took place in December 2006.

6.1 The following incentives for CBWs must be explored/developed: allowances for out of pocket expenses; positive supervision and monitoring, user fees, recognition at community ceremonies, income generating activities within their organisation, accredited and portable training, career pathing, free treatment.

6.2 Local Government structures must coordinate the work of CBWs. The national steering committee should develop an intergovernmental relationships framework.

6.3 Communities must select and recruit CBWs. CBWs must sign performance contracts with the community.

6.4 FAs should involve communities in needs assessment, planning and proposal writing.

6.5 Appropriate policies, strategic plans, regulatory and coordination mechanisms need to be developed. A national association of CBWs should be formed.

6.6 Training should be standardised and accredited. It should include conceptual understanding of development in Lesotho. CBWs should be given opportunities for training in project management.

6.7 All programmes must have appropriate monitoring and resources in place before they are allowed to go ahead.

6.8 Attention must be paid to CBWs' livelihood needs. There should be a clear distinction between voluntary and paid work. CBWs should have a standardised identity through uniforms or ID cards.

6.9 Participants at the National Symposium developed and endorsed an action programme for addressing the recommendations made during the national symposium. Pilots will be implemented informed by good practice as identified by the symposium. The findings will be used to develop a national framework around the work of CBWs in Lesotho. The **Vision** of the CBW project in Lesotho is that:

By the end of 2009, CBW systems in Lesotho are properly coordinated, supported, regulated and integrated into mainstream approaches to service delivery and that they complement the efforts of government to provide sustainable and effective services to communities.

6.10 Lesotho is now moving forward with community animal health worker systems using the private sector model. A design stage has been completed with support from Irish Aid, and it is proposed to start implementation in 3 districts with support from the SANReMP programme.

PART A INTRODUCTION

1 Introduction[3]

1.1 Background

With weak service delivery and an evident scarcity of resources, Lesotho, like many African states, faces daunting challenges in delivering services to its population, which is estimated at 2.1 million[4]. This is further exacerbated by the mountainous terrain, which has led to the country being referred to as the 'kingdom in the sky'[5]. With slightly over 70%[6] of the population residing in hard-to-reach rural areas, equitable distribution of Government resources has been and continues to be a mirage. Lack of services and opportunities in rural areas has led to an increasing rural exodus of active Basotho men and women who migrate from their villages into the towns in search of wage employment. Thus many government and civil society-initiated development programmes are aimed at reversing the existing development disparities between the rural and urban areas.

In Lesotho, 58% of the total population live below the poverty line[7]. Unemployment has increased with the retrenchment of thousands of workers from the mines in South Africa.[8] The HIV/AIDS pandemic has compounded the poverty in the country such that chronic and persistent vulnerability to hunger and poverty continues to prevail. This situation continues to compromise the livelihoods of poor rural households and there is evidence of widespread livelihoods failure. Livelihood systems have also become structurally vulnerable as a result of declining agricultural capacity, loss of economic activities, high prevalence of chronic illness and erratic weather patterns.

In many parts of the world and Africa in particular, the period between the late 1980s and early 1990s was, amongst other things, marked by the introduction of democratic governance and decentralisation policies as a way of restructuring state institutions to make them more responsive and accountable. This has also happened in Lesotho. The recent efforts towards a more decentralised approach to service delivery, the steady consolidation of democratic governance and greater political inclusiveness, are all in line with Lesotho's 2020 vision which calls for civil society to partner with government and assume the responsibility of development and service delivery.

1.2 The community-based worker project

Khanya - African Institute for Community Driven Development (Khanya-aicdd) has been managing a four-country action-research project involving Kenya, Lesotho, South Africa and Uganda to see how community-based worker (CBW) systems can be used to widen access to services and empower communities in the process. The 4-country project aims to develop revised approaches to the use of CBWs in service delivery in both the HIV/AIDS and natural resources (NR) sectors. *The project purpose was that organisations in South Africa, Uganda, Lesotho and Kenya have adapted and implemented a community-based worker system for*

[4] This is a 2003 figure. The next population census will be in April 2006
[5] Basotho, especially those residing in the rural areas are sporadic settlers because of their pastoralist tendencies. This condition has made it even more difficult for Government to deliver services
[6] The Poverty Reduction Strategy for Lesotho 2005
[7] ibid
[8] The numbers of migrant mineworkers from Lesotho fell from 61,424 at the end of 2003 to 56,353 at the end of 2004. http://www.undp.org.ls/millennium/default.php

service provision in the NR/HIV sectors, and policy makers and practitioners in the region have increased awareness of the use of CBW models for pro-poor service delivery.
Funded by the Department for International Development (DFID) in the United Kingdom, this action-research project has focused on promoting dispersed, active and locally accountable Community-based workers (CBWs), who can work in a range of sectors, addressing services which are frequently needed and are best delivered locally. The objective of the project was to build on existing experience in-country. The project has involved:

- a review of experiences in each country in the application of community-based worker systems in the natural resource (NR) and HIV & AIDS sectors;
- national and regional workshops for partners to share and exchange experiences from their own countries; and
- a study tour to Peru in October 2005 to learn from a fifth country which uses CBW systems

In Lesotho, the CBW project has operated in partnership with a range of key stakeholders including:

- CARE Lesotho and South Africa
- National AIDS Commission
- Office of the First Lady
- Central Government Ministries
- Other implementing partners – are provided at the beginning of this report.

1.3 The CBW system

The model below, shown on figure 1.3, illustrates the key components of the system: the community/informal institutions by which people organise to act collectively; a CBW; a facilitating agent supporting the CBW; and other service providers.

CBWs are essentially volunteers, selected from the community in which they live, trained to render a specific task which may best be delivered at community level, supported and supervised by a facilitating agent (FA). CBWs are usually in some way accountable to the community or a specific group within the community and to the faciliating agent that they are affiliated to. They usually receive some form of incentive (monetary and non-monetary), in most cases their costs are covered, such as travel and food, and in some cases they receive a fee or a stipend for the service they render. The CBW may play some of the following roles:

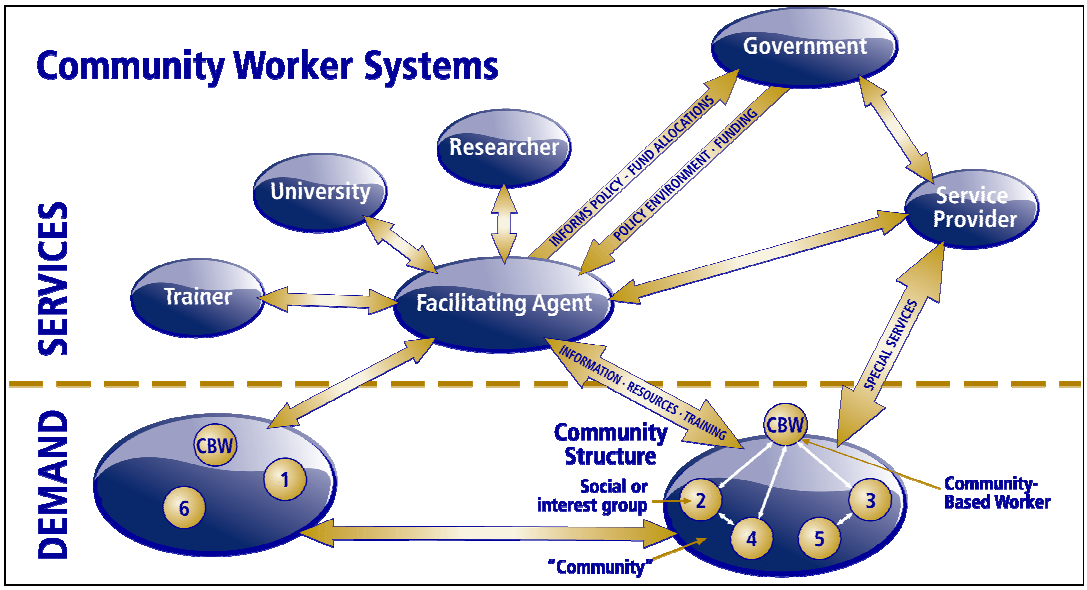
- being a conduit for information and technologies (and sometimes inputs);
- being a bridge/link person between the community and service providers/facilitating agent;
- mobilising the community for learning activities and people into groups;
- engaging in training activities with the facilitating agent, training community members and doing follow-up;
- working on their own activities and providing demonstrations from their own farm or household;
- animating the community by providing energy and enthusiasm for development activities and maintaining the momentum of development activities.

