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LESOTHO HEALTH SYSTEMS ASSESSMENT 2010



June 2010

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Strengthening
Pharmaceutical
Systems



SPS



Mission

The Health Systems 20/20 **cooperative agreement**, funded by the U.S. Agency for International Development (USAID) for the period 2006-2012, helps USAID-supported countries address health system barriers to the use of life-saving priority health services. Health Systems 20/20 works to strengthen health systems through integrated approaches to improving financing, governance, and operations, and building sustainable capacity of local institutions.

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LESOTHO HEALTH SYSTEMS ASSESSMENT 2010

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ACRONYMS

AfDB	African Development Bank
AIDS	Acquired Immune Deficiency Syndrome
AJR	Annual Joint Review
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral Drugs
AZT	Zidovudine (drug)
CDC	Centers for Disease Control and Prevention
CHAL	Christian Health Association of Lesotho
CHW	Community Health Worker
COHSASA	Council for Health Service Accreditation of Southern Africa
CSO	Civil Society Organization
DFID	U.K. Department for International Development
DHIO	District Health Information Officer
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DPCF	Development Partners Consultative Forum
EPI	Expanded Program on Immunization
EU	European Union
FBO	Faith-based Organization
FY	Fiscal year
GDP	Gross Domestic Product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
GOL	Government of Lesotho
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAART	Highly Active Anti-Retroviral Therapy
HIS	Health Information Systems
HIV	Human Immunodeficiency Virus
HMB	Hospital Management Board
HMIS	Health Management Information System

HPTC	Hospital Pharmaco-Therapeutic Committee
HR	Human Resources
HRH	Human Resources for Health
HRIS	Human Resources Information System
HSA	Health Systems Assessment
HSS	Health System Strengthening
HTC	HIV Testing and Counseling
ICAP	International Center for AIDS Care and Treatment Program
ICT	Information and Communication Technology
IFMIS	Integrated Financial Management Information System
IT	Information Technology
LCN	Lesotho Council of NGOs
LPPA	Lesotho Planned Parenthood Association
MAS	Medicines Access Survey
MCA	Millennium Challenge Account of Lesotho
MCC	Millennium Challenge Corporation
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MOFDP	Ministry of Finance and Development Planning
MOHSW	Ministry of Health and Social Welfare
MOPS	Ministry of Public Service
MOU	Memorandum of Understanding
MSH	Management Sciences for Health
MTEF	Medium Term Expenditure Framework
NASA	National AIDS Spending Assessment
NDSO	National Drug Services Organization
NEML	National Essential Medicines List
NGO	Nongovernmental Organization
NHA	National Health Accounts
NHTC	National Health Training College
NMP	National Medicines Policy
NPTC	National Pharmaco-Therapeutic Committee
NSTGs	National Standard Treatment Guidelines
NUL	National University of Lesotho

OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary health care
PIH	Partners in Health
PIU	Project Implementation Unit
PLWHA	Person(s) Living with HIV/AIDS
PMTCT	Prevention of Mother-to-Child Transmission
PPP	Public Private Partnership
PRSP	Poverty Reduction Strategy Paper
PSC	Public Service Commission
PSL	Pharmaceutical Society of Lesotho
QA	Quality Assurance
RH	Reproductive Health
SAHCD	Southern Africa Human Capacity Development Coalition
SACU	Southern Africa Customs Unions
SSA	Sub-Saharan Africa
STGs	Standard Treatment Guidelines
SWAp	Sector-Wide Approaches
SWOT	Strengths, Weaknesses, Opportunities, and Threats
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Fund
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary (HIV) Counseling and Testing
WDI	World Development Indicators
WHO	World Health Organization

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EXECUTIVE SUMMARY

The Lesotho Health Systems Assessment was conducted by Health Systems 20/20 in collaboration with the Ministry of Health and Social Welfare (MOHSW), Irish Aid, and the USAID funded Southern African Human Capacity Development Coalition and the Strengthening Pharmaceutical Systems Program (Lesotho). The assessment included the collection of data from 73 health facilities, an extensive literature review (both grey and published), and the conducting of key informant interviews at national and district levels.

The Health Systems Assessment (HSA) approach provides a framework for undertaking a rapid yet comprehensive assessment of a national health system. The approach assesses the six components of a health system, namely health governance, health financing, health service delivery, human resources for health (HRH), pharmaceutical management, and health information systems (HIS).

Lesotho achieved great strides in improving its health indicators from 1966 to 1990, with life expectancy rising from 40 years to 59 years. Lesotho has been devastated by HIV/AIDS, which has reversed the gains the country achieved in health indicators (with life expectancy dropping to age 44 in 2008, from age 59) (World Bank 2010), reduced the population growth rate, and left no sector of the economy unscathed.

Despite this calamity, the Lesotho HSA revealed that the country has a fairly robust health system. Compared to its peers, Lesotho spends \$54 per capita on health, which is higher than the \$34 per capita required to provide a minimum package of health interventions. The HSA revealed that Lesotho does not suffer from an inadequacy of funds, but rather from chronic under-spending of health resources, as well as from a less-than-optimal allocation of health resources. The assessment provides several recommendations to remedy this situation. Although the HIV pandemic is a structural challenge for Lesotho, requiring long-term, predictable, and sustainable funding, Lesotho has a number of opportunities within its grasp to address this challenge. The continued international goodwill, evidenced by increasing donor contributions for health to Lesotho, must be leveraged, coordinated, and used to strengthen the Lesotho health system. Lesotho should implement a sector-wide approach and ensure better coordination of partners for efficient allocation and use of resources. The health financing findings also revealed that Lesotho would benefit from establishing a national social health insurance scheme, to ensure adequate funding for health. The report also suggests that the country would benefit from analyzing the reasons for chronically low budget execution rates.

The paucity of HRH in Lesotho has been well documented by several studies, from which this assessment benefited. Lesotho has developed several well-crafted plans for strengthening human resource management, improving continuing education, expanding the capacity of national training institutions, and improving conditions of service for HRH. Substantial international goodwill has been secured. The principal challenge Lesotho faces is a failure to implement HRH strengthening plans, as a marked gap exists between stated intent and actual practice. Addressing HRH challenges such as those facing Lesotho will require long-term sustained efforts.

Pharmaceutical management in Lesotho has been plagued by an insufficient amount of qualified human resources, a lack of financial resources, and poor information concerning use of drugs and commodities. This has greatly affected the country's ability to procure commodities in a timely and cost-effective manner. On a positive note, the HSA revealed that this situation, especially as relates to procurement

and distribution, can be improved substantially through changes to the National Drug Services Organization payment mechanisms. Implementation of the HRH development plan, along with a continuing education development plan, can contribute to addressing the HRH shortages, and expansion of drug and logistics information systems will yield better quality data on pharmaceuticals.

Lesotho has an aging and inadequate service delivery infrastructure and faces similar challenges to its peers in this domain (e.g., insufficient number of facilities, accessibility challenges, poor technical supervision). However, the collaboration between the Government of Lesotho (GOL) and the Christian Health Association of Lesotho (the second largest provider of health services in the country) has been reinforced to address these challenges. Additionally, Lesotho has benefited from a large grant from the Millennium Challenge Corporation to rehabilitate and construct a significant number of health centers. The soon-to-be-completed Tšepong referral hospital will dramatically alter the service provision landscape in Lesotho as well. Better coordination across programs (HIV and others), integration of services, expanded use of community health workers, and improved supervision will offer Lesotho opportunities to greatly improve the reach and productivity of its service delivery system.

Historically, HIS in Lesotho has performed reasonably well compared to its peers. However, the information requirements imposed by the HIV pandemic (i.e., increased need for longitudinal patient tracking) have dramatically altered the HIS environment and exposed the inadequacy of human resources, aging and inadequate infrastructure, and insufficient coordination of partners. The GOL is aware of this situation and has taken several measures to address it. The recruitment of district health information officers is a first step in this regard. As stated above, Lesotho has the potential to better use its national resources (the HIS budget execution rate stands at 17 percent) and to tap into international goodwill to strengthen the HIS. The HSA makes several recommendations, ranging from leveraging new technologies (particularly mobile telephony) to integrating collection of data at the facility and district levels to strengthen the overall HIS.

Lesotho is engaged in deep, structural governance reforms that aim to devolve responsibility for management of social services to the decentralized level. This reform holds great promise for the health sector; however, the challenges in HRH, finance, HIS, and service delivery present a particular set of risks for successful decentralization of health services. To its credit, the MOHSW has proceeded very cautiously with the decentralization effort. Several opportunities for strengthened health governance are available through the decentralization process, including more participatory strategic and operational planning and enhanced effectiveness of existing community groups.

In short, the HSA revealed that although Lesotho faces serious health systems challenges, the country has a unique set of opportunities and strengths. Lesotho has a strong track record of adequately financing its health sector. The country has benefited from substantial international goodwill. Senior-level staff of the MOHSW are dedicated and competent. Health sector development is a priority at the highest levels of government. The magnitude of the challenges the country faces require a long-term health development plan, and the authors hope that this report will provide useful information to inform the development, and eventual implementation, of such a plan for the benefit of all the Lesotho people.

I. BACKGROUND

As the world works to address global health challenges, it has become increasingly clear that strong health systems are essential to delivering high-quality, accessible, sustainable, and safe health services. Therefore, the need to understand health systems and how to strengthen these systems is vitally important.

In recent years, Lesotho has undertaken significant health sector reform. Lesotho's National Health Plan (1995-2000) highlighted the importance of systems strengthening by placing a major focus on institutional strengthening, organizational development, human resources development, increased levels of health financing, and service delivery improvements and coordination of donors. With assistance from major development partners, Lesotho launched a series of health sector reform projects starting in 2000.

The Health Systems Assessment (HSA) approach provides a framework for undertaking a rapid, yet comprehensive assessment of a national health system. The approach assesses the six components of a health system, namely health governance, health financing, health service delivery, human resources for health (HRH), pharmaceutical management, and health information systems (HIS).

The United States Agency for International Development (USAID) supported the development of the HSA approach in response to international interest in understanding and strengthening health systems performance. Specifically, the assessment is designed to inform ministries of health and other key stakeholders on the overall state of the health system and provide a framework to help understand the strengths and weaknesses. Additionally, the HSA approach aims to inform health system strengthening (HSS) policies and strategies, by providing recommendations for action. The HSA tool¹ has been adapted and applied in Angola, Azerbaijan, Benin, Cote d'Ivoire, Ghana, Kenya, Malawi, Namibia, Nigeria, Senegal, South Sudan, Pakistan, Vietnam, Yemen, and Zimbabwe.

The Lesotho HSA had three major objectives:

- Provide a rapid assessment of the six health system components in Lesotho.
- Identify key system strengths and weakness, as well as opportunities and threats.
- Propose HSS interventions for government and/or donors to support.

¹ The Health Systems Assessment Approach manual is available at www.healthsystems2020.org/hsa.

2. METHODOLOGY

2.1 FRAMEWORK FOR THE HEALTH SYSTEMS ASSESSMENT APPROACH

Health Systems 20/20, in collaboration with the Ministry of Health and Social Welfare (MOHSW), Southern Africa Human Capacity Development Coalition (SAHCD), and Irish Aid, used the HSA tool to undertake a rapid assessment of the Lesotho health system, focusing on six dimensions: health governance, health financing, health service delivery, HRH, pharmaceutical management, and HIS.

The assessment team was composed of five people: four individuals from USAID implementing partners and one regional consultant. Each team member was responsible for one or two technical modules. Information collection and data analysis were conducted jointly with counterparts from the MOHSW.

The team relied heavily on secondary data sources, validated through key informant interviews and a district- and facility-level survey.

2.2 DESCRIPTION OF THE ASSESSMENT TOOLS

The HSA tool divides each technical module (finance, human resources, etc.) into components, which are subdivided into indicators, and then further subdivided into questions. Every country that undertakes an HSA customizes the tool to its national context. In Lesotho, the Health Systems 20/20 team worked extensively with the MOHSW and other interested stakeholders to customize the tool for Lesotho.

2.3 SAMPLING METHODOLOGY

The target population under study was the health sector of Lesotho, represented by all the public and private health facilities, the District Health Management Teams (DHMTs), the central MOHSW, and other key nongovernmental organizations (NGOs), civil society organizations (CSOs), and donors working on health in Lesotho. Additional information on the data collection sample is contained in annex A.

The assessment team administered a survey to 52 health centers and filter clinics, 21 hospitals, and 10 DHMTs using a stratified random sampling approach. In addition, team members interviewed key informants at the central MOHSW (directorates and technical units), parastatal organizations working in health, health training institutions, private facilities, professional associations and NGOs, and selected national experts as part of the assessment.

2.4 DATA COLLECTION PROCESS

The Lesotho HSA was officially launched during an orientation meeting organized in January 2010. This one-day workshop aimed to inform a range of stakeholders from government and development partners about the HSA approach.

Prior to the workshop, the technical team devoted considerable time to reviewing and adjusting questionnaires and lists of key informants with MOHSW counterparts. Finally, a training session for data collectors was organized over a three-day period.

The assessment team visited more than 100 key informants, 10 district health management teams, and 73 facilities during the assessment. Lists of national level key informants and facilities visited are included in annex B.

2.5 STAKEHOLDER VALIDATION

Following the in-country data collection, the HSA technical team, in collaboration with counterparts from the MOHSW, analyzed the data collected, reviewed additional documents, and prepared a draft for submission to MOHSW counterparts. The team submitted the final report to the MOHSW in July 2010 for final validation, prioritization of recommendations, and dissemination.

2.6 STRENGTHS AND LIMITATIONS OF THE HSA

The HSA approach differs from other health sector assessments in several ways. First, the scope of the assessment is very broad; it aims to collect information and understand the linkages within and between health system components (pharmaceuticals and finance, HIS and governance, etc.). Second, this approach is nationally representative in scope. It provides a comprehensive review of the Lesotho health system. Third, the assessment was conducted in a participatory manner, involving government stakeholders at the central, district, and facility levels, private sector providers of health care, NGOs, donors, and development partners. Fourth, the recommendations generated from the assessment aim exclusively to provide guidance to national and international partners on HSS investments and interventions.

Every assessment has limitations. Conducting a comprehensive yet rapid HSA involves some trade-offs with respect to depth versus breadth of analysis. Although valuable data were collected from the district and facility levels, most of this information was qualitative and was used to validate and supplement information collected through secondary sources and key informant interviews at the national level. The assessment was able to leverage numerous evaluations and studies that have been conducted in Lesotho in recent years and proposed action-oriented, achievable, and implementable recommendations for government and other interested stakeholders.

3. HEALTH SYSTEM PROFILE AND BACKGROUND INFORMATION

The Kingdom of Lesotho is a landlocked country, entirely surrounded by the Republic of South Africa. With a population of slightly more than 2 million and a gross domestic product (GDP) of US\$516.87 per capita (World Bank 2010), Lesotho is a lower middle income country². More than 99 percent of Lesotho's people are ethnic Basotho and an overwhelming majority (90 percent) are Christian. Sesotho and English are the national languages.

Demographic Information

The country is relatively small at 30,355 sq. km, divided into 10 districts. The mountainous terrain makes for difficult ground travel. Although 75 percent of the population lives in rural areas, only about one-quarter of the land is arable (Table 3.1 provides an overview of basic demographic indicators). Lesotho's population is growing at a rate of 0.87 percent, compared to the regional average of 2.35 percent. As shown in Figure 3.1, Lesotho's population growth trends mirror those of neighboring South Africa—demonstrating strong economic and epidemiological ties between the two countries. The sharp population growth decline, which began in 1999, is attributable to increased mortality due to HIV/AIDS.

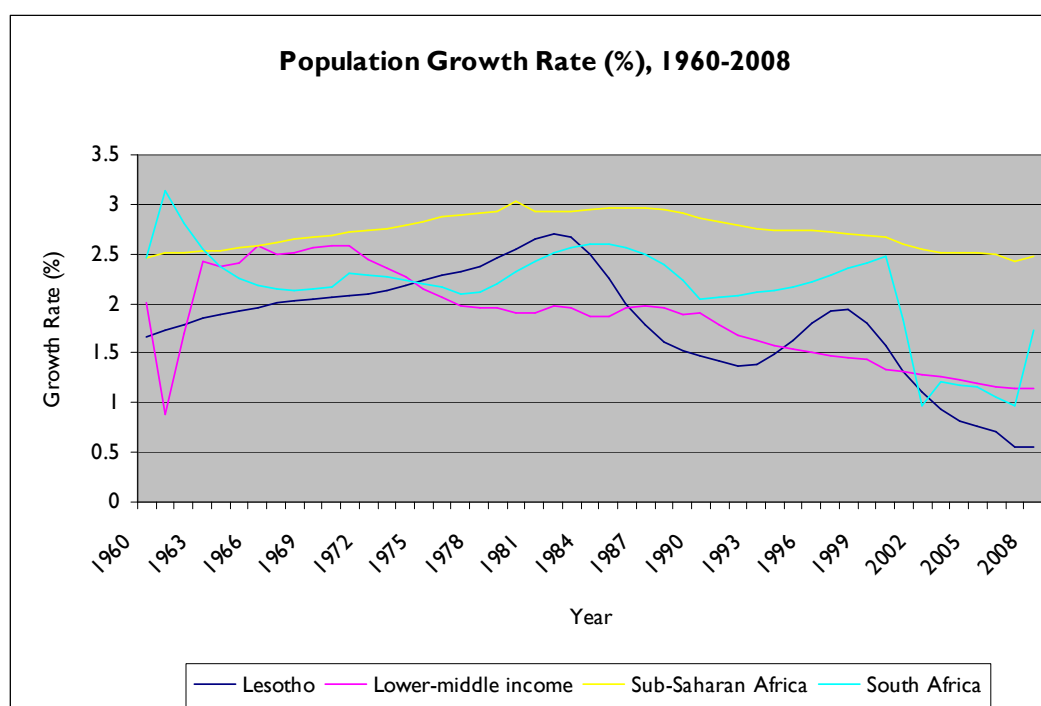
TABLE 3.1. DEMOGRAPHIC INDICATORS IN LESOTHO, COMPARED TO THE SUB-SAHARAN AFRICA REGIONAL AVERAGE

	Source of Data	Lesotho	Year of Data	Average Value in Sub-Saharan Africa	Year of Data
Core Module*					
Population, total	WDI-2010	2,049,429	2008	17,431,745	2008
Population growth (annual %)	WDI-2010	0.87	2008	2.35	2008
Rural population (% of total)	WDI-2010	74.54	2008	61.37	2008
Urban population (% of total)	WDI-2010	25.46	2008	38.63	2008
Population ages 0-14 (% of total)	WDI-2010	39.16	2008	41.49	2008
Population ages 65 and above (% of total)	WDI-2010	4.75	2008	3.26	2008

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>)

² The classification of countries by income group is based on the World Bank classification, which classifies member economies, and all other economies with populations of more than 30,000.

FIGURE 3.1. COMPARISON OF POPULATION GROWTH RATES



Source: World Bank (2010)

Reproductive Health

Table 3.2 provides a snapshot of Lesotho's reproductive health indicators. Compared to the average of other countries in the region, Lesotho has a higher contraceptive prevalence rate (although still low at 29%), lower total fertility, and higher utilization of antenatal care (ANC).

TABLE 3.2. REPRODUCTIVE HEALTH INDICATORS IN LESOTHO, COMPARED TO THE SUB-SAHARAN AFRICA REGION

	Source of Data	Lesotho	Year of Data	Average Value in Sub-Saharan Africa	Year of Data
Core Module*					
Contraceptive prevalence (% of women ages 15-49)	DHS	29.00	2004	**	--
	WDI-2010	37.30	2004	19.78	2008
Fertility rate, total (births per woman)	WDI-2010	3.33	2008	4.68	2008
	DHS	3.50	2004	**	--
Pregnant women who received 1+ antenatal care visits (%)	UNICEF	90.00	2004	70.50	2004
	DHS	90.40	2004	**	--
Pregnant women who received 4+ antenatal care visits (%)	DHS	69.60	2004	**	--
	UNICEF	70.00	2004	53.40	2004

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>)

Mortality

Lesotho has a low life expectancy rate (44.99 years), compared to the regional average of 55.14. This is due mainly to the extremely high levels of HIV and tuberculosis (TB). Table 3.3 summarizes selected mortality indicators in Lesotho.

TABLE 3.3. MORTALITY INDICATORS IN LESOTHO, COMPARED TO SUB-SAHARAN AFRICA

	Source of Data	Lesotho	Year of Data	Average Value in Sub-Saharan Africa	Year of Data
Core Module*					
Life expectancy at birth, total (years)	WDI-2010	44.99	2008	55.14	2008
Mortality rate, infant (per 1,000 live births)	WDI-2010	63.10	2008	75.96	2008
	DHS	91.00	2004	--	--
Mortality rate under age 5 (per 1,000)	WDI-2010	79.20	2008	120.29	2008
	DHS	112.80	2004	--	--
Maternal mortality ratio (per 100,000 births)	WDI-2010	960.00	2005	832.16	2005

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>)

*For data notes, please see annex E.

Lesotho has been severely affected by the HIV pandemic. In 2008, 23.2 percent of the adult population (aged 15-49) was HIV positive, the third highest rate in the world (UNAIDS 2008b). This corresponds to an estimated 62 new HIV infections and 50 deaths due to AIDS per day (UNAIDS 2008a). HIV accounts for 28 percent of male institutional deaths and 34 percent of female institutional deaths (MOHSW 2009). UNAIDS estimates that this adult prevalence rate will increase to 36 percent in the next 15 years.

In 2008, TB cases were estimated at 568 cases per 100,000 population (WHO 2008). Poverty and high rates of labor migration drive the HIV and TB epidemics. Table 3.4 summarizes the top causes of morbidity and mortality in Lesotho, as documented by WHO in 2002.

TABLE 3.4. MAJOR CAUSES OF DEATH IN LESOTHO, 2002

Top 10 Causes of Death, All Ages		
Causes	Deaths (%)	Years of Life Lost
HIV/AIDS	63	66
Lower respiratory infections	4	4
Diarrheal diseases	3	5
Cerebrovascular disease	3	1
Ischemic heart disease	3	1
Perinatal conditions	3	4
Tuberculosis	2	2
Measles	2	3
Chronic obstructive pulmonary disease	1	0
Road traffic accidents	1	1

Source: WHO (2002 (<http://www.who.int/entity/healthinfo/statistics/bodgbddeathdalyestimates.xls>))

Table 3.5 lists the top four reasons for institutional admission in 2008, with 2004 comparison data.

TABLE 3.5. INSTITUTIONAL ADMISSIONS AMONG MEN AND WOMEN

Male Admissions		2004	2008	Difference
Trauma (head injury/assault)		5.3%	14%	+8.7%
HIV/AIDS		No Figures	11%	N/A
Pulmonary Tuberculosis		19.8%	10%	-9.8%
Pneumonia		5.9%	4%	-1.9%
Female Admissions		2004	2008	Difference
HIV/AIDS	2.2%	13%	+10.8%	
Abortion	10.8%	13%	+2.2%	
Pulmonary Tuberculosis	12.1%	6%	-6.1%	
Senile Cataracts	2.1%	4%	+1.9%	

Source: MOHSW (2008)

In the 20-year period between 1990 and 2010, the risk of mortality among adult men and women in Lesotho increased by 67 percent and 174 percent, respectively, from an average of 191 to 524 per 1,000 for women and 435 to 727 per 1,000 for men (Rajaratnam et al. 2010). Although the risk in men and women in Swaziland is higher, Lesotho still compares poorly, on average, with other countries of similar size and socioeconomic development in the region, as indicated in Table 3.6.

TABLE 3.6. MORTALITY IN MEN & WOMEN AGED 15-59 YEARS (SELECT COUNTRIES)*

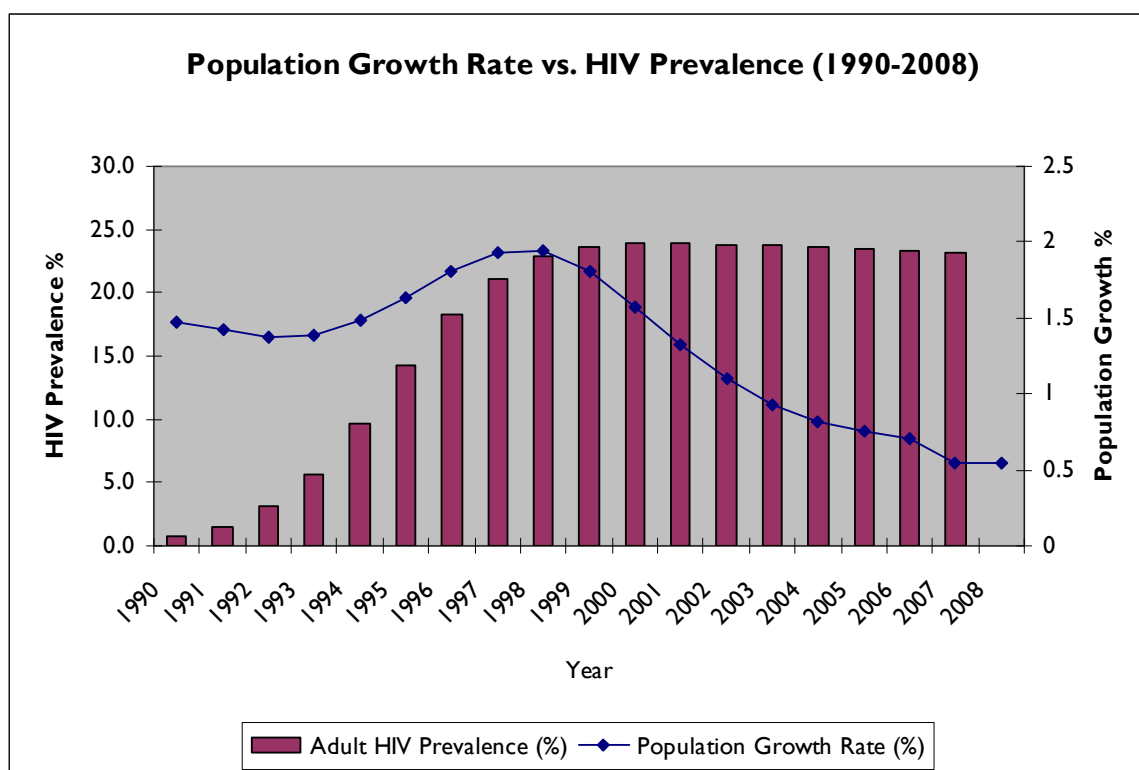
	1970		1990		2010	
	Women	Men	Women	Men	Women	Men
Botswana	183	205	147	172	412	637
Lesotho	247	482	191	435	524	727
Mozambique	292	329	229	342	470	630
Swaziland	341	443	269	372	597	765

Source: Rajaratnam et al. (2010) and World Bank (2009)

* Adult mortality risk as reported by WHO and the World Bank, represents, for a given year, the probability that an individual will die before reaching the age of 60 years on the assumption that the age-specific mortality conditions of the year are constant throughout this individual's life.

Figure 3.2 shows a juxtaposition of the HIV prevalence rates with the population growth rates between 1990 and 2007. It demonstrates the huge impact of HIV on Lesotho's population. Shortly after the HIV prevalence began stabilizing at around 20 percent, the population growth rate declined from 2 percent to 0.5 percent over a 10-year period, largely due to excess mortality caused by HIV.

FIGURE 3.2. COMPARISON OF POPULATION GROWTH RATES VS. HIV PREVALENCE RATES BETWEEN 1990 AND 2008



Source: World Bank (2009); UNAIDS, (2008); UNAIDS/WHO (2008)

3.1 POLITICAL AND MACROECONOMIC ENVIRONMENT

The Kingdom of Lesotho, formerly called Basutoland, gained independence from the United Kingdom in 1966. Lesotho is a constitutional monarchy with a dual legal system consisting of traditional customary law and common law. His Majesty, King Letsie III functions as the head of state, and Prime Minister Rt. Honorable Pakalitha Bethuel Mosisili functions as head of government with executive authority. The country is governed by a 33-member senate (22 principal chiefs and 11 royal appointees) and a 120-member national assembly (80 elected seats and 40 proportional representation seats).

Politically, Lesotho is relatively stable, with the most recent period of political instability dating back to 1998 when a contested election prompted violent protests and a mutiny. This led to electoral reforms, which oversaw the implementation of limited proportional representation starting in 2002.

In 2007, Lesotho was selected as one of 16 lower income countries eligible for the U.S. government's (USG) Millennium Challenge Corporation (MCC) assistance³. Eligibility for MCC assistance is based on 17 policy indicators that demonstrate a commitment to policies promoting political and economic freedom, investments in education and health, the sustainable use of natural resources, control of corruption, and respect for civil liberties and the rule of law. Water and private sector development comprise 55 percent of the 2007 five-year, \$362.6 million dollar MCC compact, highlighting the

³ MCC compacts are five-year grants for countries that pass MCC's eligibility criteria for good governance, economic freedom, and investments in their citizens. MCC provides well-performing countries with large-scale grants to fund country-led solutions for reducing poverty through sustainable economic growth.

importance of these two areas for development and the relative need for improvement. The MCC compact program's objectives are to improve the water supply for industrial and domestic needs and enhance urban and rural livelihoods through improved watershed management and to stimulate investment by improving access to credit, reducing transaction costs, and increasing women's participation in the economy (MCC 2007). According to the Heritage Foundation, private sector development is limited by government involvement in economic activity. Weak property rights, limited access to finance, and bureaucratic red tape stifle the entrepreneurial environment (Heritage Foundation 2010). Lesotho's economy is linked to that of its larger neighbor, South Africa, through remittances from miners and other laborers, customs revenues from the Southern African Customs Union, and the sale of water to South Africa (World Bank 2009). However, remittances from miners employed in South Africa have declined in recent years, and the economy relies on a small manufacturing base (based on farm products that support the milling, canning, leather, and jute industries), as well as on a rapidly expanding apparel-assembly sector (CIA 2010). According to the World Bank, real per capita GDP growth averaged 3.3 percent over 1991-2007, above the sub-Saharan Africa average. However, Lesotho's growth path has been closely linked to the external environment, weather conditions, and the strength and weakness of the rand to which the Maloti is pegged (World Bank 2009). Lesotho also faces extreme income distribution inequality as the country's economy is still primarily based on subsistence agriculture, especially livestock (CIA 2010). Table 3.7 provides an overview of income and inequality indicators in Lesotho, compared to sub-Saharan Africa averages.

