

Not such a different world: providing contraception services in Lesotho

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Introduction

“PTP”: three letters scrawled in the tattered notebook that served as her medical record. What did it mean? For me, it explained why my previous patient was crying inconsolably onto a nurse’s shoulder. For her it signified far more: another mouth to feed, another nervous wait for an HIV test, a shortage of blankets, an unwanted shift in her world. Clinic over, I went outside and gazed at the zig-zag skyline of the mountains. Pregnancy test positive: one of those deceptively simple acronyms that tames the complexity of our patients’ lives into something writeable, something understandable, something medical.

I was on my elective in Lesotho, a country about the size of Wales and entirely surrounded by South Africa. It was late June, winter in Lesotho, a season of glaringly bright days and densely cold nights. That day I was working at an ‘outreach clinic’ run by Maluti Adventist Hospital: each Tuesday an assortment of nurses, doctors and students crammed into a minibus and drove 2 hours from the main hospital to run a rural primary care clinic that offered contraception services. Dozens of people would be sitting on the ground waiting for us to arrive, wrapped in their traditional blankets and exchanging village gossip.

The woman who was now so upset had attended for a repeat dose of injectable contraceptive. Unfortunately one of her children had been unwell and so she had been unable to travel to the clinic for several weeks. Access to abortion in Lesotho is very restricted, so all we could offer was antenatal care.

This essay explores the general challenges facing contraception services in Lesotho before discussing specific problems encountered with current contraceptive methods and how the situation might be improved for Lesotho’s women.

Background to contraceptive services in Lesotho

The Kingdom of Lesotho has a fascinating history, only becoming independent from Britain in 1966.¹ Today it is an extremely poor country, with most of the population relying on subsistence farming.²

In Lesotho HIV is like the mountains – the backdrop to every story; 23% of the adult population carry the virus.² The epidemic contributes to a low life expectancy, which declined from 59 years in 1996 to 41 years in 2006.² There are several reasons for the high prevalence of HIV, but local people believe the main problem is that most men of working age leave for months at a time to work in the mines of neighbouring South Africa. There many men contract the virus through paying for sex or having another partner, and then infect their wives when they return home. Antiretroviral drugs are available free of charge, but I saw many patients presenting with late-stage undiagnosed disease for whom such medication was of little use.

Women in Lesotho are generally better educated than men; in 2009, 97% of adult females were literate compared to 80% of men.² In recent years the fertility rate has gradually declined and was 3.3 births per woman in 2008.² However, childbearing remains risky. In the same year, the lifetime risk of maternal death was 1 in 62 compared with a global average of 1 in 140.³

Women who know they are HIV-positive are no less likely to wish to give birth, and in some cases are keen to have a child to conceal their status.⁴ Contraception services are an important part of global efforts to reduce mother-to-child transmission of HIV, but such services are poorly integrated with HIV care in Lesotho.^{4,5}

Perhaps surprisingly, HIV-positive women report less unmet contraceptive needs than those who are HIV-negative, but in both groups over half say that services

are inadequate.⁶ In a 2009 survey, 35% of all women aged 15–49 years used a ‘modern’ form of contraception, most commonly injectables (13% of women), the pill (8%) or the male condom (10%); 1.3% used intra-uterine devices (IUDs).² Young, sexually active, unmarried women tended to use condoms rather than more reliable methods. Of those aged 15–19 years in this group, about 37% used a condom but only 4% used injectables; none reported using the pill.² Alarming analysis of data from 2004 showed that only 6.3% of HIV-positive women used a condom.⁴

Health care in Lesotho is provided by a mix of Government facilities, private providers and non-governmental agencies; the largest of these is the Christian Health Association of Lesotho (CHAL), which operates 38% of primary health care centres.⁷ The CHAL hospital I worked for provided condoms, but some Roman Catholic institutions do not. Government and CHAL facilities charge standardised, subsidised fees for contraception services.

Challenges facing contraceptive services in Lesotho

Accessing a clinic is the first task facing women who wish to obtain contraception in Lesotho. The majority of people live in rural areas where travel involves long walks, donkey rides or expensive taxis. Because of the HIV epidemic, women are often responsible for the children of deceased or ill relatives as well as their own family. It can be hard to find childcare cover to make the trip.