The FA can be from government or the non-governmental organisation (NGO) sector. The FA supports and mentors the CBW and other service providers (SP)s. FAs might provide funding for the work undertaken by the CBW, give information, support in training and provide technical supervision. Their work may inform government policy and they may act as instigators of collective action and intermediaries between people and public service providers.

Government, national institutions, international community and donors provide the enabling environment, develop/create policies and training guidelines and may fund the system. They may also participate in linking policy with practice and sometimes government may be an implementer eg in health, agriculture and social development. Government and the international community also help in strengthening capacity to address poverty.

These are all key stakeholders who need to be involved at all stages in the process for the CBW system to work effectively.

Figure 1.3: The CBW Model



1.4 Why the interest in CBW systems?

The CBW project was informed by earlier research work undertaken by Khanya-aicdd on Institutional Support for Sustainable Rural Livelihoods (SSRLs) in Southern Africa (Khanya, 2001). This work identified that if people's livelihoods are to be improved, there is a need to strengthen linkages between the micro, meso and macro levels, both in terms of improving participatory governance and in terms of improving services. Six key governance requirements were identified to address poverty. These are grouped under three themes as follows:

Empowered communities (micro)

- **Poor people** active and involved in managing their own development;
- Active and dispersed network of **local service providers** (community-based, private sector or government)*;*

Empowered local government and management of services (meso)

- **At district/local government level**, services managed and coordinated effectively and responsively and held accountable *(lower meso);*
- At **provincial level**, capacity to provide support and supervision *(upper meso);*

Realigning the centre (macro)

- **centre** providing holistic and strategic direction around poverty, redistribution, and oversight of development*;*
- **international level** strengthening capacity in-country to address poverty.

The second of these requirements implies the need for a pool of active and locally accountable community workers in a range of sectors, addressing services which are frequently needed and that can be provided locally. The pool of active community workers needs to be linked to higher levels of government and NGOs for support. In Khanya's experience of participatory development, most communities depend on locally provided services e.g. crèches, traditional birth attendants (TBAs), farmer extension schools, traditional healers, home-based carers, local spaza shops etc. There have been programmes using CBWs such as home-based care (HBC), community health workers (CHWs) and paralegals but these have remained as isolated examples and have not been scaled up.

The CBW project aims to bridge the gap by identifying how such services can be provided to all villages/communities in a cost-effective and sustainable way. It also proposes a paradigm shift from the conventional service delivery model so that all villages/communities can be adequately served. The concept contributes to increasing the coherence and effectiveness of the many ongoing efforts by poor communities to achieve their own development in the communities where they live and work. The question is how can these be made more effective and be scaled up, and what are the requirements for doing so?

1.5 Community-based worker systems in Lesotho

The social formation of the Basotho[9] can be traced back centuries, as far back as the historic migration from Menkhoaneng Butha - Buthe to the Hill of Destiny affectionately know as Thaba-Bosiu, led by the founder of the Basotho nation, Moshoeshoe I. At that time the Basotho society was feudal and the family was regarded as the basic unit of organising production. Land and livestock were the essential means of production. Those who had more wealth than others redistributed their wealth through the "mafisa" system and development was communally driven through the system of "Matsema". Since way before the colonial administration, the Basotho have relied on and continue to rely on local service providers like TBAs, circumcision school tutors, traditional healers, HBCs, wise men (Mohlomi) and traditional prophets (Mantsopa). In the 1970s and 1980s village health workers (VHW)s contributed to the effective functioning of the primary health care system. As such the concept of CBWs is not a new one to the Basotho nation. It is and has always been integral to service provision in Lesotho and a number of state and non-state organs have always used CBWs to delivery pro-poor services to communities.

However, the beginning of the 1980s and early 1990s saw a fast rise in HIV/AIDS - focused CBWs, fuelled by the proliferation of donor funded community worker type projects within this sector. This led to a steady decline of other public supported CBWs workers due to the 'attractiveness' of working in NGO - HIV/AIDS related projects and there are now not so many community-based workers providing other health services and services in other fields eg natural resources, water supply, agriculture, paralegals etc. Table 1.5 below outlines examples of services and organizations that use CBWs in service delivery.

[9] Khalapa Development Agency (2004): The Making of the Lesotho National Poverty Reduction Strategy.

Table 1.5: Types of services and organisations using CBW[10]

Type	Organisation	Sector/Focus
Paralegals	FIDA, CLARC	Justice, law and order
Home-based care givers, peer educators	Many government and non-governmental organisations. CARE, LAPCA, Office of the First Lady, sectoral Minister, CHAL, MOHSW	Prevention, mitigation and care and support for infected and affected
Data collectors	Bureau of statistics, UNICEF and many others	Vital statistics
Village Health Workers	Ministry of Health and Social Welfare, CHAL	Primary Health care
Traditional Birth attendants	Ministry of Health and Social Welfare, CHAL	Pre- intra-natal and post maternal care
	Lesotho Distance Teaching	Informal education
Agriculture	Machobane Farming system	Agriculture, food security and sustainable livelihoods
	Unified Extension Services, MoAFS & CARE Lesotho-SA Team	Agriculture and animal health

There thus appears a need for a multi sectoral approach in the use of CBWs which will address all aspects of service delivery and not just HIV/AIDS particularly in the rural areas.

1.6 The CBW project process in Lesotho

The four country project started in January 2004 (June 2004 for Lesotho) and ended in September 2007. The intended outputs were:

1. Good practice in CBW systems documented and shared;
2. Common framework for CBW models developed, with suggestions for good practice in different sectors;
3. Pilots for community-based worker systems designed and implemented, or existing practice modified;
4. Results of pilots mainstreamed into CBW implementation in at least 2 partner countries;
5. Information on CBW systems and policy implications widely disseminated and debated in southern Africa and east Africa.

The main activities included:

- a review of CBW systems and programmes within each country and identification of good practice;
- national and 4-country country workshops to share and learn from others;
- development of guidelines for implementing a CBW system through pilot projects;
- a study tour to Peru;
- undertaking of pilot projects which made some modifications to their activities to incorporate these learnings about 'good practice';
- evaluation of the pilot projects;
- the development of guidelines for community-based worker interventions, based on good practice;
- Regional workshop for policy-makers and practitioners to debate policy implications issues from southern and eastern Africa countries.

[10] The table is not an exhaustive list of all CBW type activities within Lesotho

The initial stages of the 4-country CBW project involved scoping visits to a number of potential partner countries. The visits culminated with a launch workshop in each of the partner countries which brought together practitioners and policy makers within the developmental sector and other stakeholders interested in the use of community-based workers. A National Steering Committee was established in each country to manage the process of the project and also to take forward community-based worker systems as an approach to service delivery and community empowerment. Initially, the secretariat in Lesotho was provided by CARE SA-Lesotho, as CARE was one of the initial champions for the CBW Project[11]. The Deputy Minister of Justice participated in the study tour to Peru, after which he became a key champion for the project and co-chairs the National Steering Committee with the CEO of the National AIDS Commission. To strengthen the secretariat role Khanya-aicdd took over the role, after a Khanya office was established in Lesotho.

Action-research was undertaken in each country during 2004 to review current experience and lessons and provide a situational analysis of CBW systems in that country. Subsequently all four countries came together in a workshop from 20-23 September 2004 in South Africa to share their findings and to draw out models of good practice for implementation. A small group of representatives from each partner country met again in January 2005 to discuss each model in depth and agree the core elements to pilot in their countries.

From 16-29 October 2005, 12 delegates from the four countries participated in a study tour to find out about CBW systems in Peru, comparing their own experience with experiences on another continent. This also provided an opportunity to involve strategic partners, such as Lesotho's Deputy Minister for Justice, who was to be very influential in later developments in Lesotho. The second four-country workshop was held from 1-3 November 2005 in South Africa. Participants were joined by the delegates who took part in the Peru study tour, who enriched the sharing of experiences.