TABLE 3.7. INCOME AND INEQUALITY INDICATORS IN LESOTHO, COMPARED TO SUB-SAHARAN AFRICA AVERAGES

	Source of Data	Lesotho	Year of Data	Average Value in Sub-Saharan Africa	Year of Data
Core Module*					
GDP per capita (constant 2000 US\$)	WDI-2010	516.87	2008	1,053.27	2008
GDP growth (annual %)	WDI-2010	3.95	2008	5.16	2008
Per capita total expenditure on health at international dollar rate	WHO	143.00	2006	147.78	2006
Private expenditure on health as % of total expenditure on health	WHO	38.40	2006	48.94	2006
Out-of-pocket expenditure as % of total expenditure on health	WHO	68.90	2006	78.02	2006
Gini index	WDI-2010	52.50	2003	43.81	2003

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>)

Lesotho's transportation infrastructure is composed of road, air, and water, with a small privately owned rail linkage at the border of South Africa. Road transport predominates, and, as of 2006, there were 7,437 km of existing roads, of which 16 percent were paved, 51 percent were gravel, and 33 percent were earth/other (World Bank 2006). As a land-locked country, Lesotho recognizes the link between economic growth and the need for adequate transport infrastructure and is currently using funds from the World Bank and European Commission to strengthen its transportation system and improve access to economic opportunities and services.

3.2 DECENTRALIZATION

In 1997, Lesotho passed the Local Government Act, which outlined a new local government system and created 10 district and 128 community councils (AfDB 2006). The overall objectives of the act, which

applies to every sector, were to (1) provide for good governance, ownership, and accountability in matters of public policy; (2) facilitate democratic control over the development process; (3) shift decision making, resource allocation, and local development planning into the hands of the people; (4) provide for equitable distribution of resources across the country; (5) enhance the effectiveness of development activities; (6) facilitate sustainability through matching development activities; (7) facilitate greater speed and flexibility; and (8) facilitate mobilization and maximization of local resources, technologies, and skills.

According to the law, many roles that were previously held by the national government were to be transferred to the districts and rolled out over a three-step, 12-year process, starting in 2004. The first phase involved local government elections (2005). Currently, Lesotho is in the second phase of decentralization⁴, characterized by the transfer of functions to the district and community councils (Mbetu and Tshabalala 2006). Table 3.8 provides information on the structure and roles of these local councils. Functions being devolved to local governments include limited decision-making authority over budgets, project implementation, limited revenue generation through taxes, human resources management, and data collection and analysis. Line ministries, including the MOHSW, are shifting their roles away from activity implementation towards policymaking, capacity building, and quality assurance (QA). The aim of the third phase, slated to begin in 2011, is to refine processes at decentralized levels to improve efficiency (MOHSW 2007).

TABLE 3.8. STRUCTURE AND ROLES OF LOCAL COUNCILS

Structure	Composition	Roles
Community councils (about 128)	Formed of representatives from a cluster of villages situated in rural and urban areas.	Act as a legally recognized structure performing functions delegated by the district council, drawing staff and other resources from the district councils.
District councils (10)	Two members representing each community council plus two gazetted chiefs of the district (who are members of the community councils).	Act as a corporate body with jurisdiction over the whole district.
Municipal Council of Maseru	Formed from cluster of villages within the urban area of Maseru.	Act as a corporate body with jurisdiction over the whole urban area.

Source: MOHSW (2007)

Similar to other sectors, health services are currently being decentralized in Lesotho to place decision-making authority at the district level (MOHSW 2007). Under this new system, districts will be responsible for budgeting, planning, implementing projects, managing health centers, and tracking resources, while the MOHSW will retain management of referral hospitals. The MOHSW is also responsible for overall policy formulation, resource mobilization, advocacy and partner coordination, provision of a regulatory framework for all providers, and monitoring and evaluation (M&E). The implications of decentralization are discussed in more detail in the governance section of this assessment report.

3.3 SERVICE DELIVERY ORGANIZATION

The formal system of Lesotho health facilities are divided into the national (tertiary), district (secondary), and community (primary) levels. (Table 3.9 provides information on these health system

⁴ Note: This decentralization is nationwide, not specific to the health sector.

levels.) The community level includes both health posts and health centers. The district level comprises hospitals that receive patients referred from the community level and filter clinics. The national level consists of one referral and two specialized hospitals. Any patients with conditions that cannot be addressed at the national level are referred to South Africa for care, through the national referral hospital. In Lesotho, 42 percent of the health centers and 58 percent of the hospitals are government owned, 38 percent of the hospitals and 38 percent of the health centers fall under the control of the Christian Health Association of Lesotho (CHAL), and the remaining facilities are either privately owned or operated by the Lesotho Red Cross.

In addition to the hospitals, filter clinics, health centers, and health posts recognized within the Government of Lesotho (GOL) system of health facilities, there is also an extensive network of private surgeries, nurse clinics and pharmacies providing care and/or medicines.

National level: At the national level, Lesotho has three tertiary-level hospitals: Queen Elizabeth II Hospital, Mohlomi Mental Hospital, and Bots'abelo Leprosy Hospital. Queen Elizabeth II Hospital is the national referral hospital. Any cases that cannot be treated at Queen Elizabeth II are referred to South Africa.

There is a fourth, large tertiary hospital in the process of being built through a public-private partnership (PPP). This hospital will serve as the main referral hospital in Lesotho. It will be substantially larger than Queen Elizabeth II Hospital and will be linked to a network of filter clinics.

District level: Districts have filter clinics and district hospitals. Filter clinics are a first point of care intended to lighten the load of district hospitals and function as “mini-hospitals,” offering curative and preventive services and limited inpatient care. These clinics are especially important in Maseru, where the national referral hospital doubles as a district-level hospital. Unlike health centers, filter clinics are staffed by doctors and some have pharmacy technicians. They also offer selected laboratory and radiology services (administered through the hospitals).

Although district hospitals provide both inpatient and outpatient care, their services vary widely depending on the availability of financial resources, equipment, and human resources. Treatment and diagnostic services are more complex at this level. These facilities provide minor and major operative services, ophthalmic care, counseling and care of rape victims, radiology, dental services, mental health services, and blood transfusions as well as preventive care. Some specialized care is also available for TB, HIV, and noncommunicable diseases.

Community level: Communities offer health posts and health centers. Health centers are the first point of care within the formal health system. Staffed by nurse clinicians with comprehensive skills in preventive and curative care and in the dispensing of medication, health centers offer curative and preventative services, including immunizations, family planning, and postnatal and antenatal care on an outpatient basis (with the exception of services to expectant mothers). Their mandate also extends to supervising the community public health efforts and training volunteer community health workers (CHWs).

Health posts provide community outreach services and are typically managed by volunteers. Generally, health posts are opened at regular intervals (not daily) and provide promotive, preventive, and rehabilitative care in addition to organizing health education gatherings and immunization efforts. Volunteer CHWs include traditional birth attendants and community-based condom distributors, among others.

The organizational structure of the MOHSW is depicted in annex C for reference.

TABLE 3.9. NUMBER AND TYPE OF HEALTH FACILITIES IN LESOTHO*

District	Size	Population (2006)	Tertiary Care		Secondary Care	Primary Care				Pharmacies	Total
			Referral Hospital	Specialty Hospital		Filter Clinic (All GoL)	Health Center	Private Surgery	Nurse Clinic (All private)	Pharmacy (All private)	
Maseru	4,279 sq km	431,998	1	2	4	1	47	27	34	27	143
Berea	2,222 sq km	250,006			2	1	19	3	8	3	36
Leribe	2,828 sq km	293,369			2	1	27	6	5	4	45
Botha-Bothe	1,767 sq km	110,320			2		12	2	3	1	20
Mokhotlong	4,075 sq km	97,713			1		12	2		2	17
Thaba Tseka	4,270 sq km	129,881			2		17				19
Qacha's Nek	2,349 sq km	69,749			2		11	1	1	1	16
Quthing	2,916 sq km	124,048			1		8	2	3		14
Mohale's Hoek	3,530 sq km	176,928			1		15	1	3	3	23
Mafeteng	2,119 sq km	192,621			1		20	4	9	5	39
Total		1,876,633	1	2	18	3	188	48	66	46	372

Source- Oxford Policy Management (2008), Lesotho Bureau of Statistics

*Note - These numbers differ slightly from the numbers submitted by the MOHSW for use in sampling for the HSA. The sample noted 189 health centers, with variations in Maseru, Leribe, and Quthing districts.

3.4 DEVELOPMENT ASSISTANCE FOR HEALTH

As of February 2010, 15 development partner agencies are active in Lesotho. Donor coordination, alignment, and harmonization have improved since the formation of Development Partners Consultative Forum (DPCF) in 2005, which is cochaired by the United Nations Development Program (UNDP) and Irish Aid. All resident development partners are members of the DPCF, which includes the World Bank, the U.K. Department for International Development (DFID), European Union, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), and many of the specialized United Nations agencies, in addition to member countries (United States, China, and Ireland). The DPCF provides a forum for development partners to discuss their current and planned activities, coordinate programs, and promote efficient and effective delivery of development projects (World Bank 2009). A separate entity, the Health Partners Forum, meets to discuss health-specific donor assistance under the MOHSW.

In financial year 2008/09, the total donor contribution to health provided 18 percent of total health resources for Lesotho. Key international partners included the United States [through the President's Emergency Plan for AIDS Relief (PEPFAR) and MCC], Ireland, the EU, United Nations, and other international donors and NGOs. Table 3.8 provides a summary of donor assistance for Lesotho. A more detailed matrix of donor contributions is included in annex D.

TABLE 3.10. SUMMARY OF DONOR ASSISTANCE FOR HEALTH*

Donor	Field of Intervention /Activities	Timeline / Duration	Amount / Commitment	Project Location	Counterpart
USG (PEPFAR)	PEPFAR total for Financial Year 2009	2009-2010	\$26.7M	National level	Implementing partners
	Projected PEPFAR Financial Year 2010**	2010-2011	\$29M		
USG (MCC)	Health Sector Project (5-year total \$1.22B)	2010	\$24M	National level	MOHSW
		2011	\$20M		
		2012	\$14M		
World Bank ***	HIV	2010	\$12M	National level	MOFDP
	Health	2010	\$5M		
Global Fund	Round 6, 7, & 8 – TB, HIV/OVC and HIV/HSS	2009/2010	\$31.75M	National level	MOFDP, Lesotho Council of NGOs
	Round 8 & 9– TB, HIV/OVC	Not signed	\$55.7M (requested, life of grants)		MOFDP, Lesotho Council of NGOs
EU	OVC, PLWHA,	2007-2011	14,739,000€	National level	MOHSW, Red Cross, CARE
WHO	Health	2010-2011	\$4,098,600 ⁺		
Irish Aid	CHAL, DHS, HRH, HIV/AIDS services	2009	4,350,000€	District and national levels	MOHSW, Clinton Foundation

*Unless otherwise noted, figures were received through correspondence with donor representatives.

** Draft PEPFAR Country Operational Plan 2010.

*** World Bank Project Documents www.worldbank.org.

⁺Funds directed at health program support only. Does not include funds to support resident mission.

4. HEALTH SYSTEM ANALYSIS

The health system analysis findings are organized and presented in six sections according to the health system components: health financing, HRH, pharmaceutical management, governance, service delivery, and HIS. Each section provides a brief description of the components and presents key findings. Analysis and recommendations across the six technical building blocks are included in chapters 5 and 6.

4.1 HEALTH FINANCING⁵

The main purpose of health financing is to pay for health care, but it also can be used to set financial incentives that will motivate providers to increase the supply of health care goods and services, to ensure that all individuals have access to effective public health and personal health care services and goods (WHO 2000), and ultimately to improve the health of individuals and the general population. Health systems financing comprises three interrelated functions: revenue collection, risk pooling (leading to resource allocation), and purchasing of interventions. The main challenge with health care financing is designing and implementing technical, organizational, and institutional mechanisms that are able to carry out these functions and protect people from catastrophic health expenditures⁶.

4.1.1 RESOURCE FLOWS IN LESOTHO

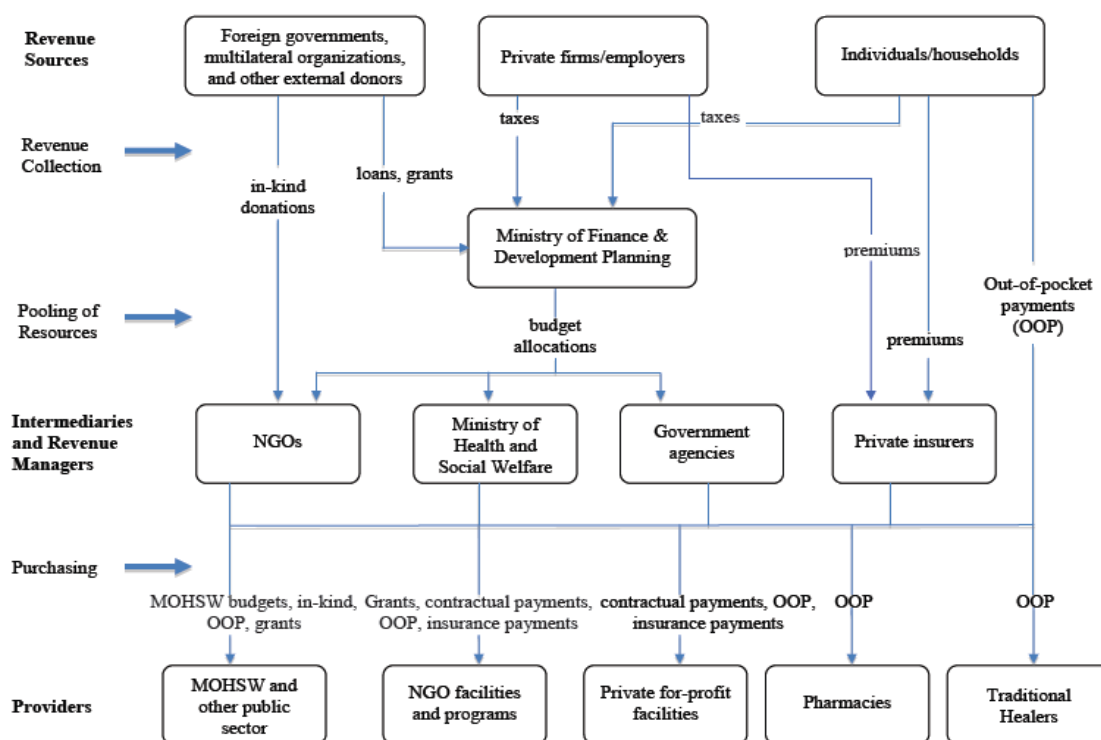
In Lesotho, revenue collection in the public sector is centralized within the Ministry of Finance and Development Planning (MOFDP). These funds come from households, private companies, and semipublic corporations in the form of tax revenues and non-tax revenues, grants, and loans from foreign governments. Funds from development partners, including international NGOs, are another source of health funding, and together with government revenues, these represent the main sources of funds for the Lesotho health system.

Other funds for health services come from direct out-of-pocket payments to health providers and household contributions to private health insurance offered by various companies, in particular, Mammoth and Bophelo Medical Aid schemes. Private and semipublic companies also finance health by contributing to premiums to medical aid schemes on behalf of their employees, providing reimbursements to employees for medical expenses, and providing health services in their on-site health facilities. Like most countries in southern Africa, Lesotho does not have a social or community health insurance scheme. As such, pooling of financial resources is highly limited. The MOHSW purchases specific services from the CHAL by allocating a “subsidy” through the recurrent budget. (See Figure 4.1.1 for more details on financial flows in Lesotho.) It should be noted that Lesotho has never conducted a National Health Accounts estimation.

⁵ Currency equivalents- US\$1 = XXX Lesotho Loti (LSL), 2004/05=6.46, 2005/06=6.36, 2006/07=6.77, 2007/08=7.05, 2008/09=8.26. Source: IMF-International Finance Statistics Sept 2009. Method used: principal rate, period average.

⁶ A catastrophic health expenditure occurs when financial contributions to the health system are equal to or exceed 40 percent of income remaining after subsistence needs have been met. Studies have indicated that when the out-of-pocket health spending is less than 15 percent of the total health spending, few households are affected by catastrophic payments (WHO 2005).

FIGURE 4.1.1. HEALTH FINANCING FLOWS IN LESOTHO, 2004/2005 TO 2008/2009*



* For the purposes of this section, years (i.e., 2004/05 to 2005/06) refer to financial, not calendar, years.

4.1.2 REVENUE COLLECTION: AMOUNT AND SOURCES OF FINANCIAL RESOURCES IN LESOTHO

Total Health Expenditure

Lesotho spent an average of 7.7 percent of its GDP on health between 2004/05 and 2008/09 reaching a peak of 8.5 percent of its GDP in 2008/09, which is almost double the average for low middle income group countries (4.5 percent), and well above the World Health Organization's (WHO) African Region average of 5.6 percent in 2006 (see Table 4.1.1). In per capita terms, there has also been an upward increase from a low of M293.62 (US\$45.5) from 2004/05 to a high of M547.7 (US\$66.3) in 2007/08. From 2004/5 to 2008/9, Lesotho spent M385.7 (US\$54.6) per capita/per annum, which was one and one-half times higher than the US\$34 per capita per annum recommended for providing a minimum package of cost-effective interventions. This implies that Lesotho is not suffering from an absolute inadequacy of financial resources, but that the country has, and allocates, resources capable of providing quality health care services to its population. However, this amount, while double the WHO African Region average (\$27/annum), remains lower than the average of its peers in the low middle income group (\$74) (WHO 2009).

**TABLE 4.1.1. ACTUAL HEALTH EXPENDITURES IN LESOTHO: 2004/05 TO 2008/09
FINANCIAL YEAR**

Indicator	Financial Year						World Bank Low Middle Income Countries Classification 2006**	WHO African Region 2006***
	2004/05	2005/06	2006/07	2007/08	2008/09	Average 2004/05- 2008/09		
Total expenditure of health as % of GDP	7.4%	7.8%	6.9%	7.9%	8.5%	7.7%	4.50%	5.60%
Per capita total health expenditure (USD*)	45.5	51.5	48.5	61.2	66.3	54.6	74.0	27.0
Per capita total health expenditure (Maloti)	293.6	327.4	328.2	431.6	547.7	385.7		
Per capita government expenditure on health (USD*)	27.7	30.3	29.2	37.0	41.8	33.2	33.0	
Per capita government expenditure on health (Maloti)	178.7	192.5	197.4	261.2	345.4	235.0		
Government expenditure on health as % of total government expenditure	9.4%	9.1%	8.1%	9.8%	11.5%	9.6%	8.4	8.6%
Public (government expenditure) spending on health as % of total health expenditure	60.9%	58.8%	60.1%	60.5%	63.1%	60.7%	43.90%	46.3%
Donor spending on health as % of total health spending	10.1%	13.7%	11.9%	17.2%	18.0%	14.2%	0.9%	8.7%
Out-of-pocket spending as % of private health spending	98.4%	95.9%	95.5%	94.8%	93.9%	95.7%	84.90%	46.8%

Source: Government expenditure print-outs (various years); annual joint review (AJR) reports (various years); Oxford Policy Management (2008); Lesotho Bureau of Statistics (2004); World Health Organization (www.who.int/nha)

* USD calculated at average exchange rate.

**Lesotho is classified by the World Bank as a low middle income country.

***The WHO African Region includes all countries in Africa (46) except Morocco, Egypt, Sudan, Tunisia, Libya, Djibouti, and Western Sahara.

Although health care resources in the Lesotho health system appear to be adequate for provision of a basic package of cost-effective interventions, there are clear indications that the health sector requires additional resources. Table 4.1.2 shows that the total budget requirement for the health sector for the Medium Term Expenditure Framework (MTEF) period for 2008/09 to 2010/11 in Lesotho is M6,595,956,268, while the available resources are estimated at M1,904,971,420, resulting in a total funding gap of M4,696,984,848. The major areas with large resource gaps are service delivery, infrastructure, and decentralization, meaning that a large proportion of these costs are long-term requirements that require sustainable financing strategies.

TABLE 4.1.2. FINANCING AND RESOURCE REQUIREMENTS FOR THE HEALTH SECTOR IN LESOTHO, 2008/09 TO 20011/09 (MALOTI)

PROGRAM AREAS	Timeframe			Total requirement 2008/09-2010/2011	Total available budget	Total funding gap
	2008/09	2009/10	2010/11			
Service delivery	362,881,162	1,170,007,486	177,229,786	1,780,265,634	356,901,410	1,424,864,224
Decentralization	415,817,162	1,216,374,986	221,871,386	1,924,745,134	420,116,510	1,509,128,624
Partnerships	141,244,000	127,597,000	124,126,000	422,967,000	98,967,000	324,000,000
Health sector restructuring and HR plan	1,586,500	1,653,000	715,000	3,954,500	296,500	3,658,000
Infrastructure maintenance and development	133,510,000	335,760,000	1,742,272,000	2,437,284,000	1,028,030,000	1,409,254,000
Research, monitoring, and evaluation	6,155,000	14,890,000	5,820,000	26,740,000	660,000	26,080,000
TOTAL	1,061,193,824	2,866,282,472	2,272,034,172	6,595,956,268	1,904,971,420	4,696,984,848

Source: MOHSW (2009)

In relation to this issue, HIV/AIDS financing has significant resource gaps. The Lesotho Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) round 8 submission estimated future resources required to deliver comprehensive prevention, treatment and care, and support services for HIV/AIDS and calculated the financing gap, as shown in Table 4.1.3. Significant gaps starting from a low of US\$31,054,132 in 2009 and reaching a high of US\$95,482,707 in 2013 are anticipated.

TABLE 4.1.3. HIV AND AIDS FINANCING GAP (US\$)

	2009	2010	2011	2012	2013
Resource needs	91,978,780	99,080,238	106,015,854	113,436,963	121,631,967
Expected available resources	60,924,648	52,497,662	55,647,652	53,079,074	26,149,260
Financing gap	31,054,132	46,582,576	50,368,202	60,357,889	95,482,707

Source: MOHSW (2009)

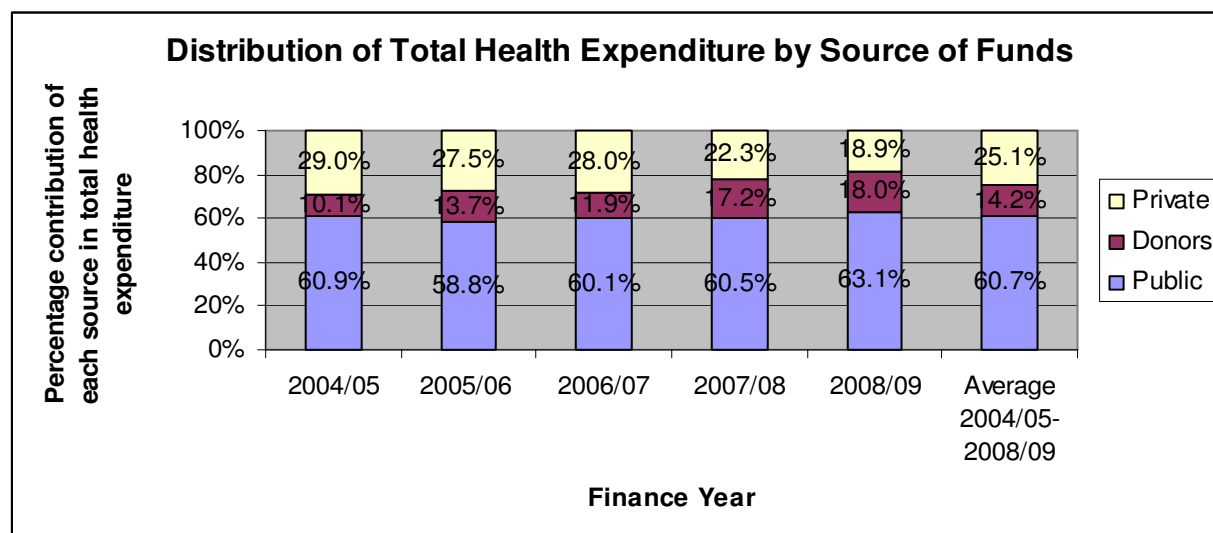
In short, the magnitude of the resource gap in both health and HIV/AIDS sectors warrants that Lesotho intensify its resource mobilization efforts and improve the efficiency of use of existing resources.

Sources of Health Funds

The major source of health expenditure in Lesotho between 2004/05 and 2008/09 was government, which contributed an average of 60.7 percent of total health spending, reaching a peak of 63.1 percent of total health spending in 2007/08. This is well above the average of its peers of the low middle income group (43.9 percent) and the WHO African Region (46.3 percent) in 2006. The second major source of health spending was private sources (households and companies), contributing an average of 24.1

percent, and donors⁷ ranked third, contributing 14.2 percent of total health spending between 2004/05 to 2008/09 (see Figure 4.1.2).

FIGURE 4.1.2. DISTRIBUTION OF TOTAL HEALTH EXPENDITURE BY SOURCE OF FUNDS, 2004/05 TO 2008/09



Source: MOHSW (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008); Lesotho Bureau of Statistics (2004); WHO (www.who.int/nha)

Government Revenue Sources

The major source of government revenues in Lesotho that were eventually spent on health from 2004/05 to 2008/09 were payments from the Southern Africa Customs Unions (SACU), which contributed an average of 55 percent of total government revenues. Tax revenue was second (32 percent), followed by non-tax revenue (9 percent) and grants (3 percent). Between 2004/05 and 2008/09, government expenditures on health (public expenditure on health as percentage of total government expenditure) averaged 9.6 percent, reaching a high of 11.5 percent in 2007/08. At 1.2 percent, this was slightly above the average of peers in the low middle income countries group and 1.0 percent below that of the WHO African Region in 2006 (see Table 4.1.1). This percentage is substantially lower than the targets set in the Abuja Declaration, which asks governments to allocate at least 15 percent of their budget to health. In 2006, African governments only allocated an average of 8.6 percent of their total expenditure to health (WHO 2006).

Despite this low health expenditure as a percentage of total government expenditures, it is clear that the financing of the Lesotho health system is very sustainable given the low reliance on donor resources. As such, health-related activities can be maintained in the event of a sudden withdrawal of donor aid. However, a high dependence on general tax revenue mechanisms for funding health systems also carries some risk. Because general tax revenue is dependent on a country's macroeconomic performance,

⁷ Anecdotal evidence suggests that some donors spend significant resources on health through NGOs and other government agencies, and these data were not available in all secondary sources reviewed. This is due to the fact that Lesotho has not conducted a National Health Accounts (NHA) exercise. As such, only donor health expenditures passing through the government budget were captured in the studies reviewed, therefore, quoted figures on donor expenditure may be significantly underestimated.

which itself is dependent on several variables (including international trade), health system funding can be drastically cut in the event of external shocks, compromising the implementation of planned activities.

Lesotho is currently facing such a situation. Since Lesotho signed the Economic Partnership Agreements with the EU in 2008, Lesotho's major source of revenue (SACU) will be reduced by almost 50 percent from 2010/11, and by nearly two-thirds by 2011/12 from 2009/10 levels, resulting in a reduction of total revenues by 13 percent and 19 percent, respectively. These reductions in total government revenues have led to deep cuts in the projected allocation (ceilings) for the MOHSW for 2010/11, 2011/12, and 2012/13 by 14.5 percent, 7.7 percent, and 7.8 percent, respectively. Further complicating this situation, Lesotho has prioritized the reduction of corporate taxes as a means of improving its investment climate.

This demonstrates that the future prospects for increased funding for health from domestic revenues in Lesotho is bleak. The fact that Lesotho has one of the highest HIV/AIDS prevalence rates in the world (23.5 percent) will inevitably lead to an increased demand for comprehensive, quality health services from MOHSW health facilities, the largest health service provider. With an inadequate resource base, it is highly unlikely that the MOHSW facilities will be able to cope (see Table 4.1.3 on HIV/AIDS resource needs). Although donor financing is increasing in Lesotho, particularly for HIV/AIDS (see Figure 4.1.14), Lesotho, like most countries that do not have Sector-Wide Approaches (SWAp) or similar mechanisms, must earmark donor funding mainly for preventive HIV/AIDS services such as Prevention of Mother-to-Child Transmission (PMTCT) and HIV testing and counseling (HTC), and, in special cases, antiretroviral therapy (ART). This signifies that the bulk of curative health care services for HIV/AIDS will be provided by MOHSW health facilities, but, ironically, the sector will have limited resources to cope.

Furthermore, it has been found that public health expenditures benefit the rich more than the poor in most African countries. A study by Castro-Leal et al. (2000) found that an estimated 30 percent of total government health expenditure benefits the top 20 percent of the population, while only about 12 percent benefits the poorest 20 percent. This is potentially the case in Lesotho; however, detailed studies need to be undertaken to determine which population groups benefit from government expenditures on health. The removal of user fees at all MOHSW and CHAL health centers in Lesotho in 2008 was intended to reverse the inequities caused by the introduction of such fees and provide access to and promote the utilization of health care services by all citizens. Thus, if a benefit incidence analysis in Lesotho finds that general tax-funded health spending is benefiting the rich more than the poor, the goal of achieving equity will remain elusive. As such, it is necessary to design alternative financing mechanisms for funding health that could reduce inequities and ensure sustainable financing for health care. One such mechanism might be the implementation of a social health insurance scheme, the feasibility of which was assessed in 2007 by WHO and MOHSW (Mathauer 2007)⁸.

Private Sources (Households and Private and Semipublic Corporations)

As shown in Figure 4.1.2, the second major source of financing health in Lesotho is private sources. Within this funding source, household out-of-pocket expenditures are the major source of funding in total private health spending, contributing an average of 95.7 percent between 2004/05 and 2008/09. This places Lesotho higher than its peers in low to middle income countries, which averaged 84.9 percent in 2006 (Table 4.1.1). This implies that Lesotho has very low prepaid health insurance coverage, with most households paying for health care through direct out-of-pocket payments at the time of use of health services. Although it is gratifying to note that the levels of direct out-of-pocket payments in private health spending decreased from a high of 98.4 percent in 2004/05 to a low of 93.9 percent in

⁸ The MOHSW/WHO social health insurance study indicated the potential and feasibility of introducing a social health insurance scheme in Lesotho; however, such a scheme is bound to face some liquidity problems in the eighth year if the favorable scenario is adopted.