The facilities may not be adequate once women make it to a clinic. The outreach facility I was at was a simple two-room shed with no running water or electricity. Providing privacy is very difficult in these cramped conditions. This was identified as a reason for stopping attending contraception services by women interviewed by Tuoane *et al.* One unmarried woman in her 20s commented: “*What separated me and other clients was just a counter ... they could hear every word of the conversation*”.⁶

Another problem is inadequate staff training. Tuoane *et al.* also interviewed staff providing contraceptive services.⁶ Three-quarters of those questioned had attended a refresher course in the last decade, but 6% had received no formal training at any time. This may account for some of the poor practices noted, such as teenagers being refused any contraception apart from condoms unless they were married, IUDs being fitted without first screening for sexually transmitted infections (STIs), and women being advised that sterilisation results in being unable to enjoy sex.

Generational differences make it harder for young people to access contraception. Sex is not undertaken before marriage in the traditional culture. However, premarital childbearing seems to be increasing and it is becoming acceptable for young people to kiss and hug in public places.⁸ Parents interviewed by Mturi in 2003 were often accepting of young people having sexual

relationships, but it was rare for parents to discuss sex with their children and only a minority felt able to offer advice about contraception.⁸ Many parents were confused by the use of the term ‘family planning’ to describe contraception services and stated that adolescents should not access these services because they were too young to start a family.

Another barrier to healthy sexual relationships is the high rate of alcohol use among both men and women in Lesotho. In Lesotho, women retain their traditional role brewing the local alcoholic drink, *joala*. This is a sorgum-based liquid of variable colour, typically served in an old plastic pot with nondescript seeds floating on the top. I struggled to finish my serving, let alone drink enough to become inebriated.

Although I have been unable to find recent figures, anecdotally alcohol abuse is widespread and is reported to be a factor in many cases of unwanted sex.^{9,10} Heavy alcohol use is viewed disapprovingly, but women who drink are especially stigmatised as the local culture maintains that women should not drink alcohol at all; drinking would traditionally be grounds for a husband to end the marriage.¹¹ It is difficult for both men and women to obtain professional help to manage substance misuse problems.

Lesotho has a high rate of sexual violence, which makes it harder for women to protect themselves from STIs and unwanted pregnancies. Brown *et al.* surveyed 939 sexually active women in the two biggest cities in 2006,⁹ where 25% reported one or more incidents of forced sex, 4% reported that sex had been demanded in return for continuing employment and 10% reported that they had engaged in unwanted sex in return for money or other gifts. Rape in marriage was not illegal until 2003; many are not familiar with the change of law and prosecutions are rare.⁹ Partners are the most common perpetrators of sexual violence.⁹

As with many developing countries, Lesotho struggles with both obesity and malnutrition. In 2009, about 17% of women aged 15–49 years were obese.² Our understanding of the effect of obesity on contraception is limited despite the high prevalence of obesity in the Western world. One trial found that the failure rate while using the combined oral contraceptive (COC) pill is higher in obese women.¹² In addition, correctly fitting IUDs and performing sterilisation procedures is more difficult in extremely overweight women.¹³ This is a particular concern in Lesotho given the low levels of staff training.

However, more than half of the children admitted to my hospital were malnourished. In 2009, about 30% of children aged less than 5 years in urban areas were moderately stunted (height-for-age between 2 and 3 standard deviations below the reference median, reflecting chronic malnutrition).² This figure was about 40% for children from rural areas.² Women in Lesotho often struggle to provide enough food for their children, which makes it imperative that they are able to control the size of their family.

Abortion is an important means by which women in many countries prevent unwanted births.¹⁴ In Lesotho abortion is illegal unless necessary to save the mother's life. However, prosecutions are rare and unsafe abortion is probably widely practised outside formal health care services. Complications of such abortions are reported to be a common cause of maternal death, but it is difficult to obtain accurate information.¹⁵ The lack of a safe, legal abortion service is another reason why ready access to effective contraception is essential.

Problems encountered with current contraceptive methods

Compared to those living in other developing countries, women in Lesotho have a relatively wide choice of contraceptive methods.¹⁶ However, none of the available methods are perfect.

Condoms

Condoms are extremely important because of the high rate of STIs. I encountered a lot of ignorance about how to use condoms, including a belief that they are responsible for spreading HIV. Women in Lesotho are often economically dependent on their partner; a study from neighbouring South Africa found that this situation made it harder for women to negotiate condom use.¹⁷

Combined oral contraceptive pill

The COC pill was the method most commonly requested at my clinic, and most women found they worked well. The main problems I encountered were running out of stock, and deliveries of unexpectedly different pill formulations. Many women requesting the pill were unsuitable because they had multiple cardiovascular risk factors such as obesity, smoking and hypertension. This could be difficult to explain through an interpreter.