The process in Lesotho did not in tandem with those of the other three partner countries. Delays were experienced, for example, in launching the project in Lesotho, which eventually happened in June 2004 while other countries had already started in January 2004. There was considerable delay in the production of the in-country review report, and no pilots were implemented, hence no evaluation undertaken of the CBW system in-country. However the process in Lesotho quickly moved to national level, with extensive commitment (as in the co-chairs already mentioned and the Office of the First Lady taking a deliberate lead on the process). This meant that there has been national commitment in a way that has not been seen in the other countries with:

- A very successful National Symposium on CBW Systems[12], organised and held in December 2006 by the Office of the First Lady with the support of the CBW Steering Committee, which the Prime Minister officially opened, and which had some 450 participants. The Steering Committee has subsequently developed an action plan to take forward the recommendations of the national symposium. This was agreed by the Office of the First Lady and other relevant stakeholders to undertake an action-learning research study to pilot the design of a coordinated framework for the work of CBW and other service providers. A concept for the pilot/ design phase focusing on coordination has also been developed.

- The agreement with the Ministry of Agriculture and Food Security to proceed with the design of a project to provide community animal health workers in all villages, funded by Irish Aid, and which commenced in October 2006. One purpose was to have a response mechanism to

[11] CARE Lesotho-SA organised and held a regional symposium on Community-based Workers in Maseru, 11-14 November 2002. The purpose of the symposium was to share the community-based approach to agricultural extension used by TEAM and which has informed the Unified Extension System of service delivery in Lesotho. (see CBW symposium report, Nov 2002.

[12] 'Strengthening community-based providers for effective delivery of pro-poor services in Lesotho'

address avian flu, when it hits Lesotho. This design has been accepted and initial implementation has been agreed in the Government of Lesotho's SANReMP Programme, funded by IFAD, and discussions are underway to extend this throughout the country.

The CBW Steering Committee has been very much locally driven and is actively taking forward CBW systems in the country.

1.7 Objective and structure of the report

This report summarises the development and results of the CBW project in Lesotho over the past three and half years and highlights some of the key learnings of the project.

The report is organised into four parts:

Part A is the introduction, which gives the background to the project, its objectives and the process that unfolded.

Part B gives background information on Lesotho government policies, systems and structures at the time when the study commenced.

Part C is a review of sample case studies of community-based worker systems in Lesotho and findings from the case studies.

Part D presents lessons learnt, recommendations and the way forward.

PART B THE SITUATION PRIOR TO THIS PROJECT

2 Government policies, systems and structures in service delivery

2.1 National policies and strategies for service provision in Lesotho

The Constitution of Lesotho 1993, section 106 (1) provides for the establishment of structures that will enable public participation in the development process. In line with this Constitutional obligation, His Majesty, King Letsie III, called on his Government to maximize public participation in planning and implementation of development programmes. These calls have laid the foundation for Lesotho's Vision 2020 and the national Poverty Reduction Strategy (PRS). The two documents are outcomes of extensive consultative and participatory processes that involved grass-root communities, the National Assembly, government ministries, the private sector, civil society organizations, academia and development partners. In preparing the PRS, over 20,000 people (representing a proportion of 1:100) in 200 villages were consulted across the country.

The PRS is intended to help the Government redirect its resources to focus on activities that will have the most impact on reducing poverty. The PRS has three interconnected goals: (i) to create jobs through the establishment of an environment that facilitates private sector-led economic growth; (ii) empower the poor and the vulnerable and improve their access to health care and education; and (iii) deepen democracy and improve public sector performance.

The research that went into the PRS indicated a high level of dissatisfaction with service delivery. The success of the PRS process, therefore will lie in the transformation of government management and the development of service delivery capacity. The public sector improvement and reform programme (PSIRP) aims to improve public financial management and the ability to monitor progress, particularly with respect to how much of the social spending improves the lives of poor communities.

Between the 1970s and the 1990s, Lesotho had an effective primary health care system. During this period, life expectancy grew and infant mortality declined but these trends have been reversed in recent years. However, the social welfare strategic plan 2005-2010 and the primary health care strategy are intent on improving the situation. As the health services are overwhelmed by the HIV/AIDS pandemic, part of the strategy involves training additional village health workers and introducing incentives for them, establishing training for traditional healers to complement health delivery and emphasising health education to prevent disease transmission.[13]

Lesotho held its first local government elections on the 30th April 2005. This event was a major move towards institutionalising grassroots democracy by involving the local population with their own development. 139 local authorities were created and follow a 'Westminster' single-member constituency model. The key objective of this intervention, as envisaged by the government, is to bring services closer to the people and the key objectives of the local councils are for them to take control of all district affairs and to form links with the central government. Lesotho has therefore taken important steps in decentralisation of power by devolution.

[13] http://www.lesotho.gov.ls/articles/2005/chapter_8.pdf

2.2 Service delivery in Lesotho

Table 2.2 below summarises development policies that can potentially be linked to the CBW model; a short explanatory note is provided against each policy.

Table 2.2: Development Policies relevant to CBW systems

Policy	Explanatory note
Vision 2020	The Lesotho Vision 2020 outlines the long term aspirations of the Basotho state, inter alia: By the year 2020, Lesotho shall be a stable democracy, a united and prosperous nation at peace with itself and its neighbours. It shall have a healthy and well developed human resource base, its economy shall be strong, its environment well managed and its technology well established.
PRS	Outlines poverty reduction strategies including the need for a decentralised developmental approach.
Concept note for the introduction of Local Government in Lesotho	This policy document provides the scope of the envisaged decentralization process.
Primary Health Care Strategy	Endorses community participation as the key to relevant and appropriate service delivery

The Poverty Reduction Strategy (GoL 2005) highlighted a number of key points in relation to service delivery within Lesotho. The general perception by the public, even those living in urban areas, was that the government was removed, distant and unavailable to the local population. They felt service delivery was relatively weak within all sectors and that these inefficiencies could not be explained away by geographical factors, as even people living in close proximity to government offices struggled to obtain critical services. There was a high level of dissatisfaction with the poor levels of service delivery and communities felt that government bottlenecks in this regard made it difficult for them to improve their livelihoods.

The report goes on to identify some of the major factors responsible for the poor service delivery. The factors identified included:

- A lack of technology in government departments;
- poor management of government officials;
- poor working conditions of government employees;
- limited coordination between government departments.

In addition, the public service in Lesotho is extremely bottom heavy with few professionals and key decision makers. These challenges are also exacerbated by weak administrative and internal communication systems. Due to this, in certain circumstances, public servants have circumvented the approved procedures to provide services in a more informal manner. However, the victims of these practices are the poor as they are unable to pay bribes for services that they have every right to receive. Weak linkages between planning and budgeting systems were also identified as being a major hindrance to service delivery due to uninformed decision-making.

So the situation when this project began was that recent policy changes and initiatives such as the PRS and the public sector improvement and reform programme gave grounds for hope that things would improve but service delivery was very weak and there was a definite need to address this at all levels.

PART C WHAT HAPPENED DURING THE CBW PROJECT

3 A review of case studies of community-based worker systems in Lesotho

3.1 Introduction

An in-country review of CBW systems was conducted as part of the CBW project in each of the four participating countries. Case studies were reviewed covering a range of CBW examples/models that were utilised in the natural resources (NR) and the HIV/AIDS field, using community-based workers. The aim of reviewing sample case studies was two folds; firstly to have a basis for comparison, the 'before' and 'after' scenario – whereby the action-research project was to use the before as the situation at the time when the project started. Second, undertaking an evaluation to benchmark changes/impacts since the project started and the way forward. This information would inform the three and half year process and 'best practice' examples drawn and shared within and across the four countries.

In this section, a number of case studies from Lesotho are reviewed. As noted earlier, the piloting phase of the project was skipped in Lesotho. There is however discussion that this is still a relevant exercise and a concept has since been developed for testing the process across the whole country.