2008/09, evidence abounds that user fees dissuade the very poor from utilizing health care services. Additionally, it has been found that user fees above 15 percent of total health spending can lead many households to incur catastrophic health expenditures (WHO 2000). In Lesotho, direct out-of-pocket payments were estimated at 24 percent of the total health spending from 2004/05 through 2008/09, well above the 15 percent mark. This implies that a high number of households in Lesotho have probably incurred catastrophic health spending. Thus, the removal of user fees in all MOHSW and CHAL health centers and the assessment of the feasibility of establishing a social health insurance scheme in Lesotho are positive measures aimed at improving access to and utilization of health care services for the majority of the population.

In addition to households, other sources of health financing are private and semipublic corporations, which pay for health services through (1) employer contributions as employee benefits to medical aid schemes, in particular to Mammoth and Bophelo; (2) the provision of onsite health care, in particular company dispensaries; or (3) reimbursements for employees' health expenses. However, no studies have been conducted on these sources' contribution to health financing in Lesotho.

Donor Funding

Donor funding is the third largest source of funding for health. International assistance has rapidly increased from a low of 10.1 percent in 2004/05 to a high of 18 percent in 2008/09⁹. The major changes witnessed between 2007/08 and 2008/09 are due to the increase in the capital budget¹⁰ of the MOHSW. This budget is funded primarily by donors, in particular the MCC and multiple external donor projects such as UNFPA, EU, OHA AFRICA, Clinton Foundation, UNDP, and Global Fund round support, which was not previously included in the GOL budget estimates. Although there has been a major increase in donor funding for health, it is unclear as to whether such an increase is sustainable, especially in view of the global recession, which has greatly affected the donor countries.

The major donor funding issue we observed through this analysis is that the majority of NGOs operating in Lesotho are funded by donors. However, most NGO health programs are not informed or guided by the MOHSW operational plans. In addition, some donors fund selected government institutions and activities off-budget. Furthermore, no framework (such as a memorandum of understanding [MOU]) exists to govern relations between NGOs working in the health sector and the MOHSW, clearly outlining what services and assistance are to be provided, where, and by whom. Although compared to other countries in the region, Lesotho has a small number of NGOs, their rapidly growing number raises concerns about the management burden on the government. The reemergence of global disease initiatives, which are often vertically managed, further complicates the situation, as there are occasional contradictions between globally driven and nationally identified health priorities (e.g., offering male circumcision as an HIV/AIDS prevention strategy versus reducing maternal deaths through provision of basic emergency obstetric care in health facilities). The assessment team also observed that human resource and other requirements necessary for scaling up global disease interventions have frequently been ignored, or human resources are poached from an already weak public health sector. The crowding out of traditional public health interventions, such as reproductive health (in particular, maternal and child health) has also occurred as local and donor resources are increasingly used to address the HIV/AIDS pandemic (more donor resources were spent on HIV/AIDS during the period under review; see Figure 4.1.14).

⁹This does not include PEPFAR actual expenditures for HIV/AIDS health services, which were not available for all the years under review.

¹⁰ Capital budget is meant for buying fixed assets or adding value to existing fixed assets with a useful life that extends beyond the taxable year—normally one year; e.g., construction of hospitals. Recurrent budget covers operations of a project/institution, mainly for a period of one year; e.g., salaries.

In summary, although donor resources for health and, in particular, HIV/AIDS have increased steadily in Lesotho, the MOHSW exercises little control over the use of these additional resources. The influx of external resources has created the erroneous perception by some stakeholders that the MOHSW is extremely well-funded, when, in fact, little actual cash moves through the ministry from new, external funding sources.

It is clear that the efficiency and effectiveness of donor funding need to be improved by eliminating the duplication of efforts and wastage of resources occurring in the Lesotho health system. As a result of this analysis, we recommend that the MOHSW work to coordinate all donors' financial assistance under a SWAp mechanism (pooled or discrete funding)¹¹ to improve this situation.

4.1.3 POOLING AND ALLOCATION OF FINANCIAL RESOURCES

Once revenues are collected, they are pooled and allocated to various health providers and prevention and public health programs. Institutions or individuals that perform this health financing function are known as financing agents. In Lesotho, the major financing agent from 2004/05 to 2008/09 was the MOHSW¹² (including government grants to CHAL appearing under the cost center 1: administration¹³), which averaged 59 percent of total health spending and rose to a high of 61.4 percent of total health spending in 2007/08. Direct household out-of-pocket payments was the second largest financing agent, averaging 24.1 percent of total health spending (see Table 4.1.4). CHAL and other government ministries ranked third and fourth at 14 percent and 2 percent of total health spending, respectively. Private health insurance represented merely 1 percent of the total health spending.

TABLE 4.1.4. FINANCING AGENTS IN LESOTHO, 2004/05 TO 2008/09 (%)

Financing agent	2004/05	2005/06	2006/07	2007/08	2008/09	2004/05 to 2008/09
MOHSW	59.6%	57.0%	58.6%	59.0%	61.4%	59%
CHAL	10.1%	13.7%	11.9%	17.2%	18.0%	14%
Other ministries	1.3%	1.8%	1.5%	1.6%	1.7%	2%
Private health insurance	0.5%	1.1%	1.3%	1.2%	1.1%	1%
Out-of-pocket	28.5%	26.3%	26.7%	21.1%	17.7%	24%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100%

Source: MOHSW actual expenditure print-outs (various years); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Budget books (2005/06, 2006/07, 2007/08, 2008/09); health insurance reports (various years).

As Table 4.1.4 indicates, MOHSW manages the largest amount of financial resources in the Lesotho health system. This is a positive sign since the MOHSW's overriding mission is to improve the health status of all Basotho people. In addition, this implies that the MOHSW's actions/decisions in resource allocation could go a long way in improving the health of the majority of the population and individuals.

¹¹ One could argue that Lesotho has a health SWAp as some donors pool their resources with GOL funds in the national budget and there are mid-year and annual joint reviews of the health sector. In addition, a Partnership Framework was signed between the GOL and USG in 2009. However, it should be clearly stated that the situation in Lesotho is not a health SWAp. Current arrangements exhibit limited features of a SWAp, therefore, Lesotho needs to establish a fully fledged SWAp mechanism of financing and managing health services.

¹² Only data on donor health expenditures through the MOHSW and CHAL were available in all the secondary documents. Health expenditures from donor resources implementing their own programs or transferred to NGOs for health purposes were not available due to the absence of NHA in Lesotho. The National AIDS Spending Assessment (NASA) for 2005/06 to 2007/08 has data on donors and NGO expenditures on HIV/AIDS, but it is difficult to isolate health expenditures from nonhealth expenditures. The figures presented are underestimated.

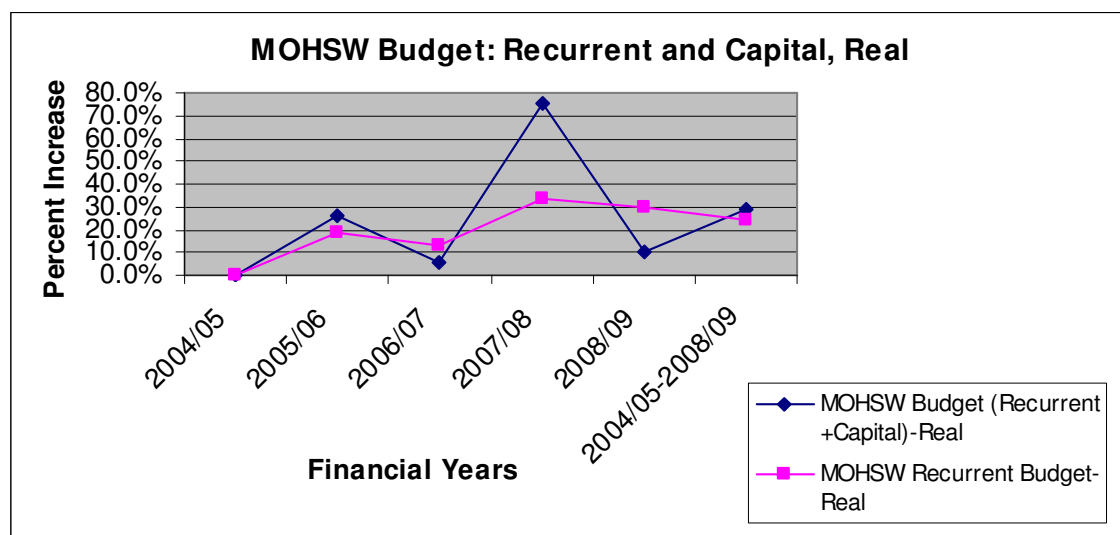
¹³ Cost centers refer to budget categories.

However, as explained in the following sections, indications are that inefficiencies and inequities exist in the MOHSW's allocation of financial resources, thus reducing the potential of the majority of the population from benefiting from these resources.

The MOHSW Budget Trends

An analysis of MOHSW budget trends for both recurrent and capital in real terms from 2004/05 to 2008/09 shows that the MOHSW budget steadily increased, experiencing a decrease only in 2007/08, in particular, for capital expenditures. Between 2004/05 and 2008/09, the MOHSW budget increased an average of 29 percent and 23.8 percent, respectively, in real terms (see Figure 4.1.3). This is a positive sign as it shows that the MOHSW budget was keeping pace with inflation.

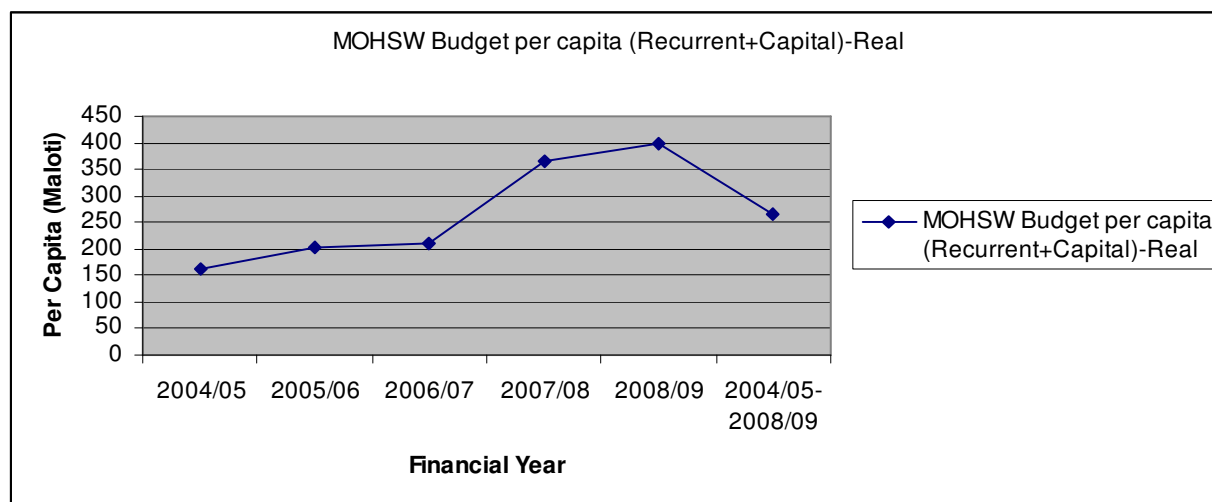
FIGURE 4.1.3. PERCENTAGE INCREASE OF MOHSW RECURRENT AND CAPITAL BUDGET IN REAL TERMS, 2004/05 TO 2008/09



Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

In per capita real terms, the MOHSW budget (both recurrent and capital) has steadily increased between 2004/05 and 2008/09. On average, MOHSW budgets (both recurrent and capita) increased by M267.3 million during the period under review (see Figure 4.1.4). This is impressive and shows that, while taking both inflation and population increases into account, the MOHSW budget has risen to provide adequate and quality health care to the population.

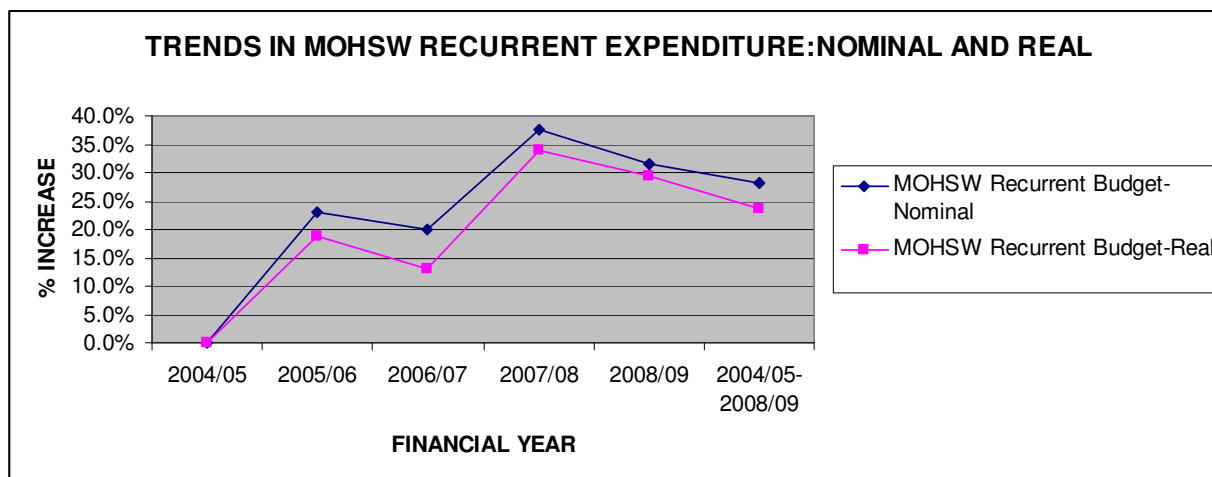
FIGURE 4.1.4. PER CAPITA MOHSW RECURRENT AND CAPITAL BUDGET (REAL), 2004/05 TO 2008/09



Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

The MOHSW in Lesotho does not have a mandated level of public spending on health as a percentage of total public spending. However, the MOHSW recurrent budget increased annually, both in nominal and real terms, from 2004/05 to 2008/09, by an average of 28 percent and 23 percent, respectively (see Figure 4.1.5).

FIGURE 4.1.5. TRENDS IN MOHSW RECURRENT EXPENDITURE BUDGET (NOMINAL AND REAL), 2004/05 TO 2008/09



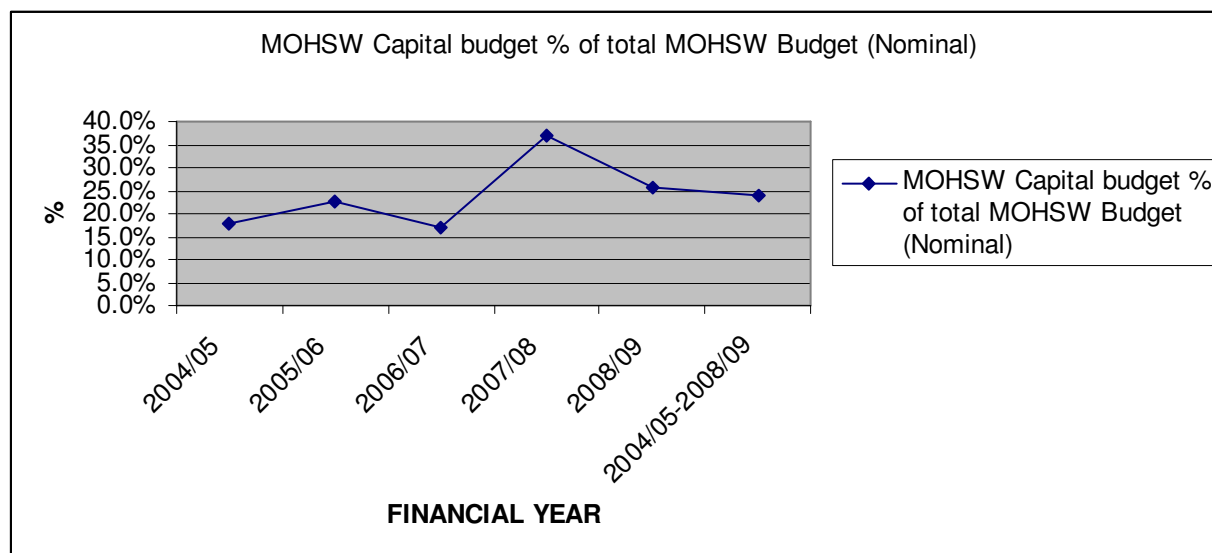
Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

Capital Budget

The capital budget in Lesotho increased from a low of 17.9 percent in 2004/05 to a high of 36.7 percent of the total MOHSW budget in 2007/08 before declining to 25.8 percent in 2008/09. On average, the

MOHSW capital budget constituted approximately 24 percent of the total MOHSW budget (see Figure 4.1.6).

FIGURE 4.1.6. MOHSW CAPITAL BUDGET – NOMINAL (%), 2004/05 TO 2008/09



Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

Human Resources for Health Budget

During the period under review, the MOHSW budget did not have a separate allocation for Human Resources (HR) (i.e., a cost center). The HR components, in particular, health worker salaries and training, were budgeted for under each program (i.e., cost center). As such, only salaries of health workers have been teased out, as seen in Table 4.1.5.

TABLE 4.1.5. MOHSW ACTUAL EXPENDITURES ON SALARIES, 2004/05 TO 2008/09 (MALOTI)

Human Resources Actual Expenditures	2004/05	2005/06	2006/07	2007/08	2008/09	2004/05 to 2008/09
Salaries	97,188,923	99,767,029	107,226,381	156,702,383	217,771,690	135,731,281
% Increase	0	2.7%	7.5%	46.1%	39.0%	19.0%

Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

Trends in Authorized Budget and Actual Expenditures

Table 4.1.6 clearly shows that the MOHSW total recurrent budget was consistently underspent, with the exception of 2004/05, which saw an overexpenditure of approximately 4.2 percent. Districts, which serve the majority of the population, underspent on average 82.9 percent and fell as low as 75.4 percent in 2007/08. Furthermore, disease control, which includes the HIV/AIDS and sexually transmitted infections (STI) program, also underspent, despite the fact that HIV is a major public health issue in Lesotho.

Table 4.1.6 clearly shows that the administration and Queen Elizabeth II cost centers had serious consistent overexpenditures, with Queen Elizabeth II averaging 23 percent and 2.5 percent during 2004/05 and 2008/09, respectively. This overexpenditure went as high as 35.4 percent in 2005/06 for the

administration cost center and 30.5 percent in 2004/05 for the Queen Elizabeth II cost center. The MOHSW's consistent underspending in its recurrent budget is mainly due to (1) lack of absorptive capacity, which itself could be attributed to severe shortages of skilled personnel to process payments, in particular, for drugs and medical supplies at the district level; (2) late arrival of funding, resulting in low budget executions in the first and second quarters of each financial year; (3) overbudgeting for positions that remain unfilled at the end of each financial year; (4) lack of synchronization between operational plans and implementation because operational plans are not regularly referenced once the financial year has commenced; and (5) a tendency by some program managers/department heads to implement activities only when they are available, which indicates a lack of delegation for implementation of activities.

TABLE 4.1.6. MOHSW RECURRENT ACTUAL EXPENDITURE PER ANNUM AS PERCENTAGE OF TOTAL MOHSW BUDGET PER ANNUM, 2004/05 TO 2008/09

Program	2004/05	2005/06	2006/07	2007/08	2008/09	2004/05 to 2008/09
Administration	128.1%	135.4%	109.0%	112.9%	129.7%	123.0%
Queen Elizabeth II	130.5%	103.7%	102.0%	103.4%	73.1%	102.5%
All districts	90.5%	90.7%	79.9%	75.4%	77.8%	82.9%
Disease control (including HIV/AIDS & STI)	91.5%	59.8%	79.9%	75.4%	77.8%	76.9%
All other programs	75.9%	92.5%	86.8%	56.0%	60.5%	74.3%
Total	104.2%	99.2%	87.1%	86.9%	86.7%	92.8%

Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

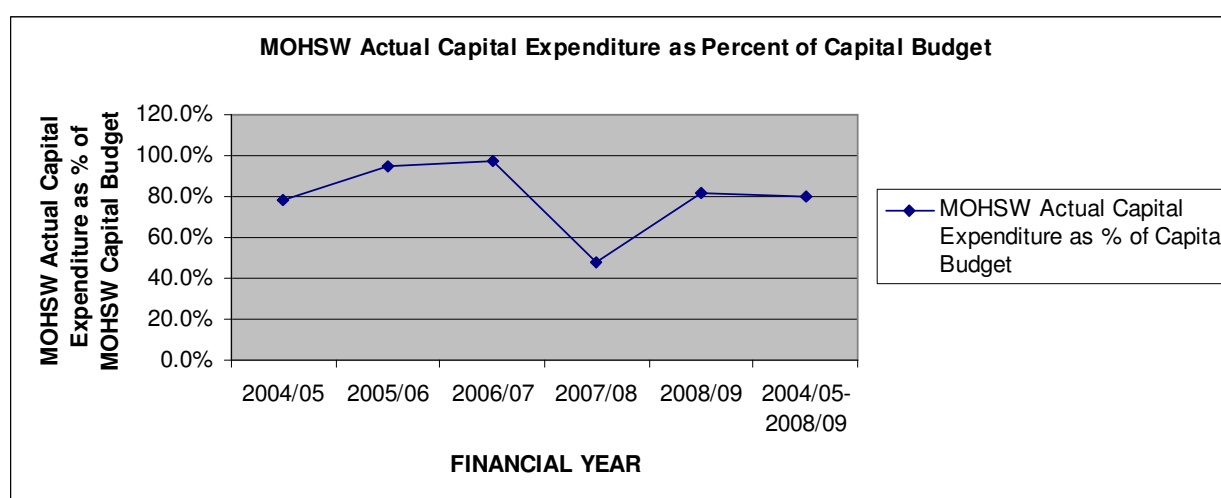
The most serious implication of consistent underspending of the MOHSW recurrent budget is that it portrays a picture that there is no need for additional funding for health care services in Lesotho in the short and medium term. Many stakeholders interviewed during this study shared the view that Lesotho is over-resourced in the health sector, with the major problem being that funds do not reach intended beneficiaries in adequate amounts and on time. A key question is to determine where the bottlenecks exist in health funding in Lesotho; otherwise, any attempt to raise additional revenues for health care services will be met with serious skepticism. The MOHSW needs to seriously address the root causes of underspending its recurrent budget before attempting to raise additional revenue.

The existence of multiple uncoordinated donors and NGO projects has caused most activities at the district and health center levels to be funded by donors and NGO financial resources (since both the government and donors/NGOs target the same beneficiaries but do not share the plans). This, in essence, substitutes government funding with donor funding. A visit to several health facilities during this study revealed that the activities of several districts and health centers are funded by donor resources, without information being shared with government. This situation could be addressed through the design and implementation of a comprehensive health sector-wide approach to health financing and management.

Overspending for the MOHSW's two cost centers (administration and Queen Elizabeth II) is caused by poor budget controls, financial management problems, and lack of clear criteria for allocating resources between cost centers (World Bank 2009). The MOHSW urgently needs to address this problem as it undermines development partners' confidence in GOL financial management systems.

Figure 4.1.7 shows that the MOHSW's recurrent budget underspending challenges apply to the capital budget as well. On average, between 2004/05 and 2008/09, MOHSW underspent 80 percent of the total budget, reaching a low of 48.1 percent in 2007/08. Some of the reasons for this capital budget underspending, especially for 2007/08, include (1) late set-up of the MCC Health Project Implementation Unit, (2) delays in reaching financial closure on the construction of a referral hospital, and (3) nonperformance of contractor on African Development Bank (AfDB) projects resulting in stoppage of major civil works. Root causes of underspending on capital expenditures need to be understood and addressed so that the sector can mobilize more resources. For example, health infrastructure needs are very high, especially considering that most health centers do not have maternity wards or basic emergency obstetric care services. This prevents expectant mothers from delivering in health facilities, which directly contributes to high maternal deaths in Lesotho.

FIGURE 4.1.7. MOHSW ACTUAL CAPITAL EXPENDITURE AS PERCENTAGE OF TOTAL MOHSW CAPITAL BUDGET, 2004/05 TO 2008/09



Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

Existence of SWAp Contribution

Although Lesotho does not have a health SWAp, several development partners provide earmarked funds to the MOFDP for the MOHSW budget (in particular, the capital budget). These include AfDB, DFID, World Bank, Irish Aid, EU¹⁴, and MCC. The majority of development partners fund various health programs and projects outside the framework of the MOHSW budget and strategic plan or 3-year sector MTEF (2008/09 to 2010/11). As previously discussed, improved donor coordination in planning, financing, implementation, monitoring, and evaluation is urgent and needs to be addressed soon.

MOHSW Headquarters and Cost Centers

In Lesotho, the MOHSW budgets are prepared in accordance with the MTEF activity-based budgeting and costing. The MOHSW prepares a three-year sector program (MTEF) with annual operational plans and with inputs from all cost centers: DHMT, administration, Queen Elizabeth II, etc. The process of developing the three-year sector MTEF program starts at all cost centers, whose inputs are consolidated at the MOHSW headquarters (see Figure 4.1.8). At the cost center level, the activities to be implemented are identified and costed as per MTEF requirements and included in the annual operational

¹⁴ World Bank project document March 2010: five donors work within the joint framework for budget support.

plans. This is a best practice example in health planning and should be encouraged as it ensures that the needs of the costs centers are taken into account and, as a result, will more likely reflect the needs of the population.

However, there are two major weaknesses with Lesotho's budgeting approach: (1) within districts, health centers and filter clinics have little or no involvement in the development of district operational plans and budgets, nor do other key stakeholders working in the district such as NGOs and CSOs. This lack of consultation, in particular with health centers, is often blamed for the inadequate provision of goods and services, causing poor quality health care services. Lack of consultation with NGOs leads to duplication of efforts and wastage of limited resources. (2) At the central level, no clear resource allocation criteria exist for the districts or any cost center, therefore, issues of equity in financial resource allocation cannot be effectively addressed¹⁵. Best practice in resource allocation for health requires that the center (MOHSW) allocate the recurrent budgets (ceilings) to the peripheral units (districts) based on *rational criteria of health needs and capacity* to benefit from health care resources. This might include use of a needs-based formula whose principal determinant is the population, weighted by various indicators such as cross-boundary flows, private sector service users, age distribution (adjusted by national utilization), gender distribution, and mortality profile (see Table 4.1.7).

TABLE 4.1.7. RANGE OF IMPORTANT INDICATORS AVAILABLE TO DETERMINE NEED FOR HEALTH SERVICES

1. Population size (resident population), adjusted for:
• Cross-boundary flows and
• Private sector service users
2. Age distribution (adjusted by national/regional utilization rates)
3. Gender distribution (adjusted by national/regional utilization rates)
4. Health status indicators:
• Mortality profile
• Morbidity profile
5. Socioeconomic indicators:
• Income
• Employment levels
• Housing (crowding)

Source: Reagon et al. (1997)

In 2007, the MOHSW, under the World Bank Project II, commissioned a study on district resource allocation and budgeting for health services in Lesotho, which clearly demonstrated that there were inequities in the distribution of financial resources between districts. This study proposed a resource allocation formula to reduce inequities between the districts based on three proxy indicators of need: (1) population of the district, which was the principal determinant, weighted by (2) the infant mortality rate of the district, and (3) the distance of the district from Maseru. The MOHSW has never implemented this formula.

MOHSW Headquarters and Ministry of Finance and Development Planning

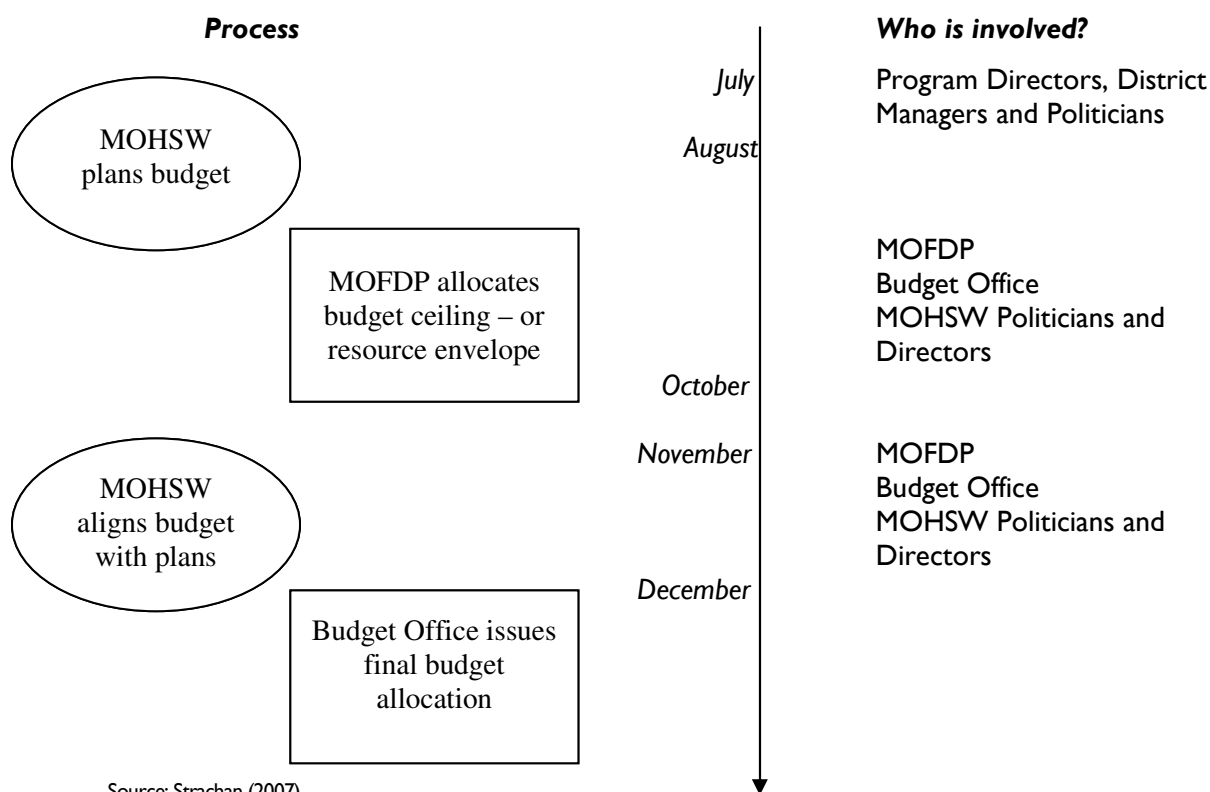
Once the MOHSW has consolidated the operational plans, the plans are costed and translated into a Budget Framework Paper, which MOHSW headquarters submits to the MOFDP with an indication of

¹⁵ Brigid Strachan of Impact Health Management Solutions studied district resource allocation and budgeting for health services in Lesotho in 2007 and developed a resource allocation formula that could be used for allocating resources between districts, but it has never been used.

total costs of the activities (draft budget). The MOFDP issues a Call Circular to all ministries and government departments with indicative ceilings, frequently after the MOHSW has already submitted its draft budget (see Figure 4.1.8 on the timelines and activities). The MOFDP ceilings are often lower than the MOHSW total draft budget. This is followed by a period of intense negotiations between the MOHSW and MOFDP senior management to agree on the allocations for the health sector. Often the draft budget for health is reduced and this results in the MOHSW cutting budgets for most cost centers. Interestingly, the MOFDP does not have a formula for determining the allocations to various ministries and government departments. It uses various factors such as the macroeconomic outlook and the actual expenditures for the previous year so that if underspending occurred, balances could be used to meet the next financial year's needs. The MOHSW's consistent underspending might explain the marginal annual increases in the MOHSW recurrent budget.