Women using the pill in Lesotho are more likely to experience factors that reduce pill efficacy than women in the UK; diarrhoea and vomiting are common due to poor water supply and contaminated food. However, there are no published data which show that the failure rate is significantly higher in practice. A particular problem in developing countries is ensuring that women who do discontinue oral contraception are able to access an effective alternative.¹⁸ This can be hard in Lesotho as many women find it difficult to visit a clinic.

Injectable contraceptives

Injectable contraceptives are the most common method in Lesotho and offer many advantages.⁴ The clinic I worked at offered a progestogen-only preparation, Depo-Provera®, which requires clinic attendance only every 12 weeks. Women using this method do not need to remember to take a pill every day or worry about the effects of diarrhoea and vomiting. There has been concern that using injectable contraception may increase risk-taking behaviour and lead to higher rates of STIs, but this has not been demonstrated in practice.^{19 20}

As illustrated in the story that introduced this essay, the major difficulty I encountered was women missing their clinic appointment. This appears to be a widespread problem; in an interview study conducted in Johannesburg, 32% of women relying on injectable contraception had forgotten or been unable to attend an appointment at some stage.²¹

Intrauterine devices

IUDs are attractive options because they are extremely reliable and cost-effective. Hormone-releasing devices are increasingly used in UK but these are 30–80 times more expensive than the copper devices used in Lesotho.²²

The two major concerns with IUDs are ectopic pregnancy and pelvic inflammatory disease (PID). Regarding the first concern, IUDs reduce the absolute risk of ectopic pregnancy by 91% because women using the device rarely become pregnant. However, pregnancies that do occur are more likely to be ectopic.²² The second concern is more difficult to assess. In countries with moderate rates of STIs the risk of PID is low and probably outweighed by the reduced risk of pregnancy-related complications, but there are no studies from areas where STIs are as common as in Lesotho.²² In a study conducted in rural Lesotho in 1995, 28.4% of adults were infected with chlamydia, 5.9% with gonorrhoea and 11.3% with syphilis.²³ Given these figures it is questionable if it would be ethical to conduct a controlled trial using IUDs in Lesotho.

Conclusions

When a child is born in Lesotho, the father is notified whether it is a girl or a boy by his friends; they pour water on the father's head if the baby is a girl, or chase and hit him with sticks if it is a boy. Unlucky fathers of mixed twins get both. Seeing this ritual in the hospital grounds made Lesotho feel like a different world from the UK, but the similarities outweigh the differences. Women in Lesotho face many of the same contraception challenges as women all over the world: accessing clinics, negotiating condom use, and dealing with imperfect methods. There are high rates of STIs including chlamydia among young British people, suggesting that we are far from having all the answers to promoting sexual health even with comparatively vast resources.²⁴

Nonetheless the problems in Lesotho are particularly acute, with high levels of unmet contraceptive need and STIs. How might these problems be addressed? It is easy to write a 'shopping list' of needs: at the top of mine would be more and better facilities, and more and better trained staff. It is far harder to think of creative improvements that could be made on an extremely limited budget. In my view, there are three important areas for development.

First, the Government of Lesotho and the international community need to create employment for men within the country, or allow families to move with their husbands to South Africa. It is hard to overstate the disruption to family life caused by husbands

living abroad, and there is no doubt in my mind that this situation contributes to HIV, STIs and unwanted pregnancies.

Second, research and resources are required to develop effective and sustainable community programmes to increase uptake of modern contraception methods, especially among young women. These should particularly emphasise the importance of using condoms to prevent STIs. The most successful programmes so far involve training community members to act as 'expert facilitators', but I did not come across any such initiatives in Lesotho.^{25 26}

Finally, work is required to develop new contraceptive methods that are longer-lasting yet reversible, safe in areas with high rates of STIs and affordable. Subdermal implants have many of the characteristics of an ideal contraceptive, but they are not used in Lesotho because they are too expensive and rely on a comparatively high level of staff training to fit correctly.²⁷

Progress in these areas would help Lesotho's women, but could also help women in the UK. Lesotho is not such a different world, and I am convinced that effective contraception is one of the most socially useful things that modern medicine has to offer worldwide.

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