3.2 The Federation of Women Lawyers - Support to the Justice sector using Paralegals

3.2.1 Context

The Federation of Women Lawyers (FIDA) Lesotho was established in 1988 and was a registered non-governmental and not for profit organisation (NGO). FIDA had a number of programmes aimed at empowering different societal groups[14] with regard to their legal/ human rights and their role in service delivery and the development process. Aware of the ignorance of many Basotho on legal issues, FIDA designed and implemented a programme aimed at training paralegals to educate Basotho about human rights and about the law of their country and its impact on their lives. Between 1994 and 1997[15] FIDA decided to implement a programme of paralegals for the following reasons:

- legal services were not accessible to most poor communities because of high service fees. Paralegals would provide legal services in a more cost-effective manner;
- as a way of simplifying and demystifying the law to make it accessible and understandable;
- services offered by the legal aid were very costly and not widely accessible, particularly in the rural areas.

FIDA defined a paralegal as a community-based person trained in different aspects of the law, including: the dual legal system, court structures, criminal law, requirements of criminal liability, purpose of punishment, criminal procedure and criminal evidence. Paralegals are not lawyers but possess practical advisory legal administrative and community education skills.

The paralegal programme was implemented between 1994 and 1997 in four districts of Lesotho namely Leribe, Quthing, Berea and Qacha's Nek.

[14] Particularly previously discriminated groups like the youth, the disabled and women
[15] Programme phased out due to lack of funding

3.2.2 Recruitment and selection

The recruitment and selection of paralegals was done at the District level. Once recruited, paralegals formed district paralegal associations for organisational purposes. The process involved the following four phases:

Volunteering and authentication by communities: FIDA introduced the paralegal system and shared recruitment criteria with the community. People were then invited to volunteer and become paralegals. The criteria included but was not limited to the following:

- People aged 18 years and above and recognised as leaders and residents of the community they will serve if they become paralegals;
- the chief and the community were then requested to provide an affidavit of legitimacy for the volunteer to confirm that the volunteer was a bona fide resident of the concerned community.

Prequalification test: After the volunteers passed the community authentication process, the FA administered a basic prequalification test to access leadership, community mobilisation and simple communication skills and then would draw up a short list of possible paralegals.

Training and examination: Potential paralegals would undergo a training process designed and administered by the FA. An examination was then administered and those who passed were awarded a certificate signed and authenticated by the Lordship Chief Justice. Paralegals were also awarded with genuine identity cards authorised by the FA and the Ministry.

Feedback to community: Following certification, the paralegal was then introduced to the community and was requested to present his/her work responsibilities and expectations to the community.

3.2.3 Roles and linkages

FIDA worked very closely with the Ministry of Justice, Human Rights Law and Rehabilitation and Constitutional Affairs. The two institutions were responsible for the design and implementation of the content of the training programme for paralegals. The Ministry, particularly the Chief Justice, was critical to the recruitment and selection process of paralegals. The chief Justice was also the only body eligible to declare one a paralegal. Although there was cooperation between FIDA, the Ministry and CBWs there was no obligation on the part of government to work with and through the paralegals. The Ministry had the discretion to decide when and how it would collaborate and support the programme.

3.2.4 Training of CBWs

Unlike many other FAs, FIDA involved the paralegals in designing the content of the training programme. The training participants were requested to identify potential areas of training and capacity building which were then incorporated into the training programme. Paralegals were trained to teach communities about basic aspects of the law and to follow-up with service providers on behalf of their clients.

Refresher courses were organised and designed from the results of the monitoring and supervision sessions undertaken by the FA every six months. Due to lack of funding it was very difficult to monitor and to supervise the work of paralegals and this has had a knock on effect on training and evaluation components of the programme. To ensure wider publicity of the paralegal programme, FIDA used radio programmes (Seboping) and written material to sensitise people about the roles and responsibilities of paralegals.

3.2.5 Incentives and remuneration

Paralegals charged as little as M20[16] depending on the nature and magnitude of the case they were undertaking. They were allowed to retain the full amount of the charged fees and were encouraged to invest some of the money in income generating projects. For example, the paralegals in Berea used some of their proceeds to start poultry farming projects and fundraising activities, like buying different tools and utensils (tents, chairs) and renting them out to the community. In addition, during training sessions, FIDA encouraged the paralegals to provide food and catering for the workshop participants, and FIDA paid the group for this service. The paralegals interviewed felt that the model worked very well for them.

At the end of every month, the paralegals would submit a written report detailing the cases they had handled, the user fees they had charged and their investment plan. It is understood that this created positive competition amongst different paralegal associations. Reporting and getting acknowledged for meritorious performance by the FA was said to motivate the CBWs.[17]

During its radio programmes, FIDA also used the opportunity to talk about best practices as a way of rewarding CBWs for their good work. The paralegals in Quthing worked on a number of food security projects supported by DFID and CARE Lesotho-South Africa, which emerged from being heard on the radio.

The review team also observed that 90 percent of the paralegals who were employed would reserve time during time-off, holidays and weekends to do paralegal work. The review team also learnt that the FA delegated a number of responsibilities to the paralegals and reimbursed the paralegal associations for costs incurred.

3.2.6 Supervision, monitoring and accountability

At the end of every month, the paralegals would submit a written report as explained. FIDA also undertook routine monitoring and inspection trips depending on the availability of funding. The paralegals themselves were expected to account to their communities but this was not legislated for and therefore depended on the willingness of the paralegals which was one of the weaknesses of the paralegal programme. Clients also rated the paralegals using a client satisfaction form designed by FIDA. However, many paralegals attested that the form was complicated and therefore not routinely used. Seven out of ten paralegals interviewed confessed to not using the form at all.

3.2.7 Effectiveness, impact and sustainability

There was a steady increase in the number of cases handled by paralegals particularly in Quthing and Leribe districts during the period between 1994 and 1997. The Quthing Paralegal Association first started handling legal cases in June 1994 and reported only five cases on the 31st of June 1994. Between July 1994 and September 1994 the number of cases handled increased by almost 700% compared to June 1994. A number of clients interviewed attested to the effectiveness of the paralegal system and called for an increased number of paralegals in rural communities.

In an interview with the Magistrate of the Berea Magistrate Court, the review team learnt that the numbers of cases brought the court were dropping because people were more aware of the legal system in Lesotho and its procedures. “Thanks to the paralegals” the magistrate remarked at the end of the interview.

[16] 20 maluti is equivalent to $3 US dollars
[17] Interview with FIDA and the Berea District Paralegal Association

3.3 Ministry of Health and Social Welfare - Community Health Worker Programme

3.3.1 Context

The Village Health Worker programme started in 1975 in Quthing. The Ministry of Health established a cadre of village health workers (VHWs) to complement services provided at hospitals, clinics and health centres within the Health Service Areas (HSA). Typically, an HSA comprises several villages within the catchment area of a designated hospital, whether Government owned or owned by the Christian Health Association of Lesotho (CHAL). The jurisdiction of HSAs cut across district boundaries. HSAs are responsible for all the health facilities within their respective areas irrespective of ownership. The HSA concept was intended to increase the level of efficiency in service delivery and ensure access to health services.

The major problems that the initiative aimed to address were:

- inequitable provision of health services because of insufficient numbers of health workers for outreach activities;
- a lack of a meaningful and integrated multi-sectoral approach to health care;
- a lack of community participation and involvement in health related matters;
- to foster a spirit of community ownership of health services.

In 1979 the Government of Lesotho (GoL) adopted the Primary Health Care (PHC) approach as a strategy to achieve the social obligation of "Health for all by the year 2000 (HFA-2000)". This undertaking, in effect, constituted a major shift away from the manner in which health services in Lesotho had usually been provided. The adoption of the PHC approach had the following objectives:

(a) The introduction of a multi-sectoral approach to the provision of health services. This approach was adopted as a means to capitalize on the work being done by other sectors in particular those sectors that enabled or facilitated access to health services, especially at the periphery. This included the literacy promotion programme, the rural roads construction programme, and the village water supply programme;

(b) The introduction of the HSA led to the division of the country into 18 Health Service Areas. Introducing a decentralised approach to provision of health services had a two-fold purpose. On the one hand it was meant to facilitate and ensure community participation in matters related to their own health. On the other hand it was meant to provide an environment for the decentralisation of functions such as planning and budgeting, both of which had, historically been considered to be exclusive to the central level.