Key informants interviewed during this study indicated they perceive this method of funding health to be based on historical totals with an adjusted percentage for the new financial year and not on the health needs of the population, as reflected in the consolidated MOHSW budget presented to the MOFDP. The MOHSW's reduction of cost center budgets following the downward adjustment of the MOHSW ceiling by MOFDP is a major disincentive to cost center management officials. As a result, center staff do not grasp the importance of participating in the annual budgeting process when the budgets are systematically reduced. As one official lamented about the budget process, "It doesn't matter whether one does it well or not; the bottom line is, it will be cut, so why waste time?"

FIGURE 4.1.8. TIMEFRAME FOR MTEF RESOURCE ALLOCATION AND BUDGET PROCESS



MOHSW Budget Allocation Structure

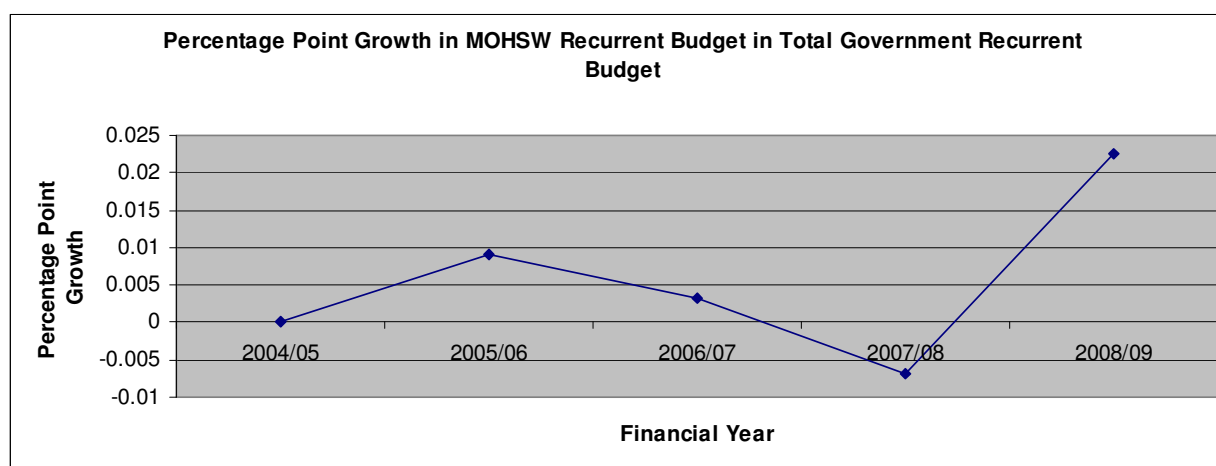
Like many sub-Saharan African countries, the MOHSW in Lesotho uses MTEF activity-based budgeting and costing systems, broken down by programs and subprograms. Line items such as salaries, training, drugs, and fuel fall under the subprogram level.

As indicated earlier, no rational criteria exist for allocating resources to districts and cost centers; therefore, it is very difficult to assess whether the budget is allocated appropriately to achieve policy and program goals. In addition, the MOHSW's monitoring of the implementation of the operational plan is seriously weak as there is no clear link between Health Management Information Systems (HMIS) and M&E (MOHSW 2009). Although the MOHSW has made tremendous strides in implementing the MTEF, several challenges still remain, particularly in the areas of low budget execution, internal controls and fiscal reporting, and activity implementation, or level costing. Budget classifications also remain unchanged. In particular, programs and subprograms basically refer to organizational structures and do not have a functional orientation. In addition, these budget classifications are not linked or integrated with the recurrent and development budget during the budget planning exercises (World Bank 2009).

MOHSW Share of Total Government Recurrent Budget

Although the GOL has indicated its commitment to health in several documents, and the MOHSW budget has been increasing in nominal and real terms, a review of MOHSW recurrent budget allocation in relation to total government recurrent expenditures shows that annual increases have been marginal from 2004/05 to 2008/09, with 2007/08 experiencing a percentage point decline of 0.7 percent (see Figure 4.1.9). As previously observed, Lesotho spent less than the Abuja Declaration target of government revenues on health. The country is in a conundrum: although Lesotho faces serious fiscal constraints in domestic revenues, there is a need for a substantial increase in government spending on health that can only be achieved through reallocation of resources from other nonpriority sectors.

FIGURE 4.1.9. PERCENTAGE POINT GROWTH IN MOHSW RECURRENT BUDGET IN TOTAL GOVERNMENT RECURRENT BUDGET, 2004/05 TO 2008/09 FINANCIAL YEAR

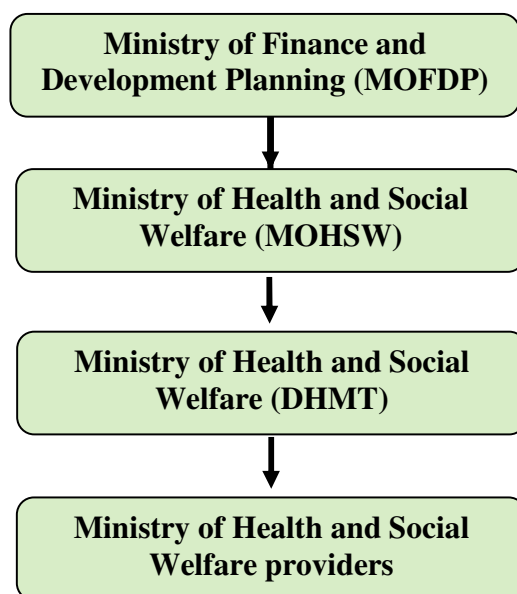


Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

Central Budget Allocations for Health in Decentralized Systems

In Lesotho, local authorities are not yet responsible for health system management because implementation of the Local Government Act of 1997 is still being discussed between MOHSW and local government. The current system operates as follows: once the MOHSW budget is approved by Parliament, the MOFDP issues a warrant to spend. To this end, the MOFDP transfers funds to the MOHSW headquarters on a quarterly basis for all its cost center programs, as per the approved budget (including the districts and CHAL). The MOHSW in turn transfers the funds to the various cost centers and only keeps funds for cost centers at the MOHSW headquarters (see Figure 4.1.10).

FIGURE 4.1.10. MOHSW DECENTRALIZATION STRUCTURE



This arrangement has some serious weaknesses, including delays by the MOFDP in transferring funds to the MOHSW and with the MOHSW transferring funds to the districts and other cost centers outside the MOHSW headquarters. This occurs frequently during the first and second quarter of each financial year, thus disrupting service delivery at the concerned cost centers. The second major weakness in this arrangement is inadequate capacity at the district level to process payments, in particular for drugs and medical supplies. As a result, the districts have significant unpaid bills owed the National Drug Services Organization (NDSO) for their procured drugs and medical supplies rendering NDSO almost insolvent. This study discovered problems at several stages of the payment systems. Within hospitals, there is a clear lack of capacity (human and infrastructure) within the Pharmacy and Accounts departments, particularly for billing and payment systems for drugs and dressings. Manual payment processes introduce significant risk for error and loss of invoices, and do not allow staff to track invoices (whether processed or not). At the district level (District Procurement Store and District Sub-Accountancy), staff have inadequate skills for managing the billing and payment system for goods and services rendered to all government departments, including health. Invoices for drugs and medical supplies are always above the district threshold for payment and are therefore referred to the National Treasury in Maseru. This causes delays and frequently results in the loss of invoices. Furthermore, key district-level informant interviews revealed that the introduction of the Integrated Financial Management Information System

(IFMIS)¹⁶ further complicated issues. The IFMIS software is viewed as not being user friendly, very unstable, and lacking in technical support. However, by cross-examining MOFDP and MOHSW officials, interviewers learned that IFMIS is very user friendly and the major problem with most district staff was that they refused to participate in IFMIS training sessions or have a poor understanding of IFMIS operations.

Much as it could be argued that decentralization of all payments for the district expenditures is among the best strategies to have been implemented by MOHSW prior to the transfer of all powers to the Ministry of Local Government, it should be noted that the transfer of payment for drugs and dressings to the districts has been very disruptive to the NDSO, tremendously affecting the delivery of services because of serious and recurrent drug stock-outs (MOHSW 2009). This issue needs to be resolved as soon as possible. A proposed solution (described in box 4.1.1) is to centralize drug payment and dressings at MOHSW (as was the case prior to 2007).

Box 4.1.1. Proposed System for Payment of Drugs and Dressings to NDSO: Prepayments of Quarterly Warrants for Medicines to National Drug Services Organization

Brief Description of the Proposed Process

- With the assistance of NDSO, facilities would prepare the budget for the drugs and dressings for the upcoming financial year. It would be cost-effective if this budget could mainly address the requirements listed in the Essential Medicines List or NDSO's Products Catalogue; NDSO has distribution data per facility that can be vital in budget preparations.
- NDSO, the Office of the Director of Pharmaceuticals, and the financial controller would then consolidate the national budget for the Essential Medicines and make it ready for presentation with other budgets for the MOHSW to the MOFDP.
- NDSO would further use those forecasts to float a national tender for the essential medicines. Such a tender would be ready by March every year.
- When the budgets have been approved, quarterly warrants would then be deposited/credited into the NDSO account, rather than giving the funds to each of the facilities as is the current situation. The NDSO would use the deposited funds to pay for the contracts that NDSO would have made with the suppliers and also pay itself for the services (procurement, storage, and distribution) it renders the facilities.
- NDSO would then prepare information per facility indicating their quarterly credit for both the drugs and dressings. On the basis of the credit available, the health facilities would then make requisitions in line with their requirements and the distribution schedule that NDSO would have circulated to all facilities.
- NDSO would then supply the health facilities in line with their orders and the delivery schedule. The delivery notes would be signed by the facilities as proof of delivery and would further be used for reconciliation purposes.
- Since this process would involve a substantial amount of money and careful planning for the supplies, it is highly recommended that a quarterly reconciliation process be carried out between NDSO, the director of pharmaceuticals, and the office of the financial controller to match (1) the funds transferred to NDSO on quarterly basis, (2) the requisition made by each of the facilities, and (3) the deliveries made by NDSO to the facilities.
- The reconciliation report would ultimately be prepared for presentation to the higher authorities, National Drug Service Committee, senior management of MOHSW, and any relevant authority within the system.

Take note that a similar system is in use in Tanzania. The Lesotho MOHSW may benefit from undertaking a study tour to Tanzania to learn from that country's experience for possible implementation in Lesotho.

If this system were implemented, it would help NDSO in its mandate as the Procurement Unit to do procurement planning in line with the Public Procurement Regulations of 2007. It would also help the director of pharmaceuticals to be directly involved in forecasting, budgeting, and distribution issues of drugs and dressings. The other beneficiary would be the office of the financial controller in that through the reconciliations process, the office would have an account of the funds transferred to NDSO, the supplies requested by the facilities, and drugs and dressings supplied by NDSO.

Source: Key Informant interviews with NDSO officials.

¹⁶ Visit www.finance.gov.ls/reforms/faq.php to learn more about IFMIS and its value added and challenges in Lesotho.

It should be noted that this proposal was attempted by the GOL in 1997 and then it was used between 2004 and 2007. At the time, the GOL was concerned with a perceived conflict of interest regarding NDSO, in as far as the centralization of drugs and dressings payment would mean the organization was responsible both for raising the orders and for supplying the drugs and dressings.¹⁷

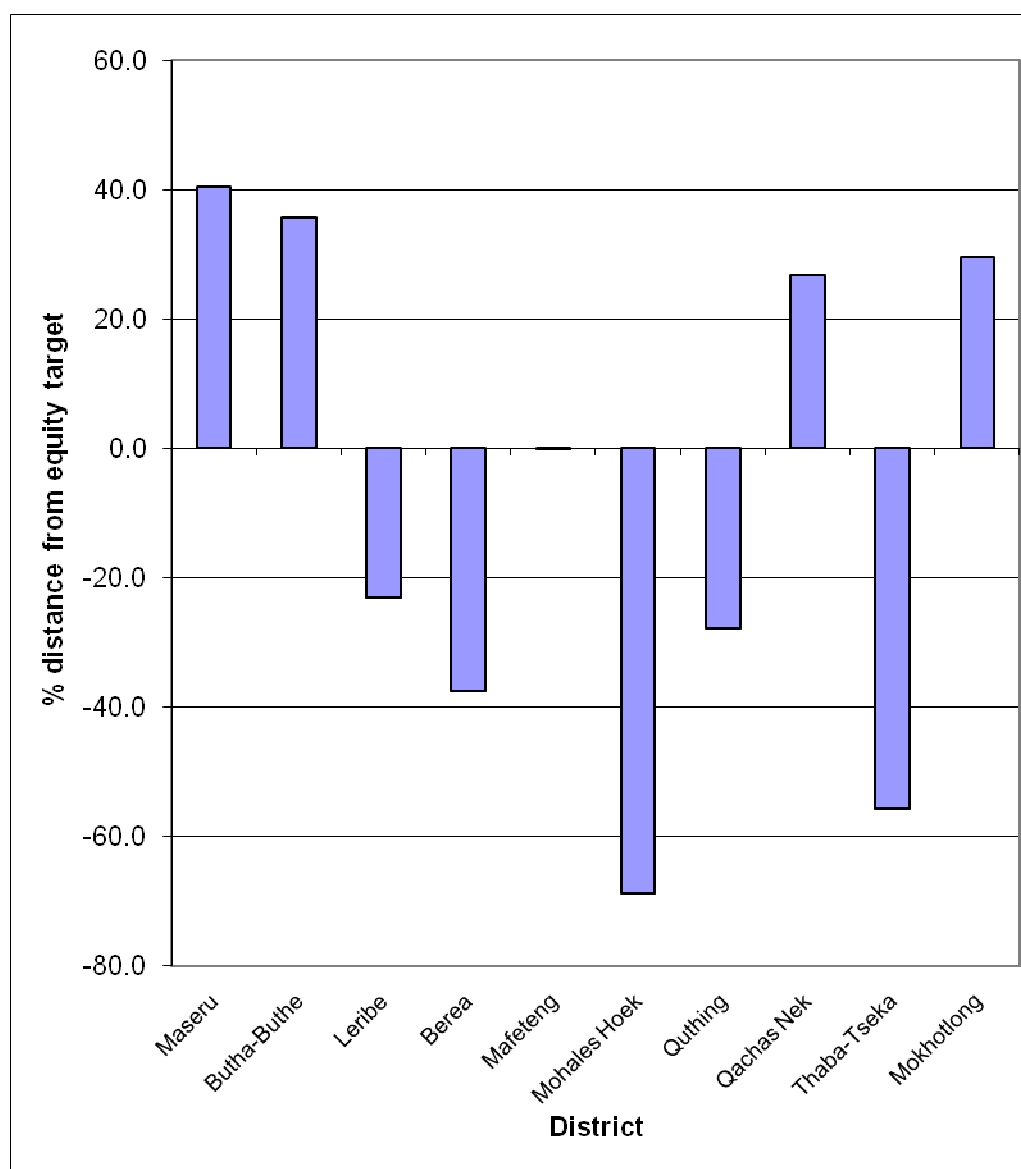
Distribution of MOHSW Recurrent Budget by Geographic Areas/Districts

There is no clear methodology for allocating the MOHSW budget to the districts. As such, persistent inequities in resource allocation exist between districts. For example, if we use population per capita as the principal determinant of health care needs and adjust it for poverty levels, which is also one of the main factors affecting demand for health care, per capita MOHSW recurrent budgets would differ by a factor of 2.2 between Maseru district and Quthing district, whereas, in reality, Quthing district has a slightly higher proportion of poor compared to Maseru (MOHSW 2008). Further compounding the situation is the fact that the outpatient visits per capita negatively correlate (-0.43) with the share of the poor in the district, suggesting financial barriers to care (Oxford Policy Management 2008). This therefore implies that if the recurrent budget were allocated according to the health needs of the population, Quthing district would have received more financial resources to spend on improving the quality of health care services at MOHSW facilities and thus reduced the probability of the population seeking care from alternative sources where fees are charged. In general, the MOHSW budget differs by a factor of 7.2 per capita between the lowest and the highest districts. This clearly shows that Lesotho should consider developing and implementing a rational resource allocation formula that explicitly builds on equity factors, as presented in Table 4.1.7. Alternatively, Lesotho may consider reviewing and implementing the resource allocation formula as proposed in a study by Strachan (2007). Strachan's proposed financial resource allocation formula is in line with international best practices and could assist the MOHSW in greatly reducing inequities in the distribution of financial resources in the health system.

Also at issue is how to obtain the best value for money ("best buys") with the available resources. Within the past 5 to 10 years, trends in health indicators have been deteriorating (World Bank 2009), while budget allocations have been consistently rising, as previously noted. This inverse relationship between the budget allocated and health outcomes is indicative of systematic failures and inefficiencies at the different levels of the public sector. It is also a reflection of resource allocation mechanisms that are not responsive to the health needs of the population. For example, Figure 4.1.11 shows the distribution of MOHSW and CHAL resources using the equity indicators proposed by Strachan if used to distribute the 2007/08 budget between districts. As clearly indicated in this figure, all the districts were either far above or far below the equity target (0 percent) except one, Mafeteng. Therefore, the development and implementation of a resource allocation formula in Lesotho could go a long way in solving some of these efficiency and equity issues in financial resource allocation.

¹⁷Through discussions with NDSO staff.

FIGURE 4.1.11. DISTRICT BUDGETS – DISTANCE FROM EQUITY TARGET



Source: Strachan (2007)

Distribution of Government Health Budget Between Levels of Care

The Oxford Policy Management 2008 study found that in 2006/07 the MOHSW spent only 9 percent of its budget on primary care and 51 percent on secondary and tertiary care, with the remaining 40 percent on central programs. Even after adjusting for the fact that hospitals provide (primary) outpatient care, this appears low. These findings clearly show that the MOHSW inefficiently funds a hospital-based and centrally organized health care system.

A further driver of higher expenditures for hospitals may be attributable to the structural organization of health services at the district level. Each district is served by a DHMT¹⁸, headed by the district medical officer, who is responsible for the planning and allocation of resources among all the functions and

¹⁸ This is still in the early phases of establishment.

facilities within the district (including hospitals, filter clinics, and health centers). In most districts, the DHMT is based at the district hospital and, in effect, also operates as a district hospital management team. Given that health centers do not manage any funds but rather simply order their requirements from the DHMT, it is hardly surprising that this situation of high expenditures at hospitals has occurred. Since the DHMT is based at the hospital, the needs of the district hospitals are more apparent than those of the peripheral health facilities. The ideal response to reducing this allocative inefficiency would be to split the district budget in two, as described in the new decentralization plan: (1) a district health budget, comprising all peripheral health facilities and prevention and public health programs under the DHMT, as per the Local Government Act of 1997, and (2) a district hospital budget. Such a split could ensure that the needs of the primary health care (PHC) facilities would be adequately addressed because the facilities would have their own resources. In addition, Lesotho could pilot a system of direct cash transfers to health centers and filter clinics, following Kenya's experience (see box 4.1.2).

Box 4.1.2: Direct Facility Funding (DFF) to Health Centers and Dispensaries in Kenya Following Reduction of User Fees in Health Centers and Dispensaries in 2004

- An innovative system of direct facility funding (known as DFF) of government health centers and dispensaries has been piloted in Coast Province of Kenya aimed at addressing the negative impacts of reducing user fees in health centers and dispensaries as per 2004 government policy.
- The operation involved the following: (1) Funds were allocated across districts, using the Kenyan Ministry of Health (MOH) resource allocation criteria, and within districts; the breakdown across facility types was 85 percent to health centers and dispensaries, 10 percent to hospitals, and 5 percent to DHMTs to cover supervision. (2) All MOH facilities with qualified staff were entitled to DFF, with funds allocated to individual facilities on the basis of workload and facility type (health centers received more than dispensaries). (3) Funds were remitted directly into the bank accounts of each facility and DHMT. (4) At the district level, the DHMT was responsible for DFF implementation with key actors being the district medical officer for health (responsible for overall supervision), facility management nurse (supporting links between facilities, the community, and district), and the district accountant (responsible for financial management). (5) Each facility should have a Health Facility Committee in place made up of local community members and the officer in charge of the facility should be trained in DFF scheme who is responsible for preparing quarterly workplans and budgets and managing DFF funds. (6) Local communities were empowered to monitor DFF through their committee members and through display of facility utilization and accounts data on blackboards at health facilities. (7) Guidelines on expenditure items for DFF funds were developed and used in implementing DFF; for example, DFF could be spent only on 10 expenditure categories (salaries of support staff; utilities; supplies and services; etc.) excluding drugs, laboratory services, construction of new buildings, or sitting allowances of committee members and professionally trained health workers salaries. (8) Facility compliance with national user fee policy was ensured, such as charging 10 or 20 Kenyan Shillings (US\$0.15 or 0.29) per visit at dispensaries and health centers, respectively, and exemptions for various special groups.
- After 2.5 years of implementation, the results show that DFF was perceived to have a highly positive impact through support staff funding, outreach activities, renovations, patient referrals, and increases in health facility activity, which in turn was perceived to have improved health worker motivation, utilization, and quality of care.
- The main challenges associated with this scheme were confusion over direct facility fund operations, the continued overcharging of user fees, and very limited understanding of the direct fund transfer scheme among the broader community.
- In conclusion, small increases in funding managed at the peripheral level may have a significant impact on performance, but must be accompanied by comprehensive training and documentation, strong emphasis on community engagement, and insistence on user fee adherence.

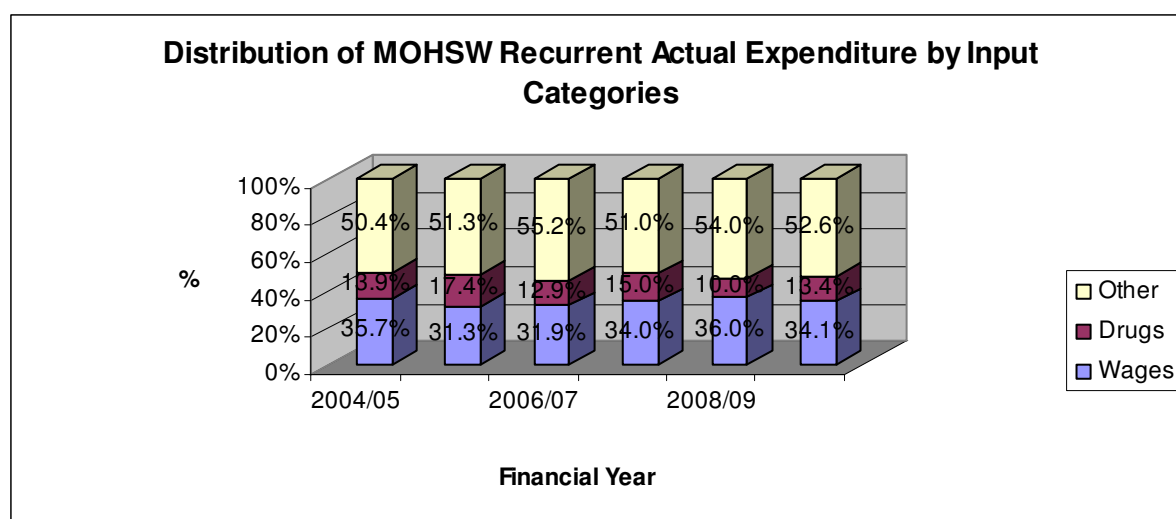
Source: Opwora et al., (2010)

However, the immediate challenge of implementing a direct transfer of facility funds to health centers and filter clinics is that health centers do not have the financial, technical, and managerial capacity to handle such transfers. Lesotho health centers face serious inadequacies in HRH across all categories of staff because these health centers are mostly manned by nursing assistants. Conferring responsibility of financial management on the centers, therefore, would more than likely exacerbate an already precarious situation.

Distribution of MOHSW Actual Recurrent Expenditures by Input Categories

The distribution of MOHSW actual recurrent expenditures between 2004/05 and 2008/09 shows that the MOHSW spent an average of 34 percent, 13 percent, and 52 percent on salaries, drugs and medical supplies, and other recurrent transactions, respectively (see Figure 4.1.12). The total amount of MOHSW recurrent expenditures spent on salaries is low, at 34 percent, compared to most countries in the region, whose average salary bills consume between 50 and 70 percent of the total recurrent expenditures (WHO 2006). One implication is that low salaries act as a disincentive and, therefore, negatively affect the performance of health workers. Actual expenditures on drugs and dressings are comparable to other SACU members (i.e., South Africa and Namibia). However, as previously mentioned, a major problem exists concerning drugs and dressings payment, which has resulted in stock-outs of drugs and dressings in most health facilities (MOHSW 2008). The average amount of resources allocated for operations (52 percent) is high compared to most countries in the region and merits further investigation.

FIGURE 4.1.12. DISTRIBUTION OF MOHSW ACTUAL RECURRENT EXPENDITURES BY INPUT CATEGORIES, 2004/05 TO 2008/09



Source: Government expenditure print-outs (2005/06, 2006/07, 2007/08, 2008/09); AJR reports (2005/06, 2006/07, 2007/08, 2008/09); Oxford Policy Management (2008)

Local-level Spending Authority

MOHSW facilities in Lesotho have various degrees of autonomy for different aspects of expenditures or inputs. Hospitals, both tertiary and district, have autonomy in procurement of supplies, gasoline, and medicines. As previously noted, health centers and filter clinics do not have any autonomy in making decisions on any recurrent expenditures or inputs, including planning and budgeting. They simply receive goods and services from the hospitals after submitting their requisition/order forms. Following placement of orders, the delivery of goods to health centers and filter clinics takes a long time to process (average of one month), hence disrupting the delivery of health services at the health center level. As proposed in this report, it would be ideal if the MOHSW recurrent budget could be split in two: (1) a budget for the district hospital and (2) a budget for the district health services, prevention and public health programs, and health centers.

The MOHSW has the overall autonomy in terms of all major procurements, such as procuring civil works for the public health system in consultation with the central government procurement agency. It is also responsible for making recommendations to the Ministry of Public Service (MOPS) on hiring and

firing of technical staff. The management of HRH in Lesotho faces twin problems: (1) the MOHSW does not feel its needs are adequately addressed or well understood by the MOPS. The MOHSW is often frustrated when requests for recruitment of additional staff, or special conditions of service for staff, are rejected or delayed. (2) The districts do not feel empowered to hire supplementary staff or discipline their staff. As a remedy, several eastern and southern African countries established Health Services Commissions and Internal Procurement Committees. These structures have been delegated authority to manage personnel and procurement issues by central government and have produced positive results with respect to transparency and accountability.

Both the central and district/tertiary hospitals have a system for tracking and auditing budget expenditures, which produces regular and reliable audit reports. The MOHSW headquarters has a strong internal audit section, which is supplemented by the Auditor General's Office.

4.1.4 MECHANISMS FOR PURCHASING HEALTH CARE SERVICES IN LESOTHO

Health Insurance

Lesotho has two main medical aid schemes—Mamoth and Bophilo, which commenced operations in the early 2000s. These schemes cover employees of various private companies and semipublic corporations, as well as individuals. Membership is very low and is estimated at less than 2,000 individuals. Coverage for the schemes is not extended to persons who do not directly pay premiums. For example, at Mamoth, the premiums are at a graduated rate starting with the principal member, then the member's spouse, any students younger than 21 years, and child dependents. An adult dependent pays the same contribution as the principal member.

The schemes cover the following services: hospitalization, emergency services, blood transfusion, dentistry, consultations and visits, medicines and injections, chronic medication, maternity, mental health, oncology, optometry, prosthesis and appliances, immune deficiency, and renal dialysis. However, the coverage of these services varies by type of benefit package purchased by the insurer. For example, Mamoth has four types of schemes: Elite Option, Standard Plus Option, Standard Option, and Primary Option, which does not include chronic illness and is not recommended for persons older than 50 years. The maximum amount of benefits under each option for all services or goods sought is clearly prescribed. As such, members are not required to co-pay at the provider's office as one way of controlling moral hazard¹⁹.