(c) The CHW programme was adopted as a national strategy for PHC in 1979 as a result of Lesotho's participation at the Alma Ata Conference held in 1979. It was perceived, at that time, that if properly implemented, the CHW programme would be crucial to Lesotho's ability to attain her stated goals within the HFA-2000 declaration. Two years earlier, a workshop on CBW programmes was held at Ts'akholo Health Centre in March 1977. The attendance at this workshop comprised professionals from all around the country who unanimously agreed to lay down the foundations for the programme as it operates today. Inter alia, the workshop drew resolutions around the responsibilities of CHWs and their relationships with health facilities and communities. Another key outcome of the deliberations at the workshop was that the Ministry of Health advocated for the integration of the CHW as part of a multi-sectoral scheme of rural socio-economic development. This was meant to integrate the work of community health workers with activities of the community-based workers from other ministries, more specifically the Ministries of Education and Agriculture and the Departments of Water and Sanitation, and Rural Development.

Later when the Traditional Birth Attendants (TBAs) were absorbed into the health system, it was discovered that the Village Health Worker (VHW) was the same person, conducting deliveries and assisting pregnant mothers in the same community. Therefore the cadre was named Community Health Worker, incorporating the TBA/VHW.

3.3.2 Recruitment and selection of CHWs

CHWs are nominated by the communities living within the jurisdiction of the HSAs. This process is facilitated by the chief and health workers who present criteria for recruitment and selection to the community in an open public meeting or 'Pitso'. The following elements are considered for eligibility:

- a permanent resident of the community;
- married and will take an oath to protect confidentiality;
- both men and women are considered for a VHW;
- willing to serve the community without expecting any form of remuneration;
- able to read or write Sesotho and minimal English because of the technicalities associated with the work of a VHW;
- not employed;
- an adult, aged 18 years and above;
- signs a recruitment contract and takes an oath of allegiance in front of his community and the FA.

The recent inventory of Community Health Workers conducted by the Ministry of Health under the support of the Development Cooperation Ireland[18] has shown that there are more female CBWs. This disparity is attributed to the migratory tendencies of able Basotho men seeking wage labour in the mines of South Africa during the early 50s.

3.3.3 The work of CHWs

CHWs are a link between the Health Centre and the community. They are the entry point for different sectoral development programmes. CHWs are multi-purpose workers responsible for a range of PHC functions including but not limited to the following:

- Awareness on health issues;
- Management of diarrhoea;
- Advise on referrals;
- Immunization;
- Vital statistics through the use of a Village Health Register;
- Family planning;
- TBA- home deliveries-intra-natal care;
- Care of pregnant women and antenatal care;
- Post delivery- post natal care;
- Follow-up of chronic ill patients e.g TB patients;
- Health education;
- Management of minor aliments;
- Supervision of TB patients on treatment – DOTS supervision of PLWHAs and or on ARVs to ensure adherence to treatment.

[18] A status report on CBWs

3.3.4 Roles and Linkages

CHWs work very closely with the traditional chiefs and are encouraged to account to them. At the time of this report, there were no visible attempts or efforts to link the work of CHWs to the recently elected and statutory Local Government structures[19] .

3.3.5 Training and support provided to CHWs

The training of CHWs is done by the FA, i.e. the Health Centre. Training covers both theoretical and practical work and is provided at different intervals. Initially CHWs are inducted and trained for two weeks on different PHC topics – the management of minor aliments, health education, supervision of TB patients, immunization, follow-up on chronically ill patients, collection and recording of vital statistics, the management of diarrhoea, and acute respiratory infections, etc. CHWs are tested to assess their readiness at the end of this induction phase. Those who score above a certain pre-determined standard are recruited as CHWs. The facilitators then present the training programme to the CHWs and agree on the training approach including suitable times. Refresher courses and further training are undertaken to introduce CHWs to new tools and methods of Primary Health Care.

3.3.6 Supervision, monitoring and accountability of CHWs

The monitoring system of the CHW system is linked to the traditional structures of governance. Chiefs play a role in monitoring the CHWs and are expected to report on them to the Health Centre. This is done through information provided by the communities themselves. The Health Centres supervise the CHWs but they have not been effective in doing so due to a lack of budgetary support from central government and there is no formal community structure charged with the mandate of monitoring the work of the CHWs.

Supervision is thus wholly dependent on the availability of funds. For example, when UNICEF pulled out as the financier of the VHW programme, the whole supervision programme collapsed. Training intervals became ad hoc and irregular because of a shortage of funds. The effectiveness of PHC also depends on the availability of services offered by other sectors like water and roads. Training of CHWs often overlooks the importance of an integrated approach to training to accommodate the training needs outside those mandated by the Health Sector. Lack of supervision also means that it is difficult and almost impossible to draw up refresher training programmes.

Financing of CHWs in the past was largely through UNICEF and the Government. UNICEF supported direct service provision whilst the GoL supported training and support operations of the CHWs. When the donor pulled out in 1988, the CHW system almost collapsed because Government had not worked out a sustainable programme beyond the donor funding period.

3.3.7 Incentives and financing of the CBW system

In the past, the Ministry of Health passed legislation that gave CHWs an entitlement to free medical treatment for themselves and their immediate families. This incentive strategy collapsed because of poor communication between the Ministry of Health and health facilities. Firstly there was no understanding of the usage of the term free medical treatment and to what extent this could stretch e.g. did it include free surgery? Secondly, some health facilities are for-profit and were of the view that the policy was not properly communicated to the service providers in order to take care of their specific interests. As a result, some health centres denied VHWs /CHWs this entitlement.

[19] The first ever Local Government Elections were held on the 30th of April 2005

3.3.8 Impact and sustainability

It is difficult to assess the impact of CHWs or the programme due to two factors:

- the lack of adequate data on the impacts and the sustainability of CBWs;
- the poor levels of supervision and monitoring.

However, it can be argued that CHWs have been the backbone of the community-based health services for a long period since the inception of the PHC concept in Lesotho.

In the past CHWs were provided with health kits after training and these kits were replenished by the HSAs periodically. Most of these kits are currently empty, hampering the services provided by CHWs. Consequentially a number of CHW have shown signs of frustration and an unwillingness to continue working. The outcome of the weakening of the CHW system is that Lesotho is struggling to meet set benchmarks by the WHO eg meeting the 80% coverage on measles and polio vaccines.

The proliferation of many community-based workers with the advent of increased HIV/AIDS donor support in Lesotho has also been to the detriment of the CHW concept. Many CHWs are now turning their backs on their roles as CHWs and converting to becoming either the "in fashion" peer educators or home-based carers in order to obtain the financial rewards, recognition and other incentives often associated with such donor-funded programmes.

3.4 Lesotho Planned Parenthood Association - Community-based Contraceptive Distributors

3.4.1 Context

A study conducted by the Lesotho Planned Parenthood Association (LPPA) to investigate the increasing child mortality rate in Lesotho, found that many women were failing to plan their families and space the birth of children. Younger children were being born while the elder sibling was still breast feeding. From these findings the LPPA recognised that clinic-based services were not meeting the family planning needs of the population and the targets of the International Planned Parenthood Association (IPPA). In 1987 LPPA developed a community-based contraception distribution (CBCD) project aimed at accelerating the distribution of contraceptives and knowledge around these issues. The project mainly targeted women.

3.4.2 Recruitment and Selection of CBWs

The community-based contraceptive distributors were nominated by communities in a process facilitated by field educators who were recruited by LPPA. One criterion was that CBCDs needed to be able to read and write to qualify.

3.4.3 Setting up CBWs Agent Service Areas

The community-based contraceptive distributors' project focused on three geographical regions of Lesotho namely:

- Central Region - Maseru and Mafeteng districts
- Southern Region - Mohale's Hoek, Quthing and Qacha's Nek districts
- Northern Region - Berea, Leribe and Butha-Buthe districts

In each region LPPA placed branch managers responsible for supervising and monitoring the distribution process.