The medical aid schemes contract with nearly all Lesotho independent service providers in different disciplines. Most doctors are general practitioners and refer complex cases to specialists. In addition, the schemes contract with private hospitals, CHAL hospitals, and the Lesotho Ambulance Network. For example, Mamoth has a contract with three major South African hospitals: Netcare, Medi-Clinic and Life Healthcare, and ER24. These providers are mainly paid through fee-for-service. No public hospitals are currently contracted to provide any health service to the insured members. This implies that all the funds paid through the health insurance scheme end up in the private health sector whose principal goal is to maximize profits. Given the fact that these contracted facilities are paid through fee-for service, it is more likely that this will lead to cost escalation, similar to the situation experienced in South Africa. The main driver of health care costs in South Africa is the medical aid schemes, which account for nearly 60

¹⁹ Moral hazard occurs when a party insulated from risk may behave differently than if it were fully exposed to the risk. For example, an insured person may engage in risky behaviors such as smoking, but, this information might not be revealed to the insurer, thereby leading to the insured consuming unnecessary health services because payment is not borne by the insured.

percent of total health care expenditures, while only benefitting less than 20 percent of the population (NDOH 2001). In Lesotho, the reason the medical aid schemes have contracted only with private sector providers is that government health facilities are perceived to provide poor quality health care services. However, it could be argued that if the same health insurance funds were spent at public health facilities, they could contribute to improving the perceived poor quality of health care services.

Although only two main medical aid schemes exist in Lesotho, a rapid assessment revealed that the country has adequate management skills to run the fast growing health insurance market. Financially, the medical aid schemes are operating on a surplus, which is reinvested so as to increase member benefits by offering a corresponding low rate increase in premiums. However, despite limited adverse selection, members are known to lend their medical cards to nonregistered dependents. Also, some providers claim amounts for services not provided. In order to deal with these two problems, the medical aid schemes have introduced member profiling, which distinguishes and spots the members' files concerning irregular claiming patterns, and provider profiling, which monitors the providers' coding and treatment.

The major factor that could seriously lead to escalation of health care costs in Lesotho is that the two medical aid schemes only contract with private providers in Lesotho and in South Africa, using a fee-for-service model as mode of payment. Fee-for-service payment mechanisms are known for escalating health care costs worldwide as simple procedures can be switched to more complicated procedures to increase fees collected from the medical aid scheme. Further compounding the situation is the perception that South African medical care is superior to that offered in Lesotho. This results in a situation whereby funds generated in Lesotho are transferred to private health facilities in South Africa; therefore, even if the two medical aid schemes can rapidly expand, the funds will not benefit the Lesotho public health systems or population. The GOL needs to critically examine the role of health insurance in risk pooling for the Basotho people such that the funds generated from insurance schemes are ploughed back into the Lesotho health system. This might be achieved through additional investment in infrastructure and human resources in health facilities. The construction of the new 425-bed hospital to replace Queen Elizabeth II Hospital in Maseru is a positive development. The two medical aid schemes within the country will likely contract with the new hospital.

Policy for User Fee Payments in the Public Sector

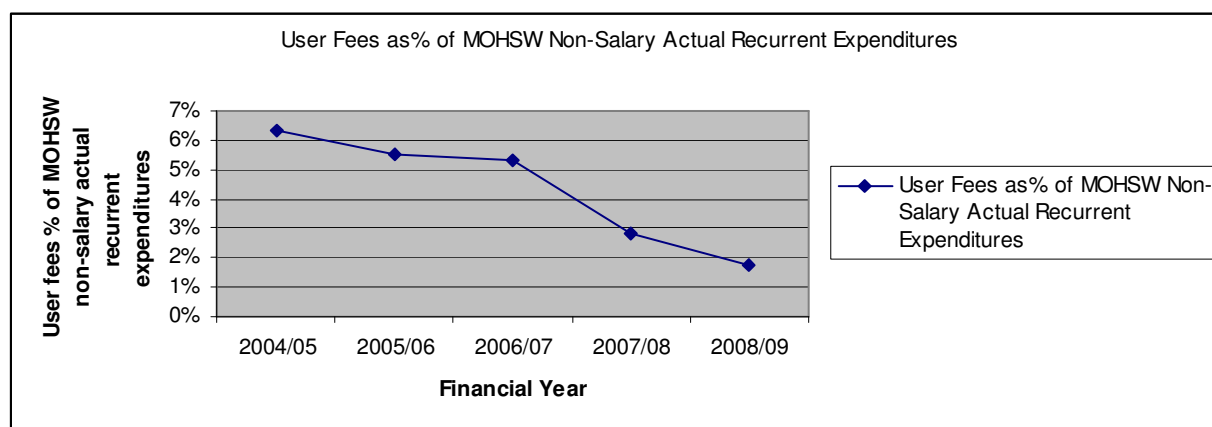
In Lesotho's public health sector, user fees are paid at district and tertiary hospitals for outpatient and inpatient services. All user fees at health centers, including CHAL health centers, were abolished in 2008. At the district and tertiary hospitals, patients pay for outpatient care and inpatient care, in addition to medicines, supplies, and lab or other diagnostic tests. Some policies waive user fees for some groups using primary care services [e.g., children under 5, elderly, poor, immunizations, preventive health services, TB directly observed therapy short course (DOTS), and ART, among others]. All exempted patients are expected to obtain a letter from MOHSW headquarters/Social Welfare Department and present it to the facility for exemption. All fees at district and tertiary hospitals are set at the national level, and formal criteria are in place for identifying patients or patient groups who are eligible for fee exemptions or waivers.

Although no detailed study has been conducted to evaluate the impact of abolition of user fees in GOL and CHAL health centers, it appears that user fees were indeed suppressing the demand for health care services. Prior to the removal of user fees at health centers, evidence suggested that user fees were negatively affecting utilization of health care services (Oxford Policy Management 2008). However, following the abolishment of user fees at health center level, 2008/09 experienced an increase in the utilization of health services in GOL and CHAL health facilities of 0.2 percent over 2007/08 (MOHSW 2008).

User Fee Revenues and MOHSW Non-salary Recurrent Expenditures

All user fees charged in MOHSW hospitals are pooled at the MOFDP, giving staff little incentive to collect fees since no direct benefit accrues to the collecting facility or individuals. A review of user fee revenues in MOHSW facilities (including the period before the fees were abolished at health centers) shows that user fee revenues as a percentage of MOHSW non-salary recurrent actual expenditures contributed, on average, 4 percent between 2004/05 and 2008/9. User fees fell from a high of 6 percent in 2004/05 to a low of 2 percent in 2008/09 (see Figure 4.1.13). The dramatic fall in user fee revenues between 2006/07 and 2007/08 could be attributed to the removal of user fees at all MOHSW health centers. Although user fee revenues decreased after the removal of user fees at health centers, it is clear that, in general, user fees were not an efficient source of revenue. This is similar to findings in other countries in sub-Saharan Africa, where studies determined that user fees in public health facilities contributed between 5 and 15 percent of non-salary operating expenses (Creese 1991).

FIGURE 4.1.13. USER FEES IN MOHSW HEALTH FACILITIES AS PERCENTAGE OF MOHSW RECURRENT EXPENDITURES, 2004/05 TO 2008/09



Source: Oxford Policy Management (2008); MOHSW (2009)

Informal User Fees in the Public Sector

The prevalence of informal user fees in public health facilities is difficult to measure because no detailed studies have been conducted to determine whether clients pay extra fees in district hospitals or in health centers (where health care should be provided free of charge). More detailed studies need to be undertaken in Lesotho to gather evidence on the prevalence of informal fees in public health facilities.

Contracting Mechanisms between MOHSW and Public or Private Service Providers: Not for Profit and For Profit

The only form of a health services contract that exists in the MOHSW is between MOHSW and CHAL. For many years, this relationship has been governed by a MOU based on the MOHSW funding CHAL's inputs while CHAL delivers health services to the population within its catchment areas. However, the new MOU, signed in 2008, describes specific issues of performance, including the following: the design and enforcement of a new accreditation system for all CHAL health facilities, the explicit definition of an essential package of health services to be provided, performance indicators to be achieved, specified mechanisms for reviews, and the financing formula and method of payment. It is clear that the MOHSW is moving toward a performance-based financing mechanism, which has the potential to improve quality of health care services and access to and utilization of health care services.

Apart from this, the MOHSW contracts out several noncore functions such as security, cleaning, and maintenance. In addition, the MOHSW has embarked on a PPP initiative that has utilized out-based aid concepts²⁰. The most prominent is the replacement of Queen Elizabeth II Hospital with a new 425-bed facility that will be supported by a network of three refurbished urban health clinics. The Tsepong consortium will design, build, partially finance, and operate the new hospital and three urban health centers under an 18-year PPP/Build-Operate-Transfer agreement.

Incentive and Performance-based Financing Schemes

Other than the two previously cited examples, no other large-scale incentive or performance-based financing programs exist in the MOHSW. However, a pilot performance-based financing project is being spearheaded by the Global Fund. International experience has shown that these are innovative financing mechanisms that have the potential to improve the quality of, access to, and utilization of health care services, as evidenced in Haiti, Rwanda, and Afghanistan (Eichler 2007).

4.1.5 HIV/AIDS FINANCING

Total HIV and AIDS expenditures²¹ in Lesotho have risen dramatically from M257.4 million in 2005/06 to M359.3 million in 2007/08 (see Table 4.1.8). The rise has largely been due to a steep increase in donor HIV and AIDS support through the Global Fund. Donor spending as a proportion of the total HIV and AIDS contribution was particularly high, rising from 60.4 percent in 2005/06 to 70.4 percent in 2007/08 (see Figure 4.1.14). Donor financing for HIV and AIDS is therefore likely to continue to increase in both relative and absolute terms for the short to medium term. Such a large increase in financial resources brings into question four key issues: (1) absorptive capacity and efficient use of the resources, (2) the sustainability of financing for HIV and AIDS goods and services should there be a turnaround in donor support, (3) whether government is really directing the national response to the crisis, and (4) the extent that the resources are used to strengthen the health delivery system overall rather than only for HIV and AIDS.

TABLE 4.1.8. SOURCES OF HIV/AIDS FUNDS IN LESOTHO, 2005/06 TO 2007/08

	2005/06	2006/07	2007/08	2005/06 to 2007/08
Public	84,865,277	100,622,748	100,622,748	61,829,341
Private	7,711,865	3,887,837	5,744,424	3,866,567
International	164,850,010	105,773,594	252,970,071	90,207,868
Total	257,427,152	210,284,179	359,337,243	155,903,777

Source: UNAIDS (2008a)

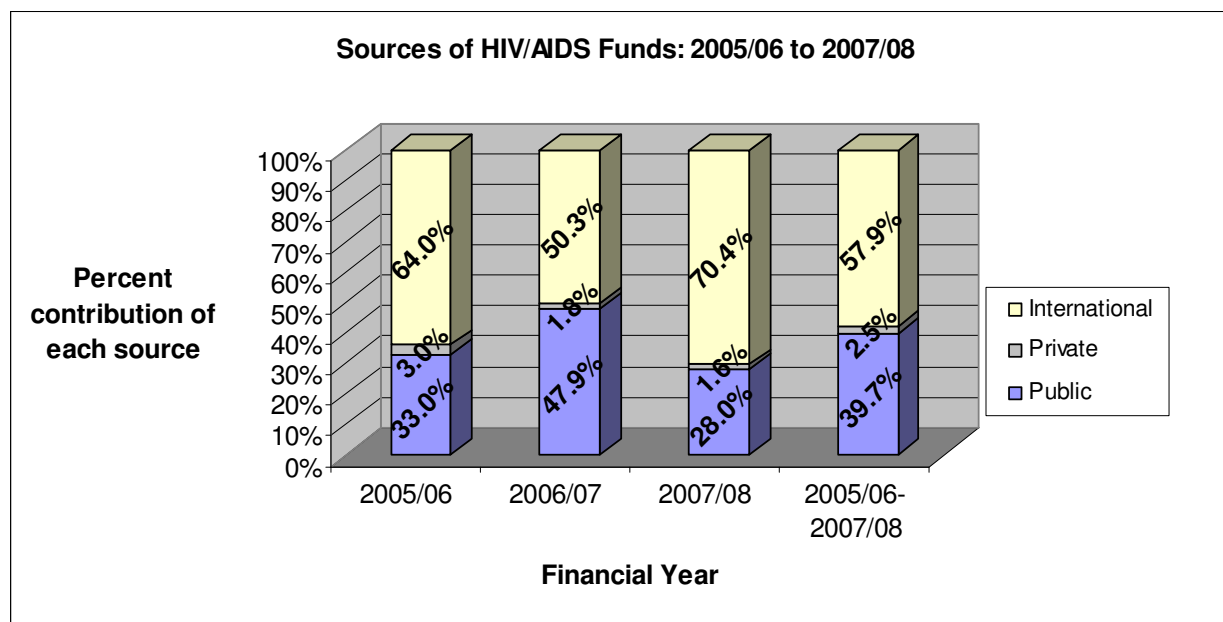
A positive factor that deserves mention is the increase in government financing of HIV/AIDS from a low of 33.0 percent of total HIV/AIDS spending in 2005/06 to a high of 47.9 percent in 2006/07 (see Figure 4.1.14). Furthermore, unlike most countries in sub-Saharan Africa, the Lesotho government funded 56 percent and 67 percent of the total cost of antiretroviral drugs (ARVs) in Financial Years 2005/06 and 2006/7, respectively, and in 2007/08, funding declined to 28 percent (UNAIDS 2008a). This therefore implies that Lesotho could at least sustain the provision of ARVs to HIV/AIDS patients in the short term in the event of abrupt withdrawal of donor support. However, it should be noted that Lesotho has one of the highest prevalence rates of HIV/AIDS in the world (approximately 23 percent of the adult

²⁰ At the center of the out-based aid approach is the premise to make explicit the service delivery obligations of the provider. This is usually in a form of contracting service delivery to a third party, usually a private company, but also NGOs, under the arrangements that link payments to the results actually delivered, not merely the financing inputs.

²¹ This excludes PEPFAR funding of HIV/AIDS activities from its partners whose data were not available to the NASA team.

population, according to UNAIDS 2008b), and with the adoption of new WHO guidelines on ART treatment (which recommends starting ART treatment at CD4 less than or equal to 250), it is likely that more individuals will be eligible for ARVs. Increased eligibility would increase the amount of resources needed for ARVs, and with the expected decline in total government revenues in the medium term, it is unlikely ART treatment could be funded by local resources alone; therefore, donor support for ARVs would be required.

FIGURE 4.1.14. SOURCES OF HIV/AIDS FUNDS IN LESOTHO, 2005/06 TO 2007/08



Source: UNAIDS (2008a)

Promotion of Affordable Private Sector HIV Prevention Services (such as PMTCT, Male Circumcision, STI Treatment)

The GOL attaches high priority to the fight against HIV/AIDS through several prevention methods, mainly prevention in the workplace, blood safety, postexposure prophylaxis, universal precautions, PMTCT, STI diagnosis and treatment, condoms, condom social marketing, voluntary counseling and testing (VCT), and community mobilization. Most of the expenditures within the HIV/AIDS prevention activities have been on STI management, which consumed 26 percent of the total prevention expenditures in 2005/06. HCT consumed 28 percent of the total prevention expenditures in 2006/07, and PMTCT consumed 29 percent of the total HIV/AIDS prevention expenditures in 2007/08.

Recently, development partners have seriously attempted to promote the use of male circumcision, which is being touted as one of the best cost-effective strategies in HIV/AIDS prevention. During this study, interviewers attempted to acquire views of some stakeholders on this HIV/AIDS prevention strategy. Most people interviewed acknowledged being aware of the discussion between the MOHSW and development partners; however, some felt that circumcision is a very sensitive issue because it touches on both cultural and religious beliefs.

4.1.6 SUMMARY OF FINDINGS

Several issues with regard to the financial functioning of the health system have emerged, which have been summarized through the strengths, weaknesses, opportunities, and threats (SWOT) in Table 4.1.9.

TABLE 4.1.9. SUMMARY OF FINANCE SWOT ANALYSIS

Strengths

- Availability of financial resources capable of providing an essential package of cost-effective interventions – Lesotho spent an average of US\$54 per capita per annum between 2004/05 and 2008/09.
- Government as the major source of health funds, adding to health system sustainability.
- High percentage of financial resources for health managed by the MOHSW, which has the main responsibility of improving the health of all Basotho people.
- More resources for health being spent in MOHSW health facilities, thus having the potential of being used to provide quality health goods and services.
- Government providing high percentage of funding for ARVs, which is rare in African countries.

Weaknesses

- Resources not reaching the cost centers on time, especially in first and second quarters, leading to disruption of provision of quality health services.
- Inequities in resource allocation between cost centers, especially districts.
- Consistent under expenditures across the board, worse at district cost centers.
- Consistent over expenditures at two cost centers—Administration and Queen Elizabeth II.
- Low risk-pooling mechanism with high household expenditures for health.
- Inefficiencies in the allocation and utilization of resources between levels of care.
- Weak links between planning, implementation, and M&E of programs and budgets.
- Duplication and waste of resources – multiple donor programs funded outside the government budget and priorities.
- Donors financing the largest expenditures on HIV/AIDS program, thus making the fight against HIV/AIDS unsustainable in the event of donor withdrawal.
- Limited knowledge of financial management and skills.
- Porous financial protocols and processes.

Opportunities

- Abolition of user fees, which are internationally known to dissuade the very poor from utilizing health services in all health centers of GOL and CHAL.
- Design of innovative financing mechanisms, in particular: adoption of principles of performance based financing in contracts with CHAL and the out-based aid financing mechanism in the construction of the new referral hospital; signing of the PPP agreement between the GOL and USG; and the inclusion of some donor resources in the GOL budget, in particular, the capital budget.
- The AJRs of the annual operational plans undertaken by MOHSW and some partners.

Threats

- Continued funding of NGOs and other government activities outside the government plans and off budget, especially for HIV/AIDS programs.
- The signing of Economic Partnership Agreements with the EU, which has led to the decline in SACU's revenues—the main source of GOL domestic revenues.
- Financial crisis in donors' home countries, casting doubt on their potential to continue funding health programs.
- Weak local capacity to finance health

4.2 HUMAN RESOURCES

Introduction

HRH are a critical component of health systems and services. Adequate human resources are essential for scaling up health interventions. The WHO website defines health workers as “all people engaged in actions whose primary intent is to enhance health.” Table 4.2.1, drawn from the handbook for monitoring and evaluation of HRH, provides a useful framework for defining the health workforce. According to the framework, categories A and C make up the skilled (trained) workforce available in a given country, while categories A and B represent the workforce employed by the health industry. The sum of A+B+C represents the total potential health workforce, and category D represents all other workers (who do not have health training and work outside the health industry).

TABLE 4.2.1. FRAMEWORK FOR DEFINING THE HEALTH WORKFORCE

Individual's training, occupation, and place of work	Working in health industry	Working in a non-health industry or unemployed/inactive
Training in health and employed in a health occupation	A. For example, physicians, nurses, and midwives working in a health care facility	C. For example, nurses working for private companies, pharmacists working at retail outlets
Training in health but not employed in a health occupation	A. For example, medically trained managers of health facilities	C. For example, medically trained university lecturers, unemployed nurses
Training in a non-health field or no formal training	B. For example, economists, clerks, gardeners working in health care facilities	D. For example, primary school teachers, garage mechanics, bank accountants

Source: Handbook for monitoring and evaluation of human resources for health, pp. 14.

4.2.1 BRIEF BACKGROUND ON HRH AND HEALTH SYSTEM PERFORMANCE IN LESOTHO

Lesotho adopted a PHC strategy in 1979 by creating 18 health service areas (MOHSW 2005). To address challenges posed by an insufficient number of HRH, Lesotho was among the first countries in the region to create a nurse clinician cadre. The country also introduced and expanded the CHW cadre to help reach PHC goals. On the service delivery front, the country created filter clinics, which were used to triage and lower patient loads at main hospitals. These measures had an impact on the provision of health services and the improvement of health indicators of the Basotho people.

As stated earlier, Lesotho achieved gains in life expectancy, infant mortality, and maternal mortality from 1970 through the mid 1990s. The advent of HIV/AIDS dramatically reversed the gains Lesotho achieved in health indicators, especially with respect to life expectancy, which dropped from 59 in 1990 to 44 in 2010²². HIV/AIDS (with a prevalence rate of 23.2%) and TB remain the foremost challenges in human and economic development in the country.).

²² The average life expectancy between 2000 and 2009 is 54 years. The most recent life expectancy average, from the World Bank's World Development Indicators 2010, is 44.9 years.

4.2.2 HUMAN RESOURCES FOR HEALTH IN LESOTHO – QUANTITY AND DISTRIBUTION

The public health crisis facing Lesotho is further exacerbated by the acute HRH crisis. According to the 2007 Price Waterhouse Coopers Public Service remuneration and job evaluation review project, the health sector faces a scarcity of skills²³ in the medical and allied professions. The study also found that critical skills²⁴ were lacking in the health sector.

Recent data on HRH in Lesotho are not available. The last census of human resources in the health sector was carried out in 2003 by the WHO African Health Workforce Observatory. The MOHSW does not have any current, complete data on human resources.

According to the Lesotho health sector human resources development and strategic plan (2005-2025), 8,600 personnel are working in the health sector in Lesotho, excluding traditional healers and traditional birth attendants. Only 44 percent of these are employed in the formal health sector operated by GOL, CHAL, NGOs, and the private health sector. The remaining personnel work in the informal sector and include an estimated 4,800 CHWs. Of the formal health sector employees, 75 percent are employed by government, 22 percent by CHAL, and the remaining 3 percent by NGOs and the private-for-profit health sector.

The strategic plan also reveals that 33 percent of the MOHSW labor force consists of nontechnical support personnel. CHAL, by comparison, only employs 17 percent of its labor force on nontechnical support functions.

Although more than 60 percent of health care is supplied at the PHC level, less than 20 percent of the formal sector labor supply is employed at the PHC level, suggesting a poor distribution of the health workforce. The largest share of the formal sector labor force is employed at the secondary level (46 percent), and 24 percent are employed at the tertiary level. As a result, as of 2004, only 31 percent of filter clinics had the full-time equivalent personnel that they required, and only 41 percent of health centers met minimum staffing standards with respect to nursing personnel. Conversely, the national referral hospital had 108 percent of their full-time equivalent nursing requirements met, and district hospitals had 50 percent of their nursing requirement filled²⁵.

Staffing at all levels of the health system is inadequate, causing poor service delivery at community health centers, where PHC is essential. Poor service delivery distorts the referral system whereby patients that should obtain care at lower-level facilities refer themselves to a higher level within the health system, rendering organization of services chaotic, impairing access to services, and negatively affecting quality of services offered²⁶.

The human resource needs assessment demonstrated that health sector personnel also suffer from a poor geographic distribution. As a result, the central region has more health personnel than the northern or southern regions. In 2004, the central region had 2.04 personnel per 1,000 population, whereas the northern region had 1.3, and the southern region had 1.13 personnel per 1,000 population.

²³ Scarce skills refers to occupations where there is a scarcity of qualified and experienced people, currently or anticipated in the future.

²⁴ Critical skills refer to key or generic skills, without which an entity (i.e., ministry) would encounter problems with overall organizational productivity, service delivery and quality.

²⁵ Normative staffing standards call for one nurse clinician or clinical officer, two nursing sisters, and three nursing assistants at each health center.

²⁶ Round 8 Global Fund Proposal (Accessed at http://www.theglobalfund.org/grantdocuments/8LSOT_1710_0_full.pdf in January 2010).

The report also revealed that although 29 percent of Basotho resided in the south, only 25 percent of PHC personnel worked in this geographic zone.

Table 4.2.2 provides information on the total stock of health workers in Lesotho.

TABLE 4.2.2. TOTAL STOCK OF HEALTH WORKERS IN LESOTHO

Category	Total number	Density per 1,000
Physicians	89*	.049
Nurses and midwives	1 123	.623
Dentists and technicians	16	.009
Pharmacists and technicians	62	.034
Environmental and public health workers	55	.031
Laboratory technicians	146	.081
Other health workers	23	.013
Community health workers	n.a.	.449
Administrative and support staff	18	.411
Total	1 532	

Source: WHO (2003)

* According to the 2009 omnibus study on health care financing, Lesotho had 134 doctors and 1,770 nurses and midwives working in the public health sector in 2006/07. Data were not available for other categories of staff. Because more recent data were approximate, they were not used for the purposes of this study.

As Table 4.2.2 indicates, the largest cadre of health workers in Lesotho is nurses, who account for 73,3 percent of the total population of health workers in Lesotho. On the other hand, dentists only make up 1 percent of the total population of health workers. Physicians account for nearly 6 percent of health workers in Lesotho.

Table 4.2.3 illustrates the stark differences between the WHO²⁷ African Region and Lesotho. Sub-Saharan Africa is widely decried as suffering from an acute HRH crisis. The number of doctors per 1,000 population in Lesotho is four times lower than the regional average (.049 versus .217). The density of nurses per 1,000 population in Lesotho is .623 versus 1.172 for the rest of the region. Similar inferences can be drawn for all other categories of staff with the exception of laboratory technicians. On average, Lesotho's total health workforce is equivalent to one-third of the African average (.850/1000 versus 2.626/1000).

²⁷ The African Region of WHO consists of 46 (mainly sub-Saharan) African countries. The North African States (with the exception of Algeria), Sudan, and Somalia are not part of AFRO.

TABLE 4.2.3. DENSITY OF HEALTH PERSONNEL PER 1,000 POPULATION IN LESOTHO COMPARED TO THE WHO AFRICAN REGION

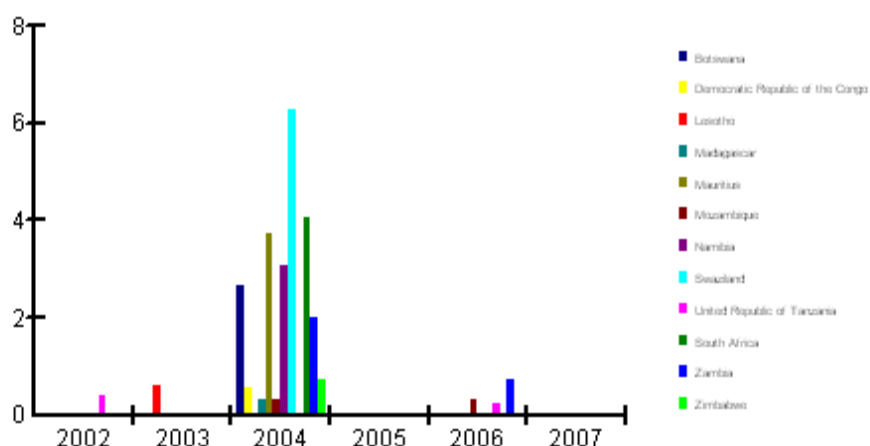
Category	Lesotho	AFRO Region
Physicians	.049	.217
Nurses and midwives	.623	1.172
Dentists and technicians	.009	.035
Pharmacists and technicians	.034	.063
Environmental and public health workers	.031	.049
Laboratory technicians	.081	.057
Other health workers	.013	.173
Community health workers	Not available	.449
Administrative and support staff	.010	.411
Total	.850	2.626

Source: WHO (2003)

As illustrated in Figure 4.2.1, Lesotho fares poorly in relation to its SADC peers with respect to nurses, which represent 75 percent of the total health workforce of the country. Swaziland, a country with a similar epidemiological profile and size, has nearly three times the number of nurses of Lesotho.

FIGURE 4.2.1. TOTAL NUMBER OF NURSES PER 1,000 POPULATION

SADC nurses



4.2.3 HUMAN RESOURCES – SPECIFIC CADRES

Nurses: Nurses are the single largest cadre of health workers in the formal sector in Lesotho, accounting for more than 73 percent of health workers (1 123/1 532)²⁸. According to the Lesotho HRH development strategy, nurses' account for 90 percent of personnel directly engaged in health service production. This cadre is relatively homogenous with respect to gender and nationality, with 95 percent

²⁸ 1,532 refers to health workers falling under category A of the health workforce evaluation framework.

of nurses being women and 99 percent of practicing nurses being Basotho in 2004. It should be noted that nurses refers to all categories of nurses (i.e., nurse clinicians, nurse midwives, and nursing assistants). The WHO African Health Workforce Observatory and the 2009 World Bank health expenditure review disclosed that the ratio of nurses in Lesotho per 1,000 population has actually decreased from the mid 1990s to the mid 2000s. Specifically, the number of nurses and midwives dropped from 1.07 per 1,000 to 0.60 in the mid 2000s. This is a major concern because the decline occurred while the country's burden of disease increased substantially due to the onset of HIV/AIDS. Although no current data are available, key informants indicated that a majority of the nurses practicing in Lesotho are nurse assistants.

Medical doctors: Physicians represent the second largest cadre after nurses, accounting for approximately 5.8 percent of health workers (89/1532). According to the HRH development strategy, the medical doctor cadre is one of the few that has a higher proportion of males versus females and also a higher proportion of non-nationals versus nationals. In 2004, the MOHSW employed 66 percent of all doctors in Lesotho.

Pharmacy personnel: According to the WHO African Health Workforce observatory, Lesotho had 62 pharmacists and pharmacy technicians in 2004. The HRH development strategy reveals that the MOHSW employs the majority of pharmacists with degrees in Lesotho. The pharmacy personnel category covers two levels of personnel: pharmacists and pharmacy technicians. As with the nursing category, key informant interviews revealed that a majority of pharmacy personnel in Lesotho fall into the latter category. Considering that prior to 2001, Lesotho did not have a degree-level pharmacy training institution, this assertion is plausible.

Laboratory personnel: According to the HRH development strategy, 75 percent of all laboratory staff are employed by the MOHSW, with 100 percent of lab technologists employed by the MOHSW. Similarly to other cadres, the laboratory staff cadre consists of two distinct types of staff: laboratory technologists and laboratory technicians.

Nutrition personnel: At the time of the HRH development strategy, Lesotho had only .0002 nutritionists per 1,000 population, or five nutritionists total in the country. CHAL employs three of the nutritionists, and the GOL employs two.

Dental personnel: The HRH development strategy states that the supply of dental personnel is very limited in Lesotho, with a coverage of .007 per 1,000 population. In 2004, none of the CHAL facilities employed dental staff. At the time of this assessment, the number of staff was so limited that only Maseru had more than one dental staff employed. Most dental staff were women (63 percent) and Basotho (93 percent).

Environmental health workers: In 2004, Lesotho had a coverage of 0.02 environmental health workers per 1,000 population, 90 percent of which were employed by the MOHSW. Approximately 66 percent of the environmental health workforce was made up of health assistants.

Community Health Workers (CHWs): CHWs have been providing health services at the household/community level in Lesotho since 1975. The CHW program was adopted as a national strategy for PHC in 1979 following Lesotho's participation at the 1978 Alma Ata Conference. In 1987, the GOL signed an agreement of cooperation with UNICEF, whose main focus was community-based health services, and this significantly contributed towards strengthening the CHW program. Challenges that have affected the growth of the community-based program include inadequate funding, increased burden of diseases, acute shortage of health professional to supervise, and inadequate incentives—all of which have led to low morale and motivation of this workforce.

Until 2008, CHWs received no remuneration, and their only benefit was free medical care for themselves and their immediate family. This benefit lost its significance with the adoption of the free PHC policy. In 2008, the government began paying CHWs a monthly salary of M300, thereby institutionalizing the community-based health service.

4.2.4 COMMUNITY HEALTH WORKERS – THE BACKBONE OF THE HEALTH WORKFORCE OF LESOTHO

Based on standards adapted by MOHSW, a CHW is responsible for approximately 40 households or two villages, depending on the size of these villages. This workforce consists of the village health worker, who is a comprehensively trained first-level health care provider, and a traditional birth attendant, who also might be a village health worker. They are supervised by facility-based health professionals who in turn are supervised at the district level by the district public health nurse. At the national level, this program is coordinated by a community-based health service coordinator in the Division of Family Health.

CHWs are essential for delivery of social welfare and health interventions at both the community and household levels, and for creating a demand for facility-based services through social mobilization. Box 4.2.1 provides more details of the specific activities that CHWs are expected to implement at the community level.

BOX 4.2.1. DETAILS ON THE SPECIFIC ACTIVITIES/STRATEGIES THAT CHWS ARE EXPECTED TO IMPLEMENT AT COMMUNITY LEVEL

Community Health Workers are responsible for the following activities, by program area:

Community environmental health

- Promotes access to safe and clean water to the population.
- Promotes wholesome and safe quality food for human consumption and for export.
- Controls vectors and rodents of public health importance.
- Promotes acceptable standards of sanitation.
- Prevents environmental risks and hazards associated with water, air, and land.
- Prevents occupational-related health hazards.
- Promotes development of housing structures of public enterprises and human settlements that comply with health standards.

Community social welfare services

- Promotes community empowerment to reduce poverty.
- Mitigates the social impact of those infected and affected by HIV/AIDS.
- Promotes child protection and development in the community.
- Provides appropriate social assistance to the elderly and adults in need.
- Promotes improved quality of life of people living with disabilities.

Health education and promotion

- Advocates for healthy lifestyles and social well-being using pitsos* and other social groupings
- Promotes positive behavior change for health.
- Conducts social mobilization for key health priorities.
- Ensures health messages targeting the community meet set standards.

Preventive health care

- Provides prompt notification of disease outbreaks.
- Promotes patients' knowledge of their HIV/AIDS status.
- Supports patients on ART.
- Supports people in need of home-based & palliative care through access.
- Encourages pregnant mothers to attend antenatal care services.
- Provides contraceptives to target clients.

- Conducts safe delivery of pregnant mothers.
- Encourages and supports immunization of children under one year.
- Promotes healthy feeding of children under five years old.
- Conducts dental caries screening of school children.
- Ensures early identification and referral of suspected mental health patients.

Basic curative care and referral of patients

- Supports, as per guidelines, patients with non-communicable diseases.
- Supports, as per guidelines, patients with communicable diseases.

Basic community-level management

- Ensures that District Planning Unit prioritization and planning supported with health information and aligned to national priorities under the guidance of health center in-charge.
- Develops and implements a health plan that is informed by council planning process.
- Ensures required medicines and other supplies are quantified, acquired, adequately stored, and rationally utilized.

Source: MOHSW

* Pitsos are public gathers/meetings open to all adults that originated in the indigenous local government administration.

4.2.5 PRODUCTION OF HUMAN RESOURCES

Production of HRH in Lesotho is undertaken by two main organizations: GOL and CHAL. Unlike the overwhelming majority of countries in the region, Lesotho does not have a medical school. The country has traditionally trained its doctors in SADC countries (South Africa, Zimbabwe, Malawi, and Zambia).

The GOL flagship training institution for health professionals is the National Health Training College (NHTC). According to the NHTC director, NHTC was set up in 1989 as a public institution of higher learning with support from Irish AID. Funded entirely by the MOHSW, the institution focuses primarily on training three cadres of staff: nurses, medical lab scientists, and pharmacists. As the national student financing agency for NHTC, the National Manpower Development Secretariat of Lesotho pays Basotho students' tuition and related fees. NHTC also receives a subvention from the MOHSW for operational costs. Although the institution currently has no other sources of income (other than government), NHTC is transitioning to become a national autonomous training institution.

NHTC offerings include a nurse assistant track (two years), a basic diploma track (three years), and a post-basic training track (one to two years). The main disciplines are general nursing, medical laboratory technology, pharmacy technology, and environmental health technology. Post-diploma trainings are available in midwifery, ophthalmic nursing, nurse anesthesiology, nurse psychiatry, and nurse clinician tracks.

As of January 2010, NHTC had approximately 30 academic staff and a total enrollment of 460 students. A major challenge facing NHTC is an insufficient number of qualified tutors. The instructor/student ratio is depicted in Table 4.2.4.

TABLE 4.2.4. TUTOR/STUDENT RATIO AT NHTC

Program	Tutor/Student Ratio
General nursing	1/50
Midwifery	1/40
Medical laboratory technician	1/10
Pharmacy technology	1/13
Environmental health	1/30

Source: Key informant interview at NHTC.

Another issue affecting the production capacity of NHTC is the lack of facilities for practical training. All students following the nursing track are required to undertake a practicum as part of their studies. Lesotho has only one teaching hospital (Queen Elizabeth II) with the capacity to host students for internships, and this capacity is limited, causing overcrowding, which has a negative impact on the quality of the practical training received.

NHTC produced a total of 149 graduates in 2009. Key informants indicated that if provided the right investments in infrastructure, additional training capacity (tutors), and increased opportunities for practical training, the institute could increase its overall student population by a factor of two or three (1,500 to 2,000) and produce 500 graduates annually.

The second government institution that trains health professionals is the Faculty of Health Sciences of the National University of Lesotho (NUL). NUL established a faculty of health sciences in 2001 at the behest of the MOHSW. The first course of study offered at NUL was nursing. The faculty subsequently expanded its offerings to include pharmacy, nutrition, and environmental health. NUL is the only degree-conferring institution in Lesotho. Graduates receive a bachelor of science degree.

The nursing program is a five-year degree-granting program. The available tracks include general nursing, ophthalmic nursing, and medical surgical nursing. Additionally, the nursing program offers a completion program for nurse assistants. This program, which is geared toward PHC nurses with the equivalent of an associate's degree, offers a degree-bearing (bachelors level) training in medical surgical nursing and community health nursing.

According to the dean of the faculty of health sciences, the nursing program at NUL produces approximately 38 graduates per annum. The data in Table 4.2.5, depicting the student load in the NUL health science programs, indicate issues exist with retention and completion of the nursing program, with only about 60 percent of students completing their program of study.

TABLE 4.2.5. NUMBER OF STUDENTS ENROLLED IN NURSING, PHARMACY, AND NUTRITION PROGRAMS AT NUL (2009 ACADEMIC YEAR)

Year of study	BSc – Nursing and midwifery	BSc – Nursing science	BPharmacy	BSc - Nutrition
1	49	0	38	13
2	58	7	42	26
3	52	0	63	19
4	43	0	31	19
5	34	0	27	0

Source: NUL Registrar

Similar to NHTC, having only one teaching hospital in Lesotho, limits opportunities for NUL's nursing students to fulfill their mandatory practical training requirement, and this adversely affects NUL's capacity to train nurses. Additionally, a limited number of instructors (nine) constrains the program's production capacity.

NUL also offers a degree-conferring program in pharmacy (bachelor of pharmacy [honors]) and a Bachelor of Science in nutrition (Table 4.2.6 demonstrates the student load of the pharmacy and nutrition programs).

The pharmacy training program is a five-year honors degree track that attracts foreign interest. One challenge the Department of Pharmacy faces is the lack of availability of tutors. Although the department

currently has nine lecturers, it does not have any pharmaceutical chemists on staff. Training of pharmacists is also impeded by insufficient facilities and laboratories.

The nutrition program is significantly under-resourced in terms of staff (four staff, including one dietician) and resources (weak laboratory infrastructure, insufficient training materials). Upon completion of studies, graduates from the nutrition program are not easily absorbed by public service (main employer) because few nutrition positions exist in the MOHSW.

The most recent offering added to the Faculty of Health Sciences is a certificate program in environmental health. The first cohort of students is currently in its third year of studies. This program has faced challenges establishing itself because of a general lack of awareness about environmental health in Lesotho and very poor resources. The program has two lecturers on staff, no laboratory facilities, and few, if any, opportunities for students to obtain internships or employment in Lesotho.

The overall budget for the faculty of health sciences is on an upward trend, as shown by the budget information presented in Table 4.2.6.

TABLE 4.2.6. FACULTY OF HEALTH SCIENCE ANNUAL BUDGET BY PROGRAM (MALOTI)

Faculty of Health Sciences			
Program	Budget 2007/08	Budget 2008/09	Budget 2009/10
Office (administration)	12,333	8,899	8,899
Nursing	3,030,643	2,043,547	2,848,855
Pharmacy	1,406,569	1,513,703	1,989,487
Nutrition	600,371	415,449	795,871
Environmental health	-	792,517	616,693

Source : NUL Faculty of Health sciences

The overall budget of the faculty of health sciences has increased from M5,049,916 in 2007/08 to M6,259,805 in 2009/10, representing a 20-percent increase in three years.

4.2.6 CHAL PRESERVICE EDUCATION AND TRAINING FACILITIES

In addition to the NHTC and NUL, four CHAL institutions operate nurse training programs. Maluti and St. Josephs hospitals both have three-year diploma nursing programs and one-year post-basic midwifery programs, and Scott and Paray hospitals operate two-year nursing assistant programs. In addition, Scott Hospital offers a two-year upgrading course for enrolled nurses through a distance learning program.

Table 4.2.7 provides information on yearly intakes and outputs, and the number of instructors/tutors per program. These four schools expect to produce 38 registered nurses, 25 midwives, 23 upgraded diploma nurses, and 40 nursing assistants per year.

TABLE 4.2.7. NURSING TRAINING IN CHAL INSTITUTIONS

Institution	Program	Yearly Intake	Expected Output	Tutors
Maluti School of Nursing	Registered Nurses	26	24	7
	Midwifery	15	15**	
Roma School of Nursing	Registered Nurses	20	14	7
	Midwifery	10	10	
Scott School of Nursing	Nursing Assistants	20	20	3
	Upgrading Course*	23	23	
Paray School of Nursing	Nursing Assistants	20	20	3
* Two-year upgrading course for enrolled nurses. This program is being phased out.				
** Eight of 15 students failed midwifery last year. However, students retake the exam and/or repeat coursework until they pass.				

No data were available on the level of funding of CHAL training institutions. Key informants indicated that CHAL institutions are confronted with similar challenges to NHTC and NUL especially as inadequate infrastructure and staffing are concerned. The lack of educators/tutors is limiting the production capacity of CHAL institutions and adversely affecting the quality of training offered.

In summary, Lesotho has an adequate number of health workforce training institutions. Production constraints are caused by an insufficient number and range of instructors (i.e., student/teacher ratio and lack of trainers in key disciplines: pharmacy, nurse midwives, etc.), few opportunities to conduct mandatory practical sessions (internships are only possible at one teaching hospital), and inadequate training materials and infrastructure (especially laboratories).

The transformation of NHTC into an autonomous institution offers substantial opportunities for strengthening the resource base through partnerships and grants with development partners (e.g., PEPFAR, AfDB) and pairing/twinning arrangements with colleges and universities outside Lesotho.

Although Lesotho can ramp up its production of health workers in a relatively short timeframe, a major challenge facing the MOHSW is the limited absorptive capacity of the sector. Despite having developed comprehensive evaluations, strategies, and plans to address the HRH crisis, the MOHSW has not been able to absorb the resources produced into the workforce. The Department of Human Resources routinely spends less than 50 percent of its annual budgetary allocation. Poor career management, lack of incentives, and inability to progress within certain cadres are major “demotivators” of health personnel. Key respondents cited this inability to absorb staff as a major “push” factor contributing to migration of health workers.

On the external front, the MOHSW has a poor track record of engaging with the Public Service Commission (PSC) to create additional new positions in sufficient numbers to address the HRH crisis. Although multiple plans and strategies have been crafted (e.g., Emergency Hiring Plan), these are seldom implemented.

Hence, ramping up production of health workers through recruitment of additional tutors and/or expansion of health training infrastructure alone will not resolve the HRH crisis. Strong measures to increase the hiring/absorption rates will have to be adopted, and instituting a strong career management system and improving conditions of service such as equipment and incentives (monetary and nonmonetary) will have to be implemented in tandem.

In summary, Lesotho has an adequate number of health workforce training institutions, with the exception of a medical school. Production constraints are caused by an insufficient number and range of instructors (i.e., student/teacher ratio and lack of trainers in key disciplines: pharmacy, nurse midwives, etc.), few opportunities to conduct mandatory practical sessions (internships are only possible at one teaching hospital), and inadequate training materials and infrastructure (especially laboratories).

To improve absorptive capacity, the MOHSW may consider proposing that government create a health services commission (similar to Malawi and Zambia) to delink hiring of HRH from the general PSC framework.

4.2.7 MANAGEMENT OF HUMAN RESOURCES

In the government sector of Lesotho, management of human resources is split between line ministries (health, education, etc.) and the PSC (which oversees all civil service employees). Since the PSC is responsible for management of the civil service, it is responsible for functions related to creating and abolishing positions, defining conditions of service, processing entry and exit from the civil service, developing employee policy manuals, defining performance management systems, and undertaking disciplinary action against employees.

As such, technical/line ministries have a limited scope of intervention. They are responsible for ensuring the HR function within a line ministry, under the broad orientations/guidelines of the PSC.

The MOHSW has an HR directorate, led by a director. The unit provides HR management services to the ministry. It processes documentation related to incoming and departing staff, training requests, leave, and promotion/demotion/administrative sanction documentation.

Recently, the HR directorate in the MOHSW has played an increasing role in raising awareness about the HRH crisis facing Lesotho, participating in a range of workforce analysis studies and strategy development activities. The HR directorate led the development of the 2005-2025 HRH development strategy, the continuing education strategy, the retention strategy, the HIV workplace policy, the emergency hiring plan, and other directives. The directorate has also embarked on implementing a human resource management information system with support from SAHCD and Irish AID.

The role of the directorate will change as decentralization is operationalized, evolving from a managerial function to a strategic function. The decentralization policy for the health sector states that the MOHSW's role will evolve to essentially focus on planning and implementing HRH development strategies.

4.2.8 DECENTRALIZED LEVEL

The Local Government Act (1997) transferred power to community, rural, municipal, and urban councils, which are coordinated by the District Development Coordinating Committee. The act also provides for a Local Government Service Commission that recruits, appoints, promotes, transfers, and dismisses staff in consultation with the relevant local authority. The overall goal of decentralization is to empower the DHMT to manage all district-based resources and be accountable for the results of the District Health Package.

In practical terms, decentralization will shift authority for all human resources at the district level (with the exception of district hospital personnel) to the local government service commission. As a result, the DHMT members and all district health staff (excluding hospital staff) will be transferred to the Local Government Service Commission and will be responsible to the district councils (MOHSW 2009).

The main structure responsible for management of health services at the district level is the DHMT. DHMTs consist of (1) a district director of health services, who may be a medical officer trained in public health or any senior health professional trained in public health; (2) a district public health nurse; (3) a district health inspector; (4) a social welfare officer; and (5) a district health information officer. The functions of the DHMTs are to supervise hospitals and health centers, plan for health delivery in districts, plan equitable allocation of resources between districts and hospitals, mobilize resources for district health service delivery, and integrate health services into district development. As of January 2009, no district in Lesotho had a full staff complement on the DHMT, with the highest ranking districts having 25 percent vacancy rates, and the lesser performing districts having filled 50 percent of their allotted positions (MOHSW 2009).

4.2.9 HUMAN RESOURCE PLANNING

Lesotho does not have a comprehensive human resources data system. The current system has three basic reporting functions: it generates a salary bill (the total wage bill of the MOH), a staff list (personnel working for the MOHSW), and a staff complement list (staff by level and occupation). This Microsoft Access-based system is manually updated by the HR directorate staff.²⁹

The current human resources data system includes data on MOHSW staff working at the central level. It is not deployed at specialist hospitals, the health sector parastatal, or the decentralized level, nor does it cover the private or not-for-profit sectors. Data elements collected are essentially administrative in nature (e.g., appointment letters, transfer letters, promotion notices).

To address this situation, the MOHSW is currently receiving technical and financial assistance from USAID through SAHCD to implement the iHRIS suite of human resource information software. A stakeholder meeting has been organized and discussions are underway to determine how iHRIS will interface with IFMIS and the PSC's HMIS.

Despite the lack of an HR data system, the MOHSW has made great strides in formulating strategies and approaches for addressing the HRH crisis. Using census and special studies to collect data on health personnel, the MOHSW spearheaded the development of the HRH strategy and development plan, the continuing education plan, the emergency hiring plan, and the elaboration of the retention strategy.

4.2.10 HRH INDICATORS

As discussed earlier, although Lesotho has elaborated an HRH development plan³⁰, which contains targets with respect to production, training, and management of health personnel, the country does not have a core set of HRH indicators to monitor HRH, and the strategic plan does not have a M&E component. The plan was elaborated in 2005/06 and has not been updated by government or partners. The MOHSW recently undertook a costing exercise of the HRH strategic plan with technical assistance from USAID's Health Systems 20/20 project. The HRH strategic plan does include staffing targets and career paths for all categories of staff.

4.2.11 BUDGET

The Directorate of Human Resources had a budget of M6,622,985 in 2009. According to MOHSW budget projections, this budget will be significantly reduced in 2010 and 2011 to M2,012,688 and M2,201,957, respectively.

²⁹ Source – Interview with staff of HRH directorate

³⁰ This plan also functions as the strategic plan.

Reductions in budget are being driven by two factors: (1) the overall GOL budget is being reduced because of Lesotho's membership in the SACU; and (2) the HR directorate consistently underspends its allocated budget, making it challenging to justify supplemental resource allocations.

The directorate routinely underperforms on expenditure, routinely spending less than 50 percent of its allocation. This reflects a problem with availing of funds (delays in receiving funds), absorption capacity, or other restrictive measures that prevent effective spending of resources.

4.2.12 HUMAN RESOURCE POLICIES

Because MOHSW employees are civil servants, the MOHSW uses a health sector-specific job classification system developed by the PSC³¹. The guidelines governing the job classification system derive from the laws governing the PSC. The ministry does not have the authority to unilaterally change the scope of job descriptions or the job classification system. Any changes must be made in consultation with, and approved by, the PSC.

The tasks of recruiting, hiring, transferring, and promoting employees are all governed by the rules of the civil service. Lesotho has a formal system/process for recruiting and hiring health personnel. All new positions are "created" by the PSC, upon proposal of a line ministry. The process of creating a position can take over a year, given the number of government agencies involved in the process (line ministry, Finance, PSC). Constraints (either donor or revenue imposed) on the overall government wage bill limit the MOH's capacity to address its HR requirements. Additionally, all ministries of government "compete" for a limited number of potential new positions under the public service.

The compensation and benefits system of the MOHSW is based on the rules and regulations of the PSC, and MOHSW employees follow the career track as defined by the commission. Whenever vacancies are posted, all qualified individuals are eligible to apply. The ministry does not have a merit award system. All civil servants receive a yearly increment determined by grade and decided by the MOFDP and PSC.

The PSC defines the employee conditions of service in the health sector. Upon commencement of employment, every new civil servant is provided with a copy of the codes of good practice, published in 2005.³² The manual consists of four sections: (1) part 1 provides a code of conduct, (2) part 2 outlines the grievance code, (3) part 3 is the disciplinary code, and (4) part 4 provides guidance on dispute resolution. The Public Service Act (2005) provides guidance on work hours, benefits, travel, leave allowances, legal issues, and termination. Lesotho law prohibits discrimination by gender or disability, but issues of equity are not explicitly addressed.

Medical doctors, dentists, and pharmacists must register with the Lesotho Medical, Dental, and Pharmacy Council to practice in Lesotho. Established by law in 1970, the Lesotho Medical, Dental, and Pharmacy Council only legally registers doctors, pharmacists, and dentists; however, other cadres (nurses) register with the council without obtaining any benefits. The Lesotho Medical, Dental, and Pharmacy Council does not receive any government subsidies. Requirements for registration are original or certified copies of certificates, letter of employment in Lesotho (for foreign doctors), completed application form, certificate of good standing from most recent registration jurisdiction, photographs, CV, and application fee (which varies by nationality of the applicant: 500 for Basotho and 570 for foreign doctors). Once registered, health professionals' requirements are not monitored, and the council does not have the capacity to require recertification. Traditional practitioners do not register with the medical council.

³¹ The PSC is a semi-independent government structure that is responsible for management of the civil service.

³² Codes of good practice is the policy manual for civil servants.

There is also a Lesotho Nursing Council, which registers all nurses in Lesotho and maintains a much stronger network of professionals than the Lesotho Medical Council. Unlike the Medical Council, the Nursing Council has an agreement with the nursing schools in Lesotho and is able to track students throughout the education system. The Lesotho nursing schools (NHTC, NUL, Maluti, Roma, Paray, and Scott) are all registered and accredited by the Nursing Council. The council also reviews the general nursing curriculum (the last review was in 2008).

The registration process for both councils is entirely manual and not computerized. Neither of the councils has the capacity to enforce registration requirements with health professionals working in the private sector.

4.2.13 PERFORMANCE MANAGEMENT

Emoluments are set by the PSC and salary increments are decided annually by the MOFDP. MOHSW employees receive two increments annually: one on the yearly anniversary of service (date of commencement of employment in the civil service), and one at the annual budget reading, which is applied to the entire civil service. Lesotho has a well-defined salary scale structure. Payment of salaries occurs on time, and wages are paid in full. No information on moonlighting was available. However, it is important to note that salary increments are not based on performance.

Job descriptions for all positions are available. These are usually standardized by level of responsibility (grade). According to the Department of Human Resources, all employees are aware of their job descriptions. No standard process exists for updating or reviewing job descriptions.

The MOHSW does not have a sector-specific performance management system. It relies entirely on the PSC's performance management system. Key informants suggested that this system is used essentially for administrative purposes (mandatory process required by the PSC), as opposed to active performance management of employees. Supervisors annually complete a generic PSC form, used by all ministries, as a performance management exercise. Work planning processes are not widely used. Employees are expected to know and understand their roles and responsibilities when assigned specific tasks.

4.2.14 SUPERVISION

Supervision of health workers covers two domains: (1) technical supervision refers to adherence to standards of care, treatment protocols, and national guidelines for management of disease and health facilities; (2) administrative supervision refers to standard human resource management practices, including performance management, discipline, and general oversight. This section addresses administrative supervision, as technical supervision is covered under the service delivery chapter.

Standards for supervision of GOL staff are determined by the PSC. These standards cover performance evaluation and discipline. According to the HR directorate, these standards apply to all ministries, including health, therefore, the MOHSW does not have a separate performance management system. Several respondents described the supervision system as a "routine" function that does not provide an adequate platform for appropriate supervision of health workers. The MOHSW does not have the authority to set separate standards for performance management of HR.

4.2.15 INCENTIVES

The MOHSW provides a standard incentive package (M275/month) to employees assigned to the mountainous regions of the country. In addition, certain cadres of staff (doctors) receive a sitting allowance when required to work over a specified number of hours. Development partners such as the

Clinton Foundation are providing a top-up allowance to nurses working in ART clinics. No information was available on incentives in the private sector.

Lesotho is currently exploring implementing a pay-for-performance scheme with support from the World Bank, as mentioned in the finance section. Pay-for-performance approaches are increasingly being promoted as strategies to ramp up the productivity of health workers.

4.2.16 TRAINING AND CONTINUING EDUCATION

Although the Department of Human Resources is responsible for coordination of in-service training and continuing education for the MOHSW, the ministry does not have a formal in-service training program. Currently, continuing education and in-service training are directly offered by various donor-supported programs, the MOHSW vertical program units, and on an ad-hoc basis. Partners that support/conduct in-service trainings include Irish Aid, Lesotho-Boston Health Alliance, Millennium Challenge Account (MCA) Lesotho, PEPFAR, the World Bank, AfDB, Partners in Health (PIH), International Center for AIDS Care and Treatment Program (ICAP), WHO, UNICEF, and UNFPA, among others.

The focus of these trainings includes leadership and management, data management, drugs and supplies management, quantification, M&E, epidemiology, project management, and strategic planning. Clinical training has also been provided in nursing, pharmacy, mental health, and a range of other disciplines.

Long-term training (i.e., specialization) is either full time or part time. Most long-term training is sponsored by government through the National Manpower Development Secretariat. MOHSW staff can apply for long-term training opportunities through the Department of Human Resources. Applications are reviewed by the department and top management. According to the HR directorate, no applications for long-term training have been successful in the last three years because of budget cuts. In addition, there appears to be a general lack of information among health workers about opportunities for long-term in-service training.

The haphazard nature of in-service training led the MOHSW to craft a continuing education strategy; this comprehensive strategy outlines the key continuing education needs by cadre and overall sector needs. The strategy was recently costed with support from Health Systems 20/20, and the MOHSW is in the process of developing an implementation plan for operationalizing the strategy.

With respect to management and leadership programs, the GOL has no such established practice. Civil servants are recruited to fill positions. The government has no dedicated talent identification or development program. As a result, the MOHSW does not have a management and leadership program.

Although the NHTC is officially an institution of the MOHSW (pending its transition to autonomy), and the GOL sets standards for training in various fields, there are few linkages and feedback loops between government and preservice training institutions. The ministry is consistently unable to absorb the full complement of health resources produced by health training institutions. This results in a situation whereby graduates in health sciences fail to find positions within the public service and, therefore, migrate to other countries to find work. There is a systematic underproduction of cadres in the dental, pharmaceutical, and laboratory technology fields.

4.2.17 SUMMARY OF FINDINGS

Table 4.2.8 summarizes the HRH strengths, weaknesses, opportunities, and threats, as presented in this section.

TABLE 4.2.8. SUMMARY OF HRH SWOT ANALYSIS

Strengths • Key strategies for addressing production, hiring, retention, capacity building, and continuing education of health workers have been developed. • Available cadre of CHWs and HTC counselors • Basic training infrastructure for some cadres (except doctors) in place.	Opportunities • Pending autonomy of national training institutions will avail more funding for training (preservice and in-service). • Strong donor commitment exists to address HRH challenges. • Innovative incentive mechanisms are being deployed (mountain allowance, etc.). • Establishment of a health service commission to address HRH specifically should be considered. • Optimization of efficiency of HRH through task shifting/multitasking/training should be considered. • Retired active HRH available in country should be engaged on short-term contracts.
Weaknesses • Insufficient numbers of health professionals in selected cadres (pharmacists, medical doctors, dentists). • Poor understanding of factors causing poor absorption of health workers. • Poor track record of strategy implementation. • Poor monitoring of strategy implementation. • Weak coordination between MOHSW, public service, and training institutions. • Low budget utilization rates. • Poor working conditions (lack of/insufficient equipment, lack of security in rural areas). • Lack of a clear career track for some cadres (nurses, nursing assistants, CHW's). • Inability to produce selected cadres of staff (radiographers, physiotherapists, dental therapists) in country.	Threats • Regional and international demand for HRH is causing scarce resources to migrate. • There is an unclear level of political commitment to addressing HRH. • Cost (resource and time) required for training HRH may be unsustainable over the long term. • Very high HIV prevalence rate will increase HRH needs (structural gap).

4.3 PHARMACEUTICAL MANAGEMENT

Pharmaceutical management is among the key areas of health system performance. The functionality of a pharmaceutical management system can be examined within the following components: budget; pharmaceutical policies, laws, and regulations; procurement; storage and distribution; appropriate use; access to quality products and services; and financing.

Assessment findings revealed that the strongest performance area in the pharmaceutical management system is proper storage and distribution of medicines and medical products followed by appropriate use of medicines and procurement. Financing is the weakest performance area, followed by pharmaceutical policies, laws, and regulations. The different components are discussed in detail in the subsequent sections.

Assessment data collected from the district level examined procurement, storage and distribution, appropriate use, and access to quality products and services. The budget and policy components were not applicable at the district level, as they are central-level performance areas, and financing data were not available at this level. Assessment results across the 10 districts indicated that at the district level, access to quality products and services is the weakest area of the pharmaceutical system. The southern region districts of Mafeteng, Mphahle's Hoek, and Quthing, as well as the northern region district of Butha-Butha, were the lowest-ranking districts in terms of access to quality products and services.

The key challenges facing the pharmaceutical sector are to attract and maintain the right caliber of personnel to regulate the drug sector in the country and to change from inefficient prescription practices to those defined under the standard treatment guidelines. Moreover, the sector is also challenged with creating appropriate incentive systems for the retention of trained staff, especially in areas outside the capital.

4.3.1 BUDGET

Data were not available for the average pharmaceutical expenditure, from either government or the private sector for the period in question. However, Table 4.3.1 shows data from WHO's World Medicines Situation, 2004, which reports that total expenditure on pharmaceuticals in Lesotho, is significantly lower than in its regional counterparts.