3.4.4 Roles and Linkages

Community-based Distributors were not linked to any other structure except the FA and the communities that they served. No other service provider or other FAs showed any interest in the

work of CBCDs, which led to the collapse of the programme in 1997. Given the conservative attitude of many Basotho, the programme also suffered huge criticism and often the target group found it difficult to practice Planned Parenthood, often having to seek permission from their spouses.

3.4.5 Training, support and supervision and accountability of CBWs

The training of CBCDs was designed and commissioned by LPPA through nurses stationed at LPPA clinics. The training modules are divided into two sections: one which trained potential distributors on the use of contraceptives and another which trained them on skills of distribution. No test was administered at the end of this first training and more often all nominees participating in the training made the grade and were recruited as distributors.

3.5 CARE Lesotho's Sexual Health and Rights Promotion Project (SHARP)

3.5.1 Context

CARE Lesotho/South Africa operates a Sexual Health and Rights Promotion project (SHARP), a cross-border community HIV/AIDS initiative involving Lesotho and South Africa. The goal of the project is to facilitate, influence and promote positive sustainable behavioural change in high risk communities that are infected/affected by HIV/AIDS while exploring and providing professional skills around safer livelihoods, providing HIV/AIDS information as well as increasing the quality of management of referrals, prevention, care and treatment at community level. The priority target groups are commercial sex workers, transporters and taxi drivers and low income women.

3.5.2 Focus on CBWs

SHARP's areas of operation are community resource centres, identified hotspots (taxi ranks, bars, shebeens, meat/vegetable markets, outside factories, clinics, border gates between South Africa and Lesotho, bus stops, night clubs and prisons), and in the project sites of collaborating partners.

In Lesotho, the programme covers Maputsoe (Leribe), Mafeteng and Maseru. The project has a small number of staff and eight of them work in collaboration with local partners (CBOs). Their reach into the community is extended through the use of community volunteers, counsellors and community workers.

The five strategies of the programme were:

- Peer education (120) – reduce vulnerability of households to HIV/AIDS by increasing the safety of sex amongst priority and vulnerable groups;
- Community-based organisations (CBOs) /Faith Based Organisations (FBOs) (20) – improve local organisations' capacity and strengthen them in providing comprehensive prevention, training, care and support activities;
- Service provision (16) – Improve the ability of service providers to co-ordinate and identify, understand and respond to the reproductive health needs of priority groups;
- Community resource centres (2) – complete the establishment and standardisation of the centres in all of the project sites;
- Scaling up of home-based comprehensive care and support (21) – by supporting replication through training and material development and dissemination.

3.5.3 Impact and Sustainability

- Over 13,657 outreach activities, these also used community volunteers which ensured high levels of community ownership and participation;
- 5,083 referrals were made to different facilities;
- Some sex workers left prostitution as a livelihood strategy and started up small scale businesses and small support groups;

- A culture of reporting was instilled among volunteers and communities being served;
- Motivation of communities was maintained through the provision of small scale grants;
- Psychosocial support for families and children was provided by project volunteers;
- Cost-effective community interventions were initiated and supported;
- Distribution of over 208,000 condoms and IEC materials in 50 different outlets;
- Formation and support of over 24 support groups.

4 Findings from the case studies

4.1 Relevance of the CBW Project and approach

Judging by results from organizations using CBWs to provide services, albeit that some of the case studies are no longer operational, the CBW system does seem to be a very relevant approach to pro-poor service delivery in Lesotho. Many organisations have achieved results in the fight against the widespread underdevelopment and poverty within the country and are providing effective responses to the HIV/AIDS pandemic. Rural communities which were left out of development programmes are being reached, enabling them to address issues that impact on their livelihoods. Participatory and partnership approaches between communities and organisations appear to have been developed and there is evidence of a certain degree of success. The programmes also appear to be helping communities break the dependency syndrome and donors have utilised their ability to reach beneficiaries at a community level as opposed to benefiting middle tier organisations.

4.2 Impact

In the HIV/AIDS sector the study identified that the CBW systems had created a better understanding of the plight of people living with HIV/AIDS and a noticeable increase in the number of people who joined the campaign against HIV/AIDS whilst negative attitudes towards PLWHA appeared to have changed. It appears that more youth have become involved in life skills programmes and that an increasing number of communities have become knowledgeable on health issues.

Increasing numbers of rural households are perceived to be taking part in activities aimed at poverty reduction. Programmes run by the Ministries of Agriculture and Food Security, Health and Social Services and Forestry and Land Reclamation, while not covered in the above case studies, are assisting communities to drive their own development, through cooperation, networking and support. In addition these programmes are assisting communities to take control of their own development through participation in problem identification, situational analysis, identification of possible solutions, implementation, monitoring and evaluation. Moreover, they are assisting communities to increase their income, improve their living conditions and improve their health, to educate their children, share information and exchange ideas for collective good.

In addition the Ministry of Health, through its Village Health Workers and Traditional Birth Attendants programme enabled communities to get access to health services. CARE Lesotho's Sexual Health & Reproduction Programme (SHARP), has been able to modify the attitudes of many Basotho towards HIV/AIDS and reduce stigma.

4.3 Sustainability

Since the CBW process is community-driven, its potential for sustainability is stronger because it can harness the power of communities to help themselves. However, much of the actual impact and sustainability will depend on how identified weaknesses are managed and supported by other stakeholders such as government and the private sector. There are both positive and negative examples from this study which illustrate that for the system to work, all aspects of the system have to be attended to – ie relevant selection criteria for choosing CBWs, a proper selection process which involves the community, funding for quality training and systems of ongoing support and supervision, integration with the relevant service providers in the same field and support from other services in the local area.

The benefits of using CBWs that emerged from the case studies were:

- Responsive collective participatory planning, programming, implementing, monitoring and evaluation;
- Community identification and ownership of problems and solutions;
- Community involvement in programmes.

Potential weaknesses are:

- Poor support and back-up of CBWS by facilitating agencies;
- Poor capacity building and training of community members in programme monitoring;
- Weak linkages with relevant role players;
- Lack of recording of achievements i.e. inadequate collection and aggregation of data;
- Lack of publicity of some of the achievements as well as weak advocacy to reinforce mass awareness;
- Little effort to steer communities away from donor dependency syndrome;
- Inadequate research of cultural attitudes before introducing a programme (as in the contraceptive distribution programme);
- Failure to sustain funding;
- Lack of uniform national structure and guidelines to inform a coordinated approach to service delivery using CBWs.

4.4 Focus on CBW systems

People interviewed as part of the Poverty Reduction Strategy argued that programmes should have a broad focus, given the different areas of need within the country. They however felt that because of its multiplier effect, HIV/AIDS awareness should be the first priority followed by improved agriculture production, literacy and poverty reduction. Cooperative efforts such as burial societies and other similar projects should also be encouraged as well as sharing of inputs and outputs.

4.5 Financing of CBWs

Financing of community-based worker projects remain a major challenge. Although several initiatives are encouraging communities to raise funds among themselves to finance their projects there is still a need for external assistance from either government or donors. Money is needed to manage programmes and develop and deliver training. Also money is needed to pay stipends to any CBW who is expected to work more than about 8 hours a week since the general consensus is that remunerated community-based workers are more committed to their work, and therefore more effective. A consultative team working on the joint United States and Lesotho Government Rapid Appraisal for HIV/AIDS Programme Expansion has recommended the following:

> *"There is a need to explore mechanisms to financially support HCBC workers in order to decrease the amount of money and resources they are personally putting into their work. Remuneration for HCBC workers should be considered."*

Interviews with CBWs reveal that they often use their own resources to do their work e.g. in transport costs to reach clients.

4.6 Relationship of community structures with CBWs

The success of the CBW system depends on an effective working relationship between all parties involved. Each party should take its share of responsibility and this depends on proper coordination of roles. Communities should be involved at all stages from planning through to evaluation. The process should accommodate and acknowledge existing local knowledge and the decentralisation processes that are ongoing which will make this easier. It is important that local committees are set up which coordinate local programmes and that CBW programmes are required to report to these and receive support from them.