TABLES 4.3.1. TOTAL EXPENDITURE ON PHARMACEUTICALS IN LESOTHO COMPARED TO SUB-SAHARAN AFRICA REGIONAL AVERAGE

	Source of Data	Lesotho	Year of Data	Average value in Sub-Saharan Africa	Year of Data
Pharmaceutical Module					
Total expenditure on pharmaceuticals (% total expenditure on health)	WHO-The World Medicines Situation -2004	12.1	2000	27.52	2000
Total expenditure on pharmaceuticals (per capita at average exchange rate in US\$)	WHO-The World Medicines Situation-2004	4	2000	9.87	2000

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>)

4.3.2 PHARMACEUTICAL POLICIES, LAWS, AND REGULATIONS

The GOL, through the MOHSW, undertook a far-reaching process of health sector reform in 2000. Pharmaceutical management was among the areas slated for reform. Reforms needed in the pharmaceutical sector involved responding to the absence of clear drug regulation policies, irrational prescription practices, and inefficiencies in drug procurement, management, and distribution. The objectives of the reform process in this area were to improve efficiency in the procurement, distribution, quality control, and use of drugs, as well as to strengthen the capacity of pharmaceutical sector personnel to carry out this mandate more efficiently.

To date, pharmaceutical reform has involved (1) a baseline study that informed the policy and legislation regulating this sector; (2) the approval of the National Medicines Policy (NMP) by the Lesotho Cabinet in 2005 (see box 4.3.1.1); (3) the development of a strategic action plan for the NMP; and (4) the implementation of capacity building for, and further definition of, the status of the NDSO.

Key priority challenges identified through the situational analysis during the policy development process included the following:

- Obsolete legislation that does not effectively regulate the pharmaceutical sector.
- Absence of a QA system that ensures quality of medicines within the country.
- Inadequate management system in the medicines supply chain.
- Absence of national policy guidelines regarding donations.
- Absence of National Standard Treatment Guidelines (NSTGs) and a National Essential Medicines List (NEML).
- Inadequate management and inequitable distribution of available financial resources.
- Inadequate numbers and inequitable distribution of pharmaceutical human resources.

Legislative reform in the health sector has gained momentum as a result of the reform process. According to the director of pharmaceuticals, the NMP is being implemented through a strategic action plan by the pharmaceuticals directorate within the MOHSW. (Box 4.3.1 provides a summary of the Lesotho NMP.) This process has resulted in the achievement of a number of milestones. Development of appropriate legislation is underway and Parliament passed the Drugs of Abuse Act in 2008. This act provides the framework, which previously had been severely weak, for the control of illicit drugs in the country. The Medicines Bill, which is in the advanced stages of development, will provide the framework for control of pharmaceuticals and seek to provide price control mechanisms for pharmaceuticals. Once the bill is enacted, the Medicines Control Act will establish the Medicines Control Council of Lesotho, and the council's mandate will be to implement the framework provided for by the Medicines Control Act. The framework will address registration of pharmaceuticals in the country and will provide a basis for the regulation of the quality and use of pharmaceuticals, as well as for the licensing, inspection, and control of pharmaceutical personnel, manufacturers, distributors, importers, pharmacies, and any other institution that handles medicines.

BOX 4.3.1. SUMMARY OF THE LESOTHO NATIONAL MEDICINES POLICY

AIM AND OBJECTIVES OF THE LESOTHO NATIONAL MEDICINES POLICY

AIM

The overall aim of the Lesotho NMP is to improve and sustain, within available resources, the health of the population of Lesotho by treating, curing, reducing or preventing diseases and conditions through the use of safe, effective, quality, affordable medicines, in both public and private sectors

OBJECTIVES

The objectives of the Lesotho NMP are to achieve the following:

- 1) Ensure that medicines of good quality, safety, and efficacy are available, at affordable cost, to all Basotho people in public and private sectors.*
- 2) Control, supervise, and evaluate the quality of pharmaceuticals.*
- 3) Promote the rational use of medicines in the public and private sectors through the provision of objective drug information, training, and continuous education with emphasis on better diagnosing, prescription writing, dispensing, and counseling.*
- 4) Promote the local production of good quality essential medicines at affordable cost.*
- 5) Be a basis for developing appropriate medicine legislation and its enforcement.*
- 6) Guide the development of appropriate pharmaceutical human resources and ensure their retention and proper deployment in the country.*

ACTION

The strategic plan to implement the NMP includes training personnel in the pharmaceutical sector, establishing a drug regulatory body, developing and implementing a drug supply management system and the Lesotho Standard Operating Procedures.

Post-marketing surveillance is currently not systemized in the country³³. Some private institutions, such as Tripharm Manufacturing, have developed their own post-marketing surveillance systems in order to track their products in the market and enable efficient product recall should the need arise. One of the core activities of the NMP is to strengthen medicines information and pharmacovigilance in Lesotho. To do this, the GOL, through the MOHSW, is in the process of establishing a medicines information center and an adverse medicines event monitoring system. All hospitals have established Hospital Pharmaco-Therapeutic Committees (HPTCs) with technical assistance from Management Sciences for Health (MSH). These committees will serve to facilitate improvement of provision of objective and evidence-based information to prescribers within the hospitals and health centers.

The MOHSW's Pharmaceuticals Directorate engaged a consultant in 2005 for the development of NSTGs and an NEML. Subsequently, the MOHSW widely distributed these documents throughout the country at both the hospital and health center levels. In November 2009, the MOHSW conducted, in collaboration with the Global Fund and MSH, a Medicines Access Survey (MAS). Provisional results of the MAS indicate that the rate of availability of the NSTGs and NEML at hospitals is 89.5 percent and 78.9 percent, respectively, while at health centers, the availability is slightly lower at 80.4 percent for NSTGs and 70.1 percent for the NEML. The National Pharmaco-Therapeutic Committee is currently in the process of reviewing the NSTGs and NEML.

³³ Per discussions with the pharmacist in charge of the Drug Regulatory Unit within the Pharmaceuticals Directorate, January 2010.

4.3.3 PROCUREMENT

All public (GOL) and private not-for profit (CHAL and Red Cross) facilities procure their pharmaceuticals from NDSO; however, CHAL facilities also regularly procure their pharmaceuticals from Tripharm, a private wholesaler. The facilities use the NDSO product catalogue for placement of orders, and, hence, international nonproprietary names are used during procurement. As per the requirements of the drug supply management system and the Lesotho Standard Operating Procedures, facilities have developed order preparation schedules and submit their orders to NDSO according to these schedules. NDSO also has an order delivery schedule and delivers orders to the facilities according to this schedule, by region. All facilities have a copy of NDSO's delivery schedule. This system was developed with the view toward rationalizing operations throughout the entire pharmaceutical sector and promoting efficiency within the sector.

This HSA and the MAS that was conducted in November 2009 have indicated that gaps exist within the system in terms of procurement operations. Provisional results of the MAS indicate that the rate of availability of Lesotho Standard Operating Procedures at the facilities is low. This will impact procurement operations at the facility level, spilling over to NDSO. A key informant interview at NDSO revealed gaps within the procurement system at the national level. This interview also revealed that the number of procurement operations per year is officially five, with tenders being floated once a year for each of the major commodity classes held by NDSO. The central medical stores should be conducting international competitive bidding to procure all the products it stores. However, in reality, NDSO runs well over 50 procurements a year, with emergency orders constituting more than 40 percent of all procurements annually. It was clear, however, that generic or international nonproprietary names are used in procurement within the public sector and at the central level (NDSO).

According to the QA manager, NDSO uses the WHO prequalification scheme and the Pharmaceutical Inspection Cooperation Scheme or International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use standards for its prequalification process. Samples are requested from all new suppliers, and these are taken to the South African Bureau of Standards laboratory and/or Potchefstroom University's Center for Quality Assurance Management for testing. Other laboratories are also used for sample testing on an ad hoc basis, as identified by NDSO.

Quantification of needs is done nationally using the consumption-based methodology at NDSO; facilities do not quantify their needs; neither do they provide NDSO with quantities.

4.3.4 STORAGE AND DISTRIBUTION

Nationally, the average performance of the system in terms of storage and distribution of pharmaceutical commodities was considered to be adequate. However, Quthing, Mophale's Hoek, and Mafeteng performed at less than adequate rates.

Lesotho Standard Operating Procedures define and provide a framework for managing the storage and distribution of pharmaceuticals within the public health sector. However, as indicated in the previous sections, the rate of availability of this document at health facilities is low, and this may have an impact on the distribution system nationwide.

NDSO manages the distribution of pharmaceuticals countrywide through an NDSO delivery system covering all GOL and CHAL health facilities. The value of inventory loss was below 5 percent, which was acceptable for most districts and the national level (NDSO). Lesotho Correctional Services Health Center was the exception, with a value of inventory loss of 10 percent. Most of the inventory loss was attributed to expiry of slow-moving items and damage. Theft was not listed among the most common

causes of inventory loss at most facilities; however, it was the main reason for inventory loss at Lesotho Correctional Services Health Center due to weak inventory control systems.

Although the performance of the sector under storage and distribution was deemed to be adequate, the assessment did identify gaps, mainly in refrigeration and cold chain systems. Furthermore, the assessment determined that refrigeration and cold chain systems exist mainly for the Expanded Program on Immunization (EPI), especially at the health center level, with essential pharmaceuticals such as insulin not having refrigeration units.

Standard operating procedures exist for all operations at NDSO, including procedures for storage and distribution of medicines for vertical programs. ARVs are procured from the AIDS Directorate's funds, but storage and distribution of these commodities is integrated into the central (NDSO) system. This is also true of TB products, which are procured with both government and Global Fund funds. Anti-TB drugs are distributed as individual patient kits under treatment categories I, I&III and III. These are then delivered to the district hospitals and DHMTs. Statistics for ARVs and anti-TB drugs are managed by the respective vertical programs, though the Global Fund Coordinating Unit has employed personnel based at NDSO to offer technical assistance in the management of ARV procurement, distribution, and information management.

4.3.5 APPROPRIATE USE OF DRUGS

Mechanisms to promote rational use of medicines have been established, including the NSTGs, the NEML, the HPTCs, and a National Pharmaco-Therapeutic Committee (NPTC).

Standard treatment guidelines and an essential medicines list have been developed with the expectation that implementation of these guidelines will address problems such as drug pilferage and inefficient supply chain systems in general. Provisional results from the MAS show that the rate of availability of standard treatment guidelines, including NSTGs, and ART and TB guidelines was shown to be 53 percent at hospital level and 64.5 percent at health center level. A gap clearly exists in the availability of critical standardized treatment guidelines across all clinical levels of health care.

At the facility level, structures for oversight of prescription practices have been set up, and HPTCs have been established at the hospital level. HPTCs are tasked with monitoring the use of drugs at hospitals and health centers and with ensuring rational drug use. However, most of these HPTCs are not yet fully functional, and more mentoring and technical assistance is still needed to ensure improved use of medicines at health facilities.

Mechanisms to improve use of medicines at health facilities exist at the national level, with the presence of NSTGs and NEML. A body that provides overall oversight for rational use, the NPTC, has also been established, with the current committee formerly appointed in 2008. The NPTC, which meets quarterly, is in the process of facilitating a review of current NSTGs and NEML.

In an interview with the director of pharmaceutical services, it was discovered that initiatives are also underway to revise the organogram of the Pharmacy Department and improve the numbers and quality of pharmacy personnel, with the view towards strengthening the central pharmaceutical administrative functions. All these initiatives are geared towards facilitating efficient management and rational use of drugs.

The gaps identified in the appropriate use of drugs in Lesotho are that the NSTGs are not widely and consistently used for training and supervision of health personnel, with training and supervision being largely dependent on subjective preferences of the supervisors at the different facilities. During 2008/09,

health personnel were sensitized on the use of these documents at most hospitals. However, this sensitization program has not been consistent or sustained.

4.3.6 ACCESS TO QUALITY PRODUCTS AND SERVICES

Access to quality products and services as a component of the pharmaceuticals management system examines whether the population has access to pharmaceuticals and whether mechanisms are in place to ensure that the quantity and quality of prescription drugs issued are acceptable. Provisional results from the MAS have indicated that, at health centers, key tracer items for obstetric care (ergometrine and oxytocin) were out of stock for more than six months on average, and ARVs for more than three months. In general, CHAL facilities experienced stock-outs for longer periods than GOL facilities, at more than five months and more than four months for these supplies, respectively.

The situation at hospitals is significantly better, with the average out-of-stock period being 17 days nationally. CHAL facilities still fare worse than GOL facilities, with the average out-of-stock period at CHAL facilities being about three weeks, as opposed to slightly less than two weeks at GOL facilities. Nationally, on average, key tracer items for TB were found to be out of stock for about two months, and ARVs were found to be out of stock for seven days.

In 2007, seven pharmacists were located at the national referral hospital, Queen Elizabeth II. There were 23 pharmacy technicians in GOL hospitals nationally and 21 in CHAL facilities. Data for the private sector were not available. WHO's 2003 statistics indicate a pharmacy personnel density of 0.3 per 10,000 and a prescriber density of 5.86 per prescriber³⁴ (WHO 2004).

According to the pharmacist in charge of the Drug Regulatory Unit within the Pharmaceuticals Directorate, no specific policy exists to increase geographic access by consumers or patients to quality products and services in remote areas. Considering the acute shortages of suitably qualified pharmacy personnel, applying special licensing provisions or incentives to increase the availability of private pharmacies in remote areas raises issues of QA of drug supply and use in remote areas.

4.3.7 FINANCING

Private pharmacies or drug outlets, which include clinics run by nurses and private surgeries run by doctors, are more concentrated in the lowlands and in the capital city of Maseru. Their distribution in the foothills, and especially the highlands, is sparse (Oxford Policy Management 2008).

In 2008, GOL spent M65,838,330.00 on pharmaceuticals. Of this amount, M33,020,972.05 was committed toward procurement of ARVs. An additional M60,770,806.40 came from Global Fund, of which 85 percent was spent on ARVs (MOHSW 2009).

The NMP articulates a need for ensuring more affordable pharmaceutical care through price control mechanisms. Although no legislation currently exists that regulates prices for pharmaceutical services in the private sector, price control mechanisms would be introduced with enactment of the Medicines Bill. This bill would serve to increase accessibility of essential medicines countrywide, across the population's economic spectrum.

³⁴ Prescriber is defined as either a double-qualified nurse or a doctor.

4.3.8 SUMMARY OF FINDINGS

Table 4.3.2 presents a SWOT analysis of pharmaceutical management in Lesotho.

TABLE 4.3.2. PHARMACEUTICAL SWOT ANALYSIS

Strengths • Presence of prescribing guidelines and essential medicines list • Presence of a NMP and its strategic action plan • Presence of a medicines supply management system, with a Pharmaceutical Management Information System • HPTC exist in all hospitals and individual hospital catalogues have been developed	Opportunities • Transport available for pharmaceutical commodities • Commitment of training institutions toward production of good quality pharmacy professionals • Commitment of MOHSW toward instituting pharmaceutical regulatory frameworks • Donor and development partners' support • Vertical program supply chains are performing well and can be used to improve logistics chain for general medicines
Weaknesses • Lack of national quantification data for pharmaceutical commodities • Weak procurement systems for general medicines • Weak regulatory frameworks for pharmaceutical commodities • Weak regulatory frameworks for pharmaceutical professionals • Inadequate supportive supervision for facilities • Lack of pharmaceuticals directorate and DRU positions in the establishment list • No pharmaceutical staff at the PHC level • Irregular updating of guiding documents such as the NSTGs and NEML • Poor adherence standard treatment guidelines	Threats • Delayed payment of NDSO by health facilities • Inefficient absorption of pharmacy graduates into the health system

4.4 HEALTH GOVERNANCE

The quality of overall governance in a country directly affects the environment in which health systems operate and the ability of government health officials to exercise their responsibilities. The Health Governance module presents an assessment of health governance functions. It focuses on three main sets of actors (the state, providers, and clients/citizens) and the linkages between these actors. The module is divided between six key indicators, summarizing these linkages. The following indicators are used:

- *Responsiveness and voice preference* examine the links between the state and client actors.
- *Client power and service delivery* examine the links between client and provider actors.
- *Information, reporting and lobbying*, and *compact* examine the links between actors in the state and provider categories.

4.4.1 BACKGROUND

Evidence presented in a study by Maureen Lewis shows a positive relationship between governance indices and measures of health performance and outcomes (Lewis 2006). International governance reviews from the World Bank Institute, the Mo Ibrahim Foundation, and Freedom House have given Lesotho high ratings on governance indicators. The MCC policy indicators, which are compiled from a range of sources, score Lesotho above average compared to its peer group on 14 out of 17 indicators. In addition, Lesotho performs well on indicators that impact health, such as government effectiveness, voice and accountability, and control of corruption, placing in the top 20 percent of low-income countries.³⁵ Lesotho also ranks ninth among 53 African countries on the Ibrahim Index of African Governance, a comprehensive ranking of African countries according to governance quality.³⁶ Governance challenges in Lesotho include highly centralized decision making, weak monitoring systems, political fragmentation, and the attrition of qualified staff. Table 4.4.1 summarizes some of the key World Bank governance indicators for Lesotho and compares these indicators to values for sub-Saharan Africa.

³⁵ <http://www.mcc.gov/mcc/bm.doc/score-fy10-lesotho.pdf>.

³⁶ <http://www.moibrahimfoundation.org/en/section/the-ibrahim-index>.

TABLE 4.4.I. COMPARISON OF GOVERNANCE INDICATORS, LESOTHO AND SUB-SAHARAN AFRICA

	Source of Data	Lesotho	Year of Data	Sub-Saharan Africa (average value)	Year of Data
Governance Module*					
Voice Accountability - Point Estimate	WB-Gov Indicators	0.04	2008	-0.54	2008
Voice and Accountability - Percentile Rank	WB-Gov Indicators	49.5	2008	33.17	2008
Political Stability - Point Estimate	WB-Gov Indicators	-0.03	2008	-0.56	2008
Political Stability - Percentile Rank	WB-Gov Indicators	43	2008	33.33	2008
Government Effectiveness - Point Estimate	WB-Gov Indicators	-0.31	2008	-0.78	2008
Government Effectiveness - Percentile Rank	WB-Gov Indicators	45.9	2008	26.77	2008
Rule of Law - Point Estimate	WB-Gov Indicators	-0.3	2008	-0.74	2008
Rule of Law - Percentile Rank	WB-Gov Indicators	46.8	2008	28.99	2008
Regulatory Quality - Point Estimate	WB-Gov Indicators	-0.63	2008	-0.7	2008
Regulatory Quality - Percentile Rank	WB-Gov Indicators	28.5	2008	29.29	2008
Control of Corruption - Point Estimate	WB-Gov Indicators	0.04	2008	-0.62	2008
Control of Corruption - Percentile Rank	WB-Gov Indicators	59.9	2008	31.35	2008

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>)

*For data notes, please see annex E.

4.4.2 RESPONSIVENESS OF GOVERNMENT TO THE PUBLIC'S NEEDS

In preparing the Poverty Reduction Strategy Paper (PRSP), the MOFDP engaged in a large-scale consultative exercise. During this process, more than 20,000 people participated in 200 community consultations. Technical working groups composed of senior government officials, key policymakers and representatives of academia, NGOs, and the private sector collated and analyzed the inputs received and subsequently costed and presented the recommendations to Parliament (GOL 2004). These inputs substantially informed the PRSP; however, for health sector-specific strategy documents, far less input is sought and very little information is available on the processes used in strategy formulation (MOHSW 2009)³⁷.

Technical directorates within the MOHSW are generally responsible for formulating policy while the Department of Planning is responsible for overall sectoral planning. Legislation is developed at the top management levels by technical directors, with assistance from a legal affairs officer or the Ministry of Justice. Neither the Health Sector Policy, the Health Sector Strategic Plan, nor the MTEF appear to have involved stakeholders outside of government and the donor community. The AJR process for the MTEF involves the MOHSW and development partners, but fails to include CSOs or communities (MOHSW

³⁷ Key Informant interviews (Irish Aid, Lesotho Council of NGOs, MOHSW).

2009). It is reported that the current operational planning process for the health sector will involve development partners for the first time³⁸; however, programs and priorities are reported to be decided by the senior management of the MOHSW, without external input. The ministry has also noted that for the upcoming review of the 2004 Health Sector Policy, community councils were visited for input³⁹. Overall, community and CSO contributions are not regarded as necessary for these processes.

Although useful feedback has been provided for policy development and planning, stakeholders do not provide input for the budget development process. In Lesotho, health budgeting starts with the MOHSW, which uses guidelines from the MOFDP to develop budget estimates for the upcoming year. The MOFDP then compiles and analyzes budgets from all ministries and submits these budgets to the Cabinet and Parliament. In Parliament, the estimates are consolidated into an appropriations bill that grants the government the authority to spend money and raise revenue for the upcoming financial year. The budgeting process does not involve consultations with the public or civil society (AfDB 2006).

Key informants outside the ministry report very limited interaction with the MOHSW on planning and policy processes. However, as discussed in the following sections, few NGOs in Lesotho have the capacity to advocate and provide the technical input into the health sector.

In this sense, government is seeking meaningful input for selected processes, such as the PRSP, but not for others, such as routine budgeting and planning in the health sector. Improving the involvement of community leaders, NGOs, and CSOs in planning and budgetary processes can help to make budgets and plans more responsive to community needs going forward.

Health sector strategies, plans, policies, and budgets are not readily available to external audiences in Lesotho. They are not posted on the ministry's website and are difficult to obtain. This demonstrates a weakness in the ministry's planning culture, which will be discussed further in the section on policy planning and implementation.

Lesotho's population distribution pattern impedes the dissemination of information. The country has an Internet penetration rate of only 2 percent, rendering public dissemination through this medium difficult. Radio penetration, however, is high, with 54 percent of households owning a radio in 2004 (MOHSW 2005). As a result, one of the main sources of information for citizens is the state-run Lesotho Radio (UNDP 2008). A summary of parliamentary proceedings (including health legislation) is broadcast daily on the radio, and newspapers cover key health debates⁴⁰. In addition, the Lesotho Nursing Council has reported using the radio as a means of disseminating health information to the public⁴¹.

Data collected revealed that six of 10 districts reported the government had used media (radio and/or television) to communicate health system information, goals, objectives, and targets to the public. Three of the remaining districts, however, as well as three of the districts that reported the government had used media, indicated that the government used pitsos and public gatherings to communicate these same messages from the national level. At the facility level, data suggest that citizens receive information through health talks, chiefs, pitsos, and CHWs (who receive information through the hospitals and health centers). Only seven of the 55 health centers and 10 of the 21 hospitals surveyed responded that the public received information via media, indicating that the lower levels of service are relying more heavily on traditional information channels, CHWs, and community councils. This reliance on traditional

³⁸ Key informant interview with the MOHSW Department of Statistics and Planning.

³⁹ MOHSW Planning and Statistic Department interviews.

⁴⁰ Key Informant interview with Lesotho Council of NGOs.

⁴¹ Key Informant interview with Lesotho Nursing Council.

channels could be a valuable asset to the MOHSW. It is unclear how much information is being gathered and fed back to the national level, and these reasons are explained further under decentralization.

4.4.3 VOICE: PREFERENCE AGGREGATION

Studies from UNDP (2008) at the national level have suggested that civil society in Lesotho is weak and fragmented. CSOs are generally unable to provide meaningful input to government on issues that affect their stakeholders due to their lack of cohesive organization, an uncertain mandate to provide input, and inadequate advocacy capacity. In light of these weaknesses, UNDP and others have been working with civil society by establishing a civil society consultative forum at the national level and building the capacity of advocates and journalists to engage with government officials (UNDP 2008). The capacity of advocacy organizations working in the health sector is similarly weak, and these organizations are mainly focused on vertical programs. The Global Fund grants through rounds 6, 7, and 8 supported civil society strengthening for TB and HIV by funding community-level engagement in HIV and TB activities through civil society and other partners. These rounds also included funds for journalist trainings, advocacy activities, and sensitization of political leaders on HIV and TB issues. It should be noted, however, that Lesotho does have an active system of traditional and more formalized councils and community groups. Although these groups may not have the capacity to advocate on their own behalf, the potential for communicating with these groups through these structures does exist. Additional information on the community and district councils will be provided in the section on service delivery and decentralization.

Councils and community groups have very limited capacity to participate in national-level health planning. One of the major reasons for strengthening the decentralized structures is to better enable community and district-level groups to participate in planning processes through the DHMTs. Currently, the formal structures the MOHSW set up to gather community input, through DHMTs, are not functioning properly in most districts due to the transitional state of the health sector decentralization process. In 2009/10, the MOHSW began switching to a system of gathering information from the DHMTs for the quarterly and annual reviews, in line with the health sector decentralization. It is unclear how much information is actually reaching the national level, as some DHMTs are participating in the MOHSW quarterly reviews and others do not have the administrative structures in place to gather information or participate in the review. For the October 2009 quarterly review, only two of the 10 districts participated (with no data collected from the other districts), and for the March 2010 review, it was anticipated that six districts would be participating.

In terms of the few national-level advocacy organizations that exist in the country, the Lesotho Council of NGOs (LCN), a potential Global Fund round 10 recipient, successfully engaged the government when its interests were threatened and noted its success in advocating for the rights of individuals living with HIV/AIDS⁴². These successes in the political sphere have not been transferrable to advocating for better health outcomes. Although the mandate of LCN does include the coordination of NGOs working on health and social development, few health-related NGOs exist in Lesotho, and those that do exist are not primarily focused on health. A selected few include the Federation of Women Lawyers, which works on cases addressing victimization and commercial sex workers; the Transformation Resource Center, which conducts some health advocacy; and Development for Peace Education, which looks at human rights for minority groups at the community level and helps these groups to participate in national policymaking. LCN attributed this limited NGO presence to the fact that only political rights, and not socioeconomic rights, are addressed in the Constitution, thereby limiting the extent to which these organizations can advocate on behalf of the public. In addition, the majority of donor funds

⁴² Lesotho Council of NGOs advocacy efforts around the HIV/AIDS bill as well as the recruitment of armed forces with regard to HIV-positive individuals.

available for strengthening advocacy efforts are directed specifically at efforts pertaining to HIV/AIDS activities, such as assisting orphans and vulnerable children (OVC) and ensuring the rights of persons living with HIV/AIDS (PLWHA). Evidence also suggests that NGOs and CSOs are not involved in the health planning and policy processes at the MOHSW. There is no documented participation of an NGO in the AJR of the MOHSW and no CSO is listed as a key stakeholder in the MCC health sector project documentation (MOHSW 2009, MCC 2007).

As mentioned earlier, health planning tends to be mostly an internal process and functions with limited input from external stakeholders. NGOs and stakeholders have also reported that they do not have the opportunity to provide input into health legislation until the bill reaches Parliament. Stakeholders such as the LCN have been invited to participate in the parliamentary health committee⁴³.

The lack of engagement between CSOs and government may mean that important ideas from the constituents that civil society represents go unheard due to (1) the CSOs' inability to raise the issues in a productive, engaging manner and (2) public officials' inability to provide the opportunities for civil society to engage, based on past experiences.

4.4.4 CLIENT POWER: TECHNICAL INPUT AND OVERSIGHT

Facility-level data show limited interactions between stakeholders and service providers outside of visits to the hospital and/or health center. The majority of client input comes from interactions with CHWs and the community councils. The formal systems currently set up under the decentralization plan to solicit this information from CHWs and feed it to higher levels of government are not fully functioning, leading to a situation in which systems once championed for community outreach are now faltering due to their being partially implemented. In addition, the Basotho do not have a culture of holding the public sector accountable for services, leading to a situation in which service providers are not being held accountable for quality service provision by the citizens they are serving.

Lesotho has an Office of the Ombudsman that is able to address citizens' complaints against public sector agencies and parastatals. Also, the Lesotho councils for nurses and medical professionals both have mandates to investigate grievances against specific medical professionals.

The goal of the Office of the Ombudsman is to handle complaints regarding any type of grievance that citizens have with public sector agencies or parastatals. Although the office is not health specific, in 2004 and 2007, the Office of the Ombudsman issued reports on the state of selected hospitals in which it had contacted health services providers during its inquiries (GOL 2004, 2007). The 2004 report clearly details discussions with health providers, but not discussions with patients, and provides recommendations for action. The health providers' complaints address issues of staffing, building maintenance, and supply shortages, among others. The second report, issued in 2007, is not available online, but was supplied by the Office of the Ombudsman upon request. The 2007 report was a follow-up to the 2004 report to see if any progress had been made on the recommendations; aside from the purchase of two pieces of equipment, none of the recommendations had been implemented.

The Lesotho Nursing Council and the Lesotho Medical, Dental, and Pharmacy Council participate in investigating claims against medical professionals. However, both councils report that investigations are conducted infrequently because of a low capacity to initiate them. Although the Lesotho Nursing Council is stronger than the Lesotho Medical, Dental, and Pharmacy Council, in both cases, patient knowledge of the councils' functions are minimal; therefore, patients do not seek the councils' services.

⁴³ Key Informant interview with Lesotho Council of NGOs.

In addition, the investigative measures employed by the councils are not strong. The Nursing Council does not have any legal staff, nor does the organization use radio to broadcast patients' rights. Although it has a better developed communication network than the Lesotho Medical, Dental, and Pharmacy Council, the Lesotho Nursing Council's communication simply flows through matrons at district hospitals to nurses at health centers⁴⁴.

4.4.5 SERVICE DELIVERY

Currently, decentralization is occurring unevenly in the health sector in Lesotho. DHMTs are not able to adequately plan, budget, and manage health services because the decentralization process, which started in 2005⁴⁵, was uneven and stalled out⁴⁶, leaving the decentralized structures only partially developed⁴⁷. Although information on the degree of decentralization is limited, MOHSW reports that all DHMTs have accounting staff and are authorized to disburse money, but inputs such as manpower, financial systems, and information management systems are lacking (MOHSW 2009). Linkages to local (village) authorities have been slow in developing, leaving gaps in the flow of information to and from the government and clients. As a result of this partially implemented system, DHMTs have had challenges distinguishing their role from that of the hospital management teams while the responsibilities of MOHSW and the Ministry of Local Government in supervising the work of the DHMT is also a cause of confusion.

In late 2009, the MOHSW relaunched the decentralization process and hiring a health decentralization coordinator. The ministry is currently developing an operational plan to move the decentralization agenda forward. This plan will help to clarify the relative roles of the Ministry of Local Government and MOHSW in supporting the DHMTs, including clarifying which staff will be moved to the Ministry of Local Government and which will remain under the control of the MOHSW. It will also accommodate some of the political and technical obstacles that have arisen since 2005. This new plan is intended to enable districts to take on the responsibility for budgeting, planning, project implementation, health center management, and resource tracking within their districts, while allowing the MOHSW to retain control of the referral hospitals. The MOHSW will also continue to be responsible for overall policy formulation, resource mobilization, advocacy and partner coordination, provision of a regulatory framework for all providers, and M&E. The proposed mechanisms for decentralization would also strengthen links and partnerships with other line ministries, development partners, NGOs, civil society, and traditional healers⁴⁸.