4.7 Selection criteria/procedures of CBWs

The review found that there are no uniform criteria applied for selection of community-based workers by service providers. While community structures are involved in selection of community-based workers, there is too much dependence on the FA. Communities have not been encouraged to take responsibility and ownership of the process. There is still a perception that recruitment is the responsibility of the FA and that communities can only be consulted. Some FAs follow the traditional route of involving the chief and village development committees, while others, especially government institutions, only involve the village structures to provide accommodation to a staff member they bring. The former seems to generate fewer problems in terms of accountability and sustainability and the latter sometimes creates problems of acceptability as in some cases the CBW may be regarded as 'foreign'.

4.8 Roles and linkages

Community-based workers are considered part of the community. They are referred to as the first line of service provision. Since they come from and live within the community they serve, it is easier for them to make individual contact with other networks. In this regard they are relied upon for a number of services as well as for advice. They play a very key role in terms of linkages within the community and between the community and other service providers.

4.9 Training, support, supervision and accountability

So far, only the Ministries of Health and Social Welfare, Agriculture and Land Reclamation have fully developed courses and run regular training for their CBWs. The Ministry of Agriculture has a reporting mechanism with communities which is documented. These ministries also have established supervision and accountability channels. In general, consultative meetings are held with community members to make sure that their stake is recognised and valued. Concerning day-to-day operational issues, village workers are accountable to and supervised by the chief of the village development council while professional matters, replenishment of supplies, training, supervision and accountability are the responsibility of FA structures. There is a successful collaborative arrangement between CARE and the Lesotho Ministries of Agriculture and Health. Peer Educators and community facilitators are accountable to CARE while Village Health Workers are accountable to the Ministry of Health and Social Welfare and chiefs. VHW programmes are totally donor supported. The Ministry of Health and Agriculture assist with the development of training materials.

4.10 Government structures and policies in relation to CBWs

Despite pronouncements made in favour of CBW systems and actual practice of CBW systems by some government ministries, official policy on CBW systems has not been formulated. Consequently, approaches and standards are determined independently by the various FAs.

Positive steps towards a coordinated response to pro-poor service delivery were taken during CBW Symposium in December 2006. The First Lady invited the delegates to take advantage of the existing decentralisation and Local Government policy reform the Government of Lesotho introduced in April of 2005. She argued that CBW approach to services delivery was the hallmark of the Local Government and governance and a means through which all communities can indeed contribute to development of this nation not only by determining their priorities but by leading in service provision within their respective communities. She called on all CBWs to hold on to principles of sustainable development and community driven development by always appreciating and being aware of their strengths and weaknesses and translating the useful knowledge into effective and smart development initiatives for the Basotho nation that can help the nation triumph against the HIV and AIDS pandemic. Further, the Prime Minister, in his speech reiterated that CBWs a sine-quo-non to Lesotho decentralisation and Local Government programme and that they should be supported as much as possible.

It is therefore necessary for government to articulate and put in place a CBW system policy that is capable of addressing inequalities caused by less than adequate provision of services in rural areas. The policy should also strive to address gender and youth issues so that all are given a fair chance of contributing towards the solution of problems that affect them. All stakeholders should come together to develop joint goals and consistent and coherent policies to make synergistic use of available resources for the greatest impact.

4.11 Impact and sustainability of CBW systems

Community-based worker systems are a useful and viable model which should be widely implemented in a country like Lesotho. The CBW system has proved to be a very effective methodology that can spread development among communities and encourage networking among community members as well as networking between communities and service provider institutions. However, for a more successful system that will widely spread community development, there is a need for a national framework for CBWs driven by a collective consortium of service providers. The successful running of such a system should include:

- National policy and strategic action plan to include all essential elements of CBW systems;
- National database and resource guide on CBW systems;
- National accreditation process for CBWs and their organisations;
- Assistance in strengthening the role of CBW systems;
- Mechanisms to financially support CBW programmes.

There is also a need for a radical examination of all the factors that limit impact and that are risk factors in terms of sustainability. Some of the factors include the policy framework, financing, involvement of stakeholders, networking, training, roles, supervision and accountability.

4.12 Cost-effectiveness of CBW systems

CBW systems reduce the pressure on scarce resources, because they bring services to people in a cost-effective manner. This point was highlighted in research conducted by Khanya (2002) which focused on the cost-effectiveness of community-based workers systems in Lesotho in the NR sector which found that CBW systems, at least in the NR sector, can be more efficient in terms of service delivery. However, adequate training, support and supervision must be given to community-based workers to minimise the risk of compromising professional standards. Attrition rates and the cost of recruitment and retraining CBWs also needs to be factored into the debate about cost-effectiveness.

4.13 Conditions under which CBWs are most effective

CBWs are most effective when they:

- work with and through existing community structures;
- are supported to initiate activities, looking particularly at the need to involve women, young people and children;
- develop networks with community members and organisations that will be useful to the efforts initiated;
- focus on particular geographical areas so as to achieve synergy between different actions in that area;
- apply a bottom-up approach that will empower and enable participation with a top-to-bottom approach that will challenge present structures, processes and procedures and support changes that will make these more user friendly and consequently easier to work with;
- strongly supported and empowered by the facilitating agent.

PART D LESSONS LEARNT AND RECOMMENDATIONS

5 Key learnings

Historically, community-based workers have always existed among the Basotho. Given the scarcity or resources and the critical shortage of service providers, community-based worker systems are probably the best means of ensuring equitable and sustainable distribution of resources and services. There is also political willingness to champion the work of CBWs within the country. The 2005 Local Government elections and creation of local councils provides a platform for a complete paradigm shift in service delivery. Given the current levels of unemployment in Lesotho, further compounded by migrant labour retrenchment, Lesotho has an abundance of human resources which could be trained to provide services. Community learning and development is critical to the empowerment of both individuals and communities. For people of all ages it provides opportunities to develop their potential and improve the quality of their lives and to participate in local and national democratic processes as well as creation of wealth. Community empowerment contributes to the building of social capital, skills, resources, networks, opportunities, confidence and motivation.

All stakeholders, the government, private sector, NGOs and CBOs need to situate community learning/ development more firmly within the policy mainstream for the improvement of public services, community regeneration and social inclusion. Despite the existence of a common vision for 2020, development initiatives are still sectoral and not integrated. This must be addressed urgently at a policy level.

As with any system, there is always room for innovation and improvement. There is a compelling need to greatly increase the number of players to further test systems developed by some of the path finders such as CARE Lesotho-South Africa. However this can only be achieved through developing definite guidelines supervised by a coordinating body which is something which this four country action-research project has been working towards.

The findings of this review indicate that funding is critical to implementation of community-driven development projects. Therefore government, international donors and the private sector must make the procedures for accessing available funds less complicated. Implementing agencies such as communities, NGOs, government and donors must also put in place and adhere to clear and simple accountability systems.

6 Recommendations[20]

The CBW Steering Committee organised a two day national symposium on community-based workers systems which took place in Lesotho in December 2006. The 450 participants attending the symposium proposed the following recommendations as strategies for strengthening community-based worker systems in Lesotho: [21]

6.1 Incentives and remuneration

- CBWs must be given incentives for the work they do but this can come in different forms;
- An allowance where possible should be paid to CBWs for out of pocket expenditure and to meet daily requirements particularly where CBWs require resources to do their work and are obliged to pay out of their own pockets;
- Consistent support, supervision, monitoring and evaluation are also incentives;
- Agreement on a user fee, a portion of which can be retained by the CBW to meet their daily livelihood requirements, particularly where they work;
- Being included in the protocol list of leaders in their areas during community ceremonies;
- CBW programmes should have an income generation component aimed at ensuring that CBWs raise income to meet their livelihood needs and be able to sustain their service delivery;
- Voluntarism should not exceed 4.5 hours a day. CBWs working beyond 4.5 hours a day should be remunerated;
- Certain CBWs should be trained in project management tools eg writing proposals to donors;
- Government should develop an appropriate fund and funding mechanism for the work of CBWs that can be funded by donors;
- Nationally accredited training should be developed that will give CBWs academic credits should they later engage in further academic training;
- Career pathing so that CBWs can move towards becoming full professionals should they wish to;
- CBWs should receive free treatment in government and other institutions and this should be legislated for properly.