Since CHAL owns roughly one-third of all health services in Lesotho, this assessment must include a discussion of the association. CHAL is governed by an executive board that oversees the policies and overall management of the association. It is composed of representatives from each member denomination, and the number of seats allocated to each organization is based on the number of facilities they operate. Three nonvoting members of this board are appointed by the GOL. Boards of hospitals administered by CHAL must include one nonvoting representative from GOL. These boards oversee the direction of the hospital, while hospital management committees oversee the day-to day

⁴⁴ Key Informant interviews with the Lesotho Nursing Council and the Lesotho Medical, Dental, and Pharmacy Council.

⁴⁵ Decentralization started in 2005 with three pilot districts. This quickly turned into a countrywide decentralization.

⁴⁶ As reported in Annual Joint Review Reports from both 2007/08 and 2008/09.

⁴⁷ As of 2008, most DHMTs had only filled 60 percent of core staff positions, and only 30 percent of DHMTs had dedicated space at district offices (MOHSW 2009).

⁴⁸ Information is provided based on the MOHSW 2010 draft paper on decentralization.

operations of CHAL hospitals⁴⁹. These bodies are analogous to the health management teams at government hospitals.

As discussed in the finance section, CHAL facilities are financed through a combination of external grants, user fees, and government funding. As of February 2007, the GOL and CHAL are governed by an MOU, which aims to harmonize service provision, provider salaries, and user fees between CHAL and GOL facilities and register and certify CHAL facilities with the government. Prior to signing the MOU, CHAL facilities charged significantly higher user fees and paid lower salaries than government health facilities. Under the new MOU, CHAL facilities are expected to generate about 8 percent of their operating expenses from user fees (Mathauer 2007).

As indicated in the finance, HIS, and human resource sections, Lesotho is not currently providing performance-based incentives to providers mainly because it does not have the capacity to do so. Currently, the health system does not have a functioning health information management system, which prevents policymakers from generating and collecting necessary benchmarks for facility or provider performance. This lack of data also hampers efforts to rationally budget resources or reasonably respond to health system issues. Funds are inequitably distributed across the country and between levels of care, leaving health centers severely underfinanced, critically low on human resources, and without incentives for the facilities or providers to improve performance.

Aside from hospitals and a few CHAL health centers, health facilities are not charging user fees in Lesotho. Therefore, transparency in the pricing of services was not noted as an issue at the health centers. Information on the allocation and utilization of resources at health centers is not available to the public.

4.4.6 INFORMATION, REPORTING, AND LOBBYING

With the expansion of decentralization in Lesotho, DHMTs are now responsible for generating and using their own health statistics. Database management for these statistics exists at three levels. First, each health center daily records all routine health activity, such as births, morbidity, and mortality, on paper forms, which are then transcribed into monthly reports to DHMTs. Second, the DHMTs compile summary reports for the national level. Finally, the Health Planning and Statistics Unit enters the reports sent from the districts into an MS Access database and analyzes the data (MOHSW 2003).

As of 2003, no data processing occurred at the district or facility level, though the HMIS decentralization plan calls for this to be implemented (MOHSW 2006). Although morbidity and mortality data are recorded in all hospitals, supervision is currently weak and guidelines do not govern the recording and reporting of data. Data filing and management also need improvement (MOHSW 2003). The MOHSW believes that decentralizing responsibility to the districts by having data management personnel at each district will improve data ownership, use, and supervision.

Currently, use of data is limited at the service provider level, as data are analyzed at the district level and health centers provide limited feedback on reports. Health centers use a manual data collection system, which is submitted to the district level without being tabulated and documented, indicating that health centers are not tracking and using their statistics. Furthermore, only 28 of the 73 health centers surveyed reported receiving feedback from the district level on the data submitted.

⁴⁹ MOU between the GOL and CHAL, 2007.

The 2007 GOL-CHAL certification report found that more than one-half of all hospitals have qualified accounting staff and budgeting procedures in place, 62 percent and 68 percent, respectively (GOL/CHAL 2007). Budget tracking is conducted at the district level. The IFMIS and HMIS systems are discussed in detail in the finance and HIS sections of this report; however, very serious issues exist concerning the use of these two systems since the systems are not functioning as intended to provide data to the national level for policy and planning. In addition, within the district, there is little or no consultation with the lowest levels of the health system or other key stakeholders working in the district (such as NGOs and CSOs) requesting their input for the district operational plans and budgets.

4.4.7 COMPACT: DIRECTIVES, OVERSIGHT, AND RESOURCES

Service providers are not being held accountable for quality service provision by either the clients or the central level. The district-level capacity to supervise facilities is low, leading to a situation in which supervisory visits are not happening regularly in most districts. Although six out of 10 districts indicated that they had a specific schedule for supervision, these visits are not occurring regularly; only two of the 10 districts said that the supervisory visits were conducted as planned, and one district noted that no supervisory visits were happening at all. ICAP, the Global Fund, and Council for Health Service Accreditation of Southern Africa (COHSASA) were mentioned as organizations contributing to improved service delivery quality; however, although such groups seem to be filling a gap in technical oversight in service delivery, ICAP, for example, has a limited mandate to mentor facilities and a limited reach.

In 2007, Medical Care Development International conducted an Accreditation and Certification Summary Report. This report offered guidelines for certifying the quality of services provided at all GOL and CHAL facilities in Lesotho (GOL/CHAL 2007). The development of the certification procedure was a component of the partnership agreement signed between CHAL and GOL in 2000, as well as the 2007 MOU, which required that CHAL facilities undergo a certification procedure to meet minimum quality standards before receiving government funding. In 2006, GOL decided that all health facilities and hospitals, public and CHAL, with the exception of Queen Elizabeth II, would have to undergo the certification procedure.

Certification procedures include visits from specifically trained staff who look at II certification standards developed by the MOHSW QA team based on standards from the Joint Commission International Accreditation Standards for Hospitals. A health facility was deemed to be “certified” if it had attained a rating of 80 percent or better on all II standards. According to the 2007 survey, none of the health centers or hospitals in Lesotho are certified²³.

CHAL has signed an MOU that requires its health facilities to undergo a certification and recertification process every three years. The certification standards are based on achieving indications laid out within the QA program. Monitoring of the CHAL facilities is carried out by the MOHSW through reporting and performance reviews (Mohapi et al. 2004). A further discussion on the accreditation procedures for health facilities can be found in the service delivery section.

Lesotho currently has an M&E plan to monitor health system performance. This plan has five indicators: quality, equity, access, efficiency, and the impact of health sector reform. Within the plan is a framework for monitoring these core health indicators that is focused on decentralizing the data collection and analysis. For example, the DHMTs are tasked with collecting information from health facilities in their districts. Some level of analysis takes place at this stage as well. The information is then passed to the M&E unit at MOHSW (MOHSW 2005).

Knowledge of the importance of and need for strengthened oversight and leadership structures and systems is relatively high at the central level. Key informant interviews indicate that senior MOHSW personnel are aware of their responsibility as “policy and strategic planning guardians.” Furthermore, they recognize the need for operational plans and tools to guide service provision and improve quality. However, translating this into practice lags. There is no operational plan for the strengthening of leadership in MOHSW at the central level, although this has been identified as a critical need. The planning capacity and culture at the central level have been traditionally weak, and this is further exacerbated by the increasing number of partners, organizations (NGOs), and interventions that are not linked to each other or to existing MOHSW plans and strategies. Furthermore, policymakers lack timely, quality data for decision making due to the systemic HIS constraints and the poor linkages between the ministry’s M&E and the HIS data. (For more information on HIS, refer to the section on health information systems.) Moreover, review of the 2009 AJR shows that the implementation plans are not results based because there is no real link between the activities being planned or implemented and the performance bottlenecks, limiting the possibility for meaningful outcomes (i.e., performance improvement).

4.4.8 SUMMARY OF FINDINGS

Table 4.4.2 presents a SWOT analysis of governance in the Lesotho health system.

TABLE 4.4.2. GOVERNANCE SWOT ANALYSIS

Strengths • Above average country governance indicators • Network of CHWs and existence of community councils • Traditional modes of community participation through pitsos and chiefs	Opportunities • Decentralization – through strengthened DHMT district advisory boards and community councils • Lesotho Council of Nurses network
Weaknesses • Weak CSOs and NGOs for client advocacy and HSS • Low levels of civic engagement for health • Weak data collection and reporting procedures/structures • No evidence of service providers advocating for policy, program, or procedural changes • No participatory strategic planning process for the health sector • Incomplete/partial decentralization • Low capacity to advocate and participate effectively • Planning capacity at the district level • Very few health-focused CSOs at the national level • Inadequate supervision, oversight, and feedback	Threats • Impending political changes (especially as relates to implementation of the decentralization act)

4.5 SERVICE DELIVERY

WHO defines service delivery as the way inputs are combined to allow the delivery of a series of interventions or health actions (WHO 2001). This chapter presents a profile of the Lesotho health service delivery system, as well as an indicator-based assessment of the system. Table 4.5.1 provides a brief overview of some of the key service delivery indicators, compared to the average values for sub-Saharan Africa.

TABLE 4.5.1. REGIONAL COMPARISON OF LESOTHO SERVICE DELIVERY INDICATORS

	Source of Data	Lesotho	Year of Data	Average Value in Sub-Saharan Africa	Year of Data
Service Delivery Module*					
Number of hospital beds (per 10,000 population)	WHO	13.00	2006	14.81	2006
Percentage of births attended by skilled health personnel	DHS	55.40	2004	**	--
	WDI-2010	55.40	2004	51.25	2008
DTP3 immunization coverage: one-year-olds (%)	DHS	82.80	2004	**	--
	WHO	91.00	2007	85.22	2007
Contraceptive prevalence (% of women ages 15-49)	DHS	29.00	2004	**	--
	WDI-2010	37.30	2004	19.78	2008
Pregnant women who received 1+ antenatal care visits (%)	UNICEF_Chidinfo.org	90.00	2004	70.50	2004
	DHS	90.40	2004	**	--
Life expectancy at birth, total (years)	WDI-2010	44.99	2008	55.14	2008
Mortality rate, infant (per 1,000 live births)	WDI-2010	63.10	2008	75.96	2008
	DHS	91.00	2004	**	--
Maternal mortality ratio (per 100,000 births)[5]	WDI-2010	960.00	2005	832.16	2005
Prevalence of HIV, total (% of population aged 15-49)	UNAIDS 2008	23.20	2007	5.75	2007
	DHS	23.40	2004	**	--
Unmet need for family planning	DHS	31.00	2004	**	--
Children under five years sleeping under insecticide-treated bednets	WDI-2010	--	--	29.27	2008
Children under five years with diarrhea receiving oral rehydration	DHS	41.90	2004	**	--
	WDI-2010	52.90	2004	45.12	2007
Children under five years with acute respiratory infection (ARI)	DHS	58.80	2004	**	--
ART coverage among people with advanced HIV infection (%)	WHO	22.00	2006	21.88	2006

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>).

*For data notes, please see annex E.

The overall goal of the Lesotho MOHSW is to achieve a sustainable increase in access to quality preventive, curative, and rehabilitative health care services in Lesotho. The MOHSW, which is currently implementing its second three-year sector program MTEF (2008/09 to 2010/11), focused on the following key service delivery objectives for the first year (2008/09) (MOHSW 2009):

- Contribute to the reduction of morbidity and mortality and mitigate physical, mental, and social deprivation.
- Increase access to quality promotive, curative, preventive, and rehabilitative health and social welfare on the basis of equity and social justice.
- Provide and administer an effective and efficient system of disease and catastrophes surveillance for both local and global concerns.
- Coordinate partnership and regulate, monitor, and evaluate delivery of health and social welfare services in the country.
- Mobilize effectively, allocate, and efficiently manage health resources within the MOHSW.
- Coordinate, support, and conduct health systems research for policy and practice facilitation.
- Contribute to the development of human resources for health and social welfare.

4.5.1 SIZE OF THE HEALTH DELIVERY SYSTEM

Lesotho's health service delivery system consists of three major sectors: the public, not-for-profit, and private for-profit. Table 4.5.2 shows the distribution of health facilities (excluding pharmacies) by level and sector. Although CHAL remains an independent not-for-profit organization (and is included in this table as a not-for-profit organization), an MOU signed by CHAL and the GOL in 2007 effectively constituted a single service delivery system for the hospitals, filter clinics, and health centers nationwide⁵⁰. Each district has at least one hospital and all the referral and specialty hospitals are in Maseru. There is a fourth, large tertiary hospital in the process of being built, in Maseru, which will serve as the main referral hospital in Lesotho. When complete, this hospital will change substantially the provision of health services in Maseru and neighboring districts.

TABLE 4.5.2. HEALTH FACILITY DISTRIBUTION, BY LEVEL AND SECTOR

	Public		Nonprofit*		Private		Total
	No.	%	No.	%	No.	%	No.
Referral hospitals	1	100%	0		0		1
Special hospitals	2	100%	0		0		2
District hospital	9	50%	8	44%	1	6%	18
All hospitals	12	57%	8	38%	1	5%	21
Filter clinics	3	100%	0		0		3
Health centers	79	43%	80	39%	29	18%	188
Private surgery	0		0		48	100%	48
Nurse clinic	0		0		66	100%	66
All primary facilities	82	27%	80	26%	143	47%	305
Total Facilities	94	29%	88	27%	144	44%	326

Source: Oxford Policy Management (2008)

* Nonprofit includes CHAL and Red Cross facilities.

⁵⁰ The MOU unites CHAL's 81 facilities and the 82 public facilities, which constitutes 77 percent of the hospitals, health centers and filter clinics in the country.

Private surgeries and nurse clinics are all private sector facilities and they are not included in the formal system of health facilities in Lesotho. Private health facilities are geographically skewed towards Maseru with 55 percent of the private facilities based in Maseru. These numbers would be skewed even further if the 46 pharmacies, 27 of which are in Maseru, were included in the calculations. Table 4.5.3 provides a comparison of the number of public, not-for-profit, and private sector facilities by region.

TABLE 4.5.3. HEALTH FACILITY DISTRIBUTION, BY SECTOR, REGION, AND POPULATION*

	Maseru		Lowlands		Foothills		Highlands		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Public	18	13%	14	18%	39	38%	23	44%	94	25%
Nonprofit	20	14%	23	31%	27	27%	18	35%	88	24%
Private	105	73%	38	51%	36	35%	11	21%	190	51%
Total	143		75		102		52		372	
As % of all facilities	38%		20%		27%		14%		100%	
Regional population (2006)	431,998		442,627		704,665		297,343		1,876,633	
% of total population residing in region	23%		24%		38%		16%			
Size of the region	4,279 sq km		4,341 sq km		11,041 sq km		10,694 sq km		30,355 sq km	
Population density (pop. per sq km)	101		102		64		28		62	
Facilities per 100,000 population	33.1		16.9		14.5		17.5		11.5	

Source: Oxford Policy Management (2008)

* Lowland districts include Berea and Mafeteng. Foothill districts include Botha-Buthe, Leribe, Mphahle's Hoek and Quthing. Highlands districts include Mokhotlong, Qachas-Nek and Thaba Tseka. Hospitals, filter clinics, health centers, nurse clinics, private surgeries are included in these totals.

As depicted in Table 4.5.3, hospital, health center and filter clinic coverage and distribution is uneven but, this is due to the highly variable terrain and the large concentration of private facilities in Maseru. In the highland region, although it has the highest number of facilities per 100,000 population outside of Maseru, providing access to services is particularly problematic due to the rough terrain, high altitude, poor road network, and low population density. Horseback or single-engine propeller aircraft are often the only means by which to access remote communities.

CHAL, the largest nonpublic organization of facilities, plays a crucial role in providing first or frontline care to at least 30 percent of the population, most of whom live in remote areas where coverage by government-owned facilities is relatively poor⁵¹.

Other not-for-profit organizations include the Lesotho Planned Parenthood Association (LPPA), established in 1968; the Red Cross, established in 1971; and PIH, established in 2006. The LPPA operates 10 urban-based clinics in eight districts, offering family planning, VCT, STI management, and opportunistic infection management services, as well as cancer screening (VIA and Pap smear), sexual reproductive health services, training, edutainment, and information provision. LPPA also has an outreach program working through community-based distributors, which specifically targets factories, villages, and youth.

The Red Cross has four health centers, in Leribe, Maseru, Mafeteng, and Mokhotlong districts. It provides comprehensive primary preventive, curative, and rehabilitative services. The Red Cross also implements a preventive HIV initiative among the sexually active age groups, including youth, through

⁵¹ Key Informant Interviews with PIH and CHAL.

training of peer educators, production and dissemination of HIV/AIDS material, distribution of condoms, and provision of counseling and home-based care services for infected and affected persons.

PIH runs or provides support to nine MOHSW and CHAL clinics, serving rural communities in the highlands through implementation of the Rural Initiative Program. It provides HIV and TB care and treatment in rural communities in the mountains, implementing various interventions for children under 5, and provides clinical support, training (nurses and village CHWs), and home visits. PIH relies on the support of the Lesotho flying doctors, a service supported by the GOL, Irish Aid, and the Mission Aviation Fellowship, to serve remote mountainous areas. In the four years since its inception, the Rural Initiative Program has reported a marked increase in service utilization (from an average of eight to 140 patients per day). It has also trained 2,000 CHWs, of whom 1,390 are now on active duty. The initiative has also strengthened infrastructure through installation (VSAT, electricity, solar technology) and rehabilitation (e.g., upgrading of X-ray facilities). The most severe challenges threatening the program's sustainability are related to costs of services, distance, and inaccessibility.

The growing private for-profit sector, although it outnumbers the public and not-for-profit sectors in quantity of facilities, still plays a lesser role than the public and not-for-profit sectors in outpatient visits. In 2006/07, 37 percent of outpatient visits in the country and 68 percent in Maseru were to a private provider (World Bank 2009). The Omnibus Study in Health Care Financing (Oxford Policy Management 2008) identified 190 private providers (including pharmacies, nurse clinics, private surgeries, health centers and hospitals), with nearly 90 percent of these located in four districts: Maseru, Berea, Mafeteng, and Leribe. Most private practices in the country were reportedly run by one or more doctors, complemented with nursing and administrative staff.

4.5.2 STRUCTURE, COMPOSITION, AND CAPACITY OF HEALTH SERVICE DELIVERY SYSTEM

The health service delivery system in Lesotho is a four-tier structure (as detailed in Table 4.5.4) that includes referrals to neighboring South Africa through the national referral hospital. As discussed earlier in the assessment report, responsibility for delivery of health care services is decentralized to the DHMTs.

TABLE 4.5.4 STRUCTURE OF THE HEALTH SERVICE DELIVERY SYSTEM

Level	Facility Type	
Primary level	Health posts	Based at community level
		Form the basis of outreach for communities
	Health centers	186 facilities nationwide
		First contact of the formal health system
	Filter clinics	Essentially 'mini hospitals'
		Relieve the load on the district hospitals
Secondary level	District hospitals	District focal point for management and service delivery
Tertiary level	Referral hospitals	Queen Elizabeth II National Referral Hospital (absorbs the bulk of general referrals)
		Mohlomi Mental Hospital
		Bots'abelo Leprosy Hospital
		Senakatana AIDS Clinic
Quaternary level	South Africa	Referral through QE II National Referral Hospital

To address the numerous challenges the Lesotho health sector faces, which directly influence service delivery, especially at the district level, the GOL instituted a series of health sector reforms. These reforms have resulted in a number of crucial changes, including (1) the redefinition of the structure of

the MOHSW, with the establishment of a flat functional structure to streamline functions and responsibilities to the lower levels; and (2) a 'reworking' of the facility establishment list.

In developing and implementing health sector reforms, the MOHSW has given particular focus to the inadequate human resource capacity and the effects of the HIV/AIDS pandemic. The combination of these factors, exacerbated by increased pressures due to the increase in noncommunicable diseases⁵², has put the sector under tremendous strain and gravely affected the long-term sustainability of quality service delivery programs.

4.5.3 PROGRAM PLANNING AND MANAGEMENT

Implementation of plans and recommendations related to the health sector reforms, including the new (yet incomplete) MOHSW organizational structure and decentralization, have slowed. This is attributed to a number of reasons, including (1) the MOPS' pending approval of the changing roles of the MOHSW central units, (2) stalled formalization of the description/definitions of decentralized units, (3) lack of implementation of the recommended manpower needs of the MOHSW, and (4) the fact that no performance review has been carried out to determine the progress and/or assess the achievements of the reform process. Other major constraints identified are related to the inadequacy of technical and management capacity, including at the central level. Key issues related to the management capacity within the sector include (1) leadership and the decision-making process, (2) control of resources, (3) equipment and supplies, (4) use of information for planning, and (5) human resource capacity.

Leadership: Knowledge of the importance and need for strengthened structures and systems is relatively high at the central level, with senior MOHSW personnel expressing awareness of their (personal) responsibility as 'policy and strategic planning guardians' and recognizing the need for operational plans and tools to guide service provision and improve quality (MOHSW 2009). However, despite being identified as a critical need, no operational plan is in place for strengthening leadership in MOHSW at the central level.

The central level is unable to properly coordinate the implementation of priority activities, including the increasing number of partner and not-for-profit organization interventions that are not necessarily linked to each other or to existing MOHSW plans and strategies. As discussed earlier, in the governance section, this inability to coordinate implementation of health activities has led to a low level of accountability with respect to nondelivery of services and interventions and it is affecting the quality of service delivery.

Control of Resources: Key health sector resources are controlled external to the MOHSW. The MOPS and the MOFPD have the mandate and authority to set directives related to health sector human and financial resources, which are not always in line with the long-term objectives and plans of the MOHSW. Also, development partners maintain a high level of control, either directly or indirectly, over health system activities through donor-funded projects, some of which are not in-line with the MOHSW's strategic plan.

Equipment and Supplies: The health sector's capacity to provide equipment and supplies throughout the system is inadequate in terms of availability and use. Key informant interviews revealed that MOHSW does not have a definitive sector equipment replacement plan or strategy. The equipment procurement system is unclear and it is not certain whether an equipment maintenance policy exists. In addition, the MOHSW lacks properly qualified equipment maintenance personnel relying, therefore, on externally

⁵² Key Informant interview with MOHSW.

trained/based personnel, usually from South Africa. The combination of these factors has resulted in different health facilities in different districts having different equipment. Interviews with key informants also revealed nonuse of working equipment due to lack of proper training.

Although the equipment and training support given by development partners in recent years (especially to the HIV/AIDS and TB sectors) has made a significant and positive impact, as evidenced by the indicator-based assessment, this has been ad hoc to some extent, with the focus on single disease/vertical programming.

Use of Information for Planning: The lack of current and valid data, poor use of existing data, and the fact that information is not always timely and/or of acceptable quality, compromises the decision-making processes that inform policy, strategy, and implementation in the health sector. Although there are established information systems, they suffer considerable HR constraints, and the linkage between HIS and M&E is poor, which may be a factor contributing toward the tendency to develop autonomous/siloed systems.

The MOHSW has various mechanisms in place, such as the AJR process, to identify systemic bottlenecks. However, it is unclear whether performance monitoring is carried out with specific intention to identify and resolve performance gaps.

Human Resource Capacity: Other key issues related to the technical constraints the MOHSW faces are rooted in the human resource crisis. The lack of trained and skilled human resources remains the core issue. The country does not have a medical school and is limited to a finite number of training opportunities in teaching hospitals. Therefore, the country's ability to train and increase the number of health workers in Lesotho, without assistance from training institutions outside of Lesotho, is limited. As a result, clinical service delivery capacity, especially among the higher-level cadres, is still greatly dependent on externally sourced health workers. (See the HRH section for further discussion of the HRH crisis.)

There is some concern within the health system that, with the creation of new decentralized structures and effective merging of clinical and administrative/management roles within facilities, district medical officers will face leadership and management-related situations they are ill equipped to handle. This, as well as the potential for misunderstanding and confusion of roles, may further affect the planning and implementation processes at the district level and thus the efficiency and quality of service delivery.

4.5.4 SERVICE DELIVERY AND DECENTRALIZATION

The current decentralization process is a dominant issue in the Lesotho health sector. The Lesotho MCA, through the support of MCC, has a dedicated Project Implementation Unit (MCA-PIU) established within the ministry which is supporting this decentralization process.

One of the initial activities of the MCA-PIU was to review the decentralization strategy. Study findings indicated a lack of clarity within the Local Government Act concerning the health sector's position within the decentralized framework. This raised key questions concerning the sector's control of and responsibility for finances and personnel, among other areas. To address these concerns, the MCA-PIU identified a firm to implement the MOHSW Health Systems Strengthening Project, with specific focus on decentralization, human resource development, HMIS, and DHMTs. With the assistance of the project, the MOHSW will implement the process of physical decentralization, including the transfer of human resources to the local authorities. Reorientation of the service delivery framework will initially involve only part of the public health services, the intention being to devolve the entire package over the course of the next six years.

The process faces an uphill task to improve service delivery, particularly with regard to the capacity of available human resources. For example, the process will require creating new mandates for and within the DHMTs, local councils, and health professionals, in addition to increasing the number of deployed (competent) human resources. Such plans and process, however, although clearly identified, are constrained by a series of factors, a major one of which is the ‘institutionalized shortage’ of human resources that has been created. Although the GOL Cabinet approved the transfer of staff to the local government, the MOFDP issued a promulgation blocking the creation of all new staff positions. Therefore, despite MOHSW’s willingness to transfer staff, as required by the decentralization process, this cannot be done; on the one hand, structures and posts exist on paper, but, in reality, they remain unfilled due to their being disallowed.

As part of its strategy to address some of the MOHSW’s immediate and long-term needs, the MCA-PIU will focus on a number of HRH development activities that directly affect sector capacity to deliver quality services. These include supporting the implementation of the Continuing Education Strategy; developing and reviewing the HRH Retention Strategy; developing and institutionalizing a new career and progression path for the staff to be decentralized; and providing support to training institutions through the engagement of tutors and other human resources.

During key informant interviews, concerns as to how the decentralization process will affect HIS, specifically the HMIS, were also raised. The creation of new, or the augmentation of existing, silos may further worsen the situation (i.e., different components of the information system unable to “talk to each other,” thus affecting decision-making processes, which, ideally, should rely on existing, real-time, and valid data).

Despite the initiatives underway, slow progress of the decentralization of functions has severely affected service delivery capacity. The necessary systems and guidelines for a successful decentralization have not been put in place or adequately developed. Decentralized structures, that lack the capacity to assume their functional roles, are being created and empowered to take on their official roles. Key shortcomings of the decentralization process include:

- The extent to which accountability and responsibility for the delivery of health services has devolved to the local government is unclear.
- Although DHMTs were established, progress of implementation has been slow; only a number of pilot districts have DHMT offices and/or a full complement of staff.
- The MOHSW has requested the creation of several key district-level posts, important to the delivery of services (District Director of Health Services, District Medical Officer, Senior Pharmacy Technologist, Senior Information Officer, District Accountant), but the positions have not been filled. This exacerbates the already existing weaknesses in the decentralized DHMT and hospital management team units.

4.5.5 SERVICE DELIVERY AND THE GOL/CHAL MEMORANDUM OF UNDERSTANDING

A key component of the health sector’s capacity to deliver services to the population is the collaboration between the GOL/MOHSW and CHAL. Established in 1974 as an amalgamation of Christian churches, the CHAL provides nearly 40 percent of the national health services delivery, offering nearly all the services the GOL does through its network of eight hospitals and 73 health centers and village health posts.

As the major stakeholders and partners in national service delivery, the GOL and CHAL formalized their long-standing relationship by signing an MOU in February 2007, which established the Joint Commission for Cooperation to guide joint activities related to improving service delivery. Implementation of the MOU started in January 2008, after more than five years of discussions, but there are still several unresolved issues that need to be addressed to strengthen the union. Issues of particular interest to CHAL include accreditation, certification, staffing, and financing, all of which affect its capacity to deliver services to the population, especially in the less accessible regions, and its financial sustainability.

The staffing freeze imposed by the GOL and the staffing norms determined by the MOHSW have left CHAL less able to cope with the increasing demand for services, which requires the expansion of its workforce. CHAL reports that HIV/AIDS and TB service delivery have been particularly affected by the continued lack of human resource capacity.

The key factor in the threat to financial sustainability is the GOL's abolition of user fees. Despite support from a number of development partners (Global Fund; University Research Council; and the Clinton Foundation), the abolition of user fees has negatively affected CHAL's ability to retain personnel and sustain supplies.

4.5.6 LABORATORY SERVICES

Although laboratory services remain grossly understaffed, recently significant progress has been made in strengthening the capacity to deliver services to a wider section of the population. In 2008/09, all hospital laboratories reported having essential laboratory equipment for CD₄, chemistry, and hematology (with the exception of one). The testing capacity of the country, for both HIV/AIDS and TB, has increased. New and larger CD₄ analyzers have been installed at four hospitals, and new software has been installed in existing service equipment. This is expected to improve the national capacity to report both CD₄ count and CD₄ percentage, and thus the accuracy and efficiency with which the treatment and monitoring is done. The MOHSW has also constructed a new clean-room facility (Molecular TB Laboratory) and introduced new line probe assay technology, resulting in the reduction of turnaround time for detection of anti-TB drug resistance from the previous 21 days to three days. MCC is also working with the GOL/MOHSW to build a new central laboratory and train laboratory staff. Table 4.5.5 depicts the availability of essential equipment at hospital laboratories in 2007/08 and 2008/09.

TABLE 4.5.5. HOSPITAL LABORATORIES WITH ESSENTIAL EQUIPMENT

	CD ₄		Chemistry		Hematology	
	2007/08	2008/09	2007/08	2008/09	2007/08	2008/09
QE II	☒	☒	☒	☒	☒	☒
Mafeteng	☒	☒	☒	☒	☒	☒
Mohale's Hoek	☒	☒	☒	☒	☒	☒