6.2 Roles and linkages

- Local Government (council structures) should play a coordinating role for the work of CBWs but this coordination should be well defined and agreed with CBWs;
- Local Government should involve CBWs in community-based planning exercises so that CBWs are able to direct interventions towards priorities identified by the communities;
- The CBW Steering Committee should develop a framework for intergovernmental relationships that defines the roles of Ministries, District Councils, office of the District Administrators, Community Councils, individual councillors, chiefs and communities vis-à-vis the work of CBWs. These frameworks should be as precise as possible indicating the fiscal responsibilities and resource requirements of each stakeholder.

20 This section draws heavily from both the CBW "Proceedings of the National Symposium on community based worker systems: strengthening community based providers for effective delivery of pro-poor services in Lesotho" report and the "concept note for action-research on strengthening community based services/service providers for effective pro-poor service delivery in Lesotho: Implementing recommendations of the National symposium" report.

[21] Recommendations were based on six different themes

6.3 Recruitment and selection

- Communities must select and recruit the CBW and this should be done through a public meeting convened by the councillor, the facilitating agent and the chief of the area. However, this should be done after carefully assessing which CBWs already exist in the community and whether there is a need for additional CBWs;
- The CBW should sign a performance contract with the community through a sub-committee selected by the community to represent their views and this should be chaired by the councillor working together with the chief of the concerned area. The performance contract should stipulate at what intervals the performance of the CBWs will be reviewed and evaluated. The communities should be empowered to make recommendations regarding recognition and sanctioning of CBWs to the FAs.

6.4 Focus of the work of CBWs

- As with all other community services and interventions, the focus of the CBWs' programmes and projects should be informed by community needs and priorities as outlined in their community-based plans;
- FAs should consult communities and draw up proposals based on the requirements of the community. Moreover, the FAs should find means of assisting communities to draw up proposals themselves.

6.5 Coordination and regulation

- The Steering Committee (SC) and other stakeholders should develop an appropriate policy and strategic plan for strengthening the work of CBWs in Lesotho;
- The SC and the Office of The First Lady should assist and promote the formation of a National Association of CBWs which would assist the regulation and coordination of all aspects CBW work;
- The National SC and the Office of The First Lady should approach the Ministry of Local Government and agree on issues related to the coordination of CBWs at both the macro, meso and micro levels;
- Government should develop an appropriate intergovernmental relationship framework that mainstreams and integrates the work of CBWs.

6.6 Training and capacity building

- Training should be designed on a needs identification analysis;
- CBWs should be trained as trainers and compensated for the trainings they offer;
- HBC manuals and content should be standardised and accredited;
- CBW training should first and foremost focus on the conceptual understanding of development in Lesotho;
- CBWs should be trained in project management and formulation and as well as developing strategies for their work.

6.7 Monitoring and supervision

- Monitoring should be done through the community, the responsible council, the councillor and other stakeholders working in the region;
- No project or programme should be allowed in the community unless appropriate monitoring and resources have been committed to such a process because this compromises the work of CBWs.

6.8 Effectiveness and reliability

- To be effective, reliable and motivated CBWs should be recognised by Government officials;
- CBWs should have some form of incentive and means through which they are able to respond to their daily livelihood challenges;
- CBWs should be equipped with appropriate resources that enable them to perform their duties effectively;
- The FAs should train CBWs in appropriate frameworks that enable the work of the CBWs to be quantifiable;
- The programmes and projects implemented by different FAs within communities should have a sustainability clause linked to the policy framework for the work of CBWs.
- There has to be a clear distinction between volunteer and paid work and this should form the basis for agreeing on the incentives for CBWs;
- CBWs should have a standardised identity eg uniforms or Identity cards.

6.9 Way forward

In order take forward the recommendations, the participants at the National Symposium agreed an action programme which was presented by the Chief Executive of the National AIDS Commission and endorsed by the Office of the First Lady. An integral part of this plan is that the National CBW Steering Committee (SC) will develop a holistic pilot programme which will seek to address issues and concerns facing CBWs by incorporating the recommendations made during the national symposium. The holistic pilot programme will be an **action-learning** programme aimed at addressing HIV/AIDS prevention, care and support whilst also incorporating issues of gender and youth. The pilots will be implemented by organisations and CBWs that took part in the symposium and the approach or pilot guidelines will be informed by good practice as shared by the different participants and the findings will be used to develop a national framework around the work of CBWs in Lesotho. Such a framework will then be used to develop a country-wide implementation programme in the area of HIV/AIDS and food security. The actual action plan to achieve this is presented below on table 6.9.

Table 6.9: Action plan - moving beyond the symposium

Action required	Responsible person
Develop concept note for pilot programme	Office of the First Lady
Share and request inputs on the concept note for the pilot and review concept at headquarters level	CBW SC and office of the First Lady
Preparatory meeting with stakeholders at District level	Office of the First Lady the CBW SC and CBWs involved in the symposium, Government departments and other stakeholders
Pilot design with relevant stakeholders at community level (develop guidelines for the pilot)	As above
Roll out pilot programme	As above
Briefing session of stakeholders and monitoring and evaluation of the pilot programme	As above
Write up experiences and review and evaluate pilot cycle	
Document experiences and develop a national rollout programme towards the development of a general framework for the management of the work of CBWs.	As above

The major stakeholders highlighted within the action plan include:

- Community based workers;
- Central Government Ministries and representatives at the District level;
- Local Government structures;
- Office of the First Lady;
- CBW Steering Committee;
- NGOs;
- Christian Council of Lesotho;
- UNDP Lesotho;
- Other donors;
- Lesotho Council of Non-Governmental Organisations (LCN);
- Association of People Living with HIV/AIDS;
- OVC Coordinating Committee.

The concept note developed after the symposium outlined the following **Vision** of the CBW project in Lesotho is that:

By the end of 2009, CBW systems in Lesotho are properly coordinated, supported, regulated and integrated into mainstream approaches to service delivery, and that they complement the efforts of government to provide sustainable and effective services to communities.

Currently the project is in its design phase and as such a specific set of objectives with key actions has been put into place. The main outputs and related main activities to carry out these outputs were also defined, including include:

1. Stakeholders are committed, involved and own the process
1.1 Identify relevant stakeholders at the centre
1.2 Circulate the concept to relevant stakeholders
1.3 Invite relevant stakeholders for discussions
1.4 Revise concept note accordingly and agree on a pilot area
1.5 Request DA (the pilot area) to invite stakeholders at the district level
1.6 Convene meeting with stakeholders at District level and agree a work programme

2. **The design pilot phase is well publicised**
2.1 Design communications strategy
2.2 Implement communications strategy

3. Donors aware and funding pilot and rollout phase
3.1 Circulate symposium report and concept note for donors
3.2 Convene meeting with donors and review concept accordingly

4. **Coordination of the pilot framework and guidelines developed**
4.1 Convene community meetings around developing framework and guidelines
4.2 Develop pilot guidelines and a monitoring and evaluation system
4.3 Implement a monitoring and evaluation system

5. Experiences documented and shared.
5.1 Write up experiences based on monitoring process (ongoing)
5.2 Convene a stakeholders' workshop to present ongoing pilot experiences
5.3 Draft good practice manual and share with policy makers

These actions and learnings form a concrete programme that now require funding and actual implementation timeline to allow the concept of CBWs to be promoted at policy level, nationally

and will enable an informed policy framework for CBWs to be drawn up and implemented within the country. In addition a practical first step has been taken with the Community Livestock Worker programme (see 6.10).

6.10 Taking forward community livestock workers in Lesotho

Lesotho has already moved forward on implementing a CBW model through a national system for community animal health workers. An initial project was developed as a partnership between the Ministry of Agriculture and Food Security and Khanya-aicdd, and funded by Irish Aid, and a study tour was carried out to Kenya to learn from their experience. This phase developed guidelines and a design for an implementation phase to be rolled out in Lesotho. A cadre of community livestock workers are proposed, part of a private sector model of CBWs, linked into the Departments of Livestock Services and Field Services, and linked with the private sector drug distribution system. This design has been accepted by the Ministry and Irish Aid is open to support an implementation phase. It has also been agreed that the Ministry's SANReMP programme operating in the 3 southern districts of Mohale's Hoek, Mafeteng and Quthing should implement this as a first stage.

Annex 1 References

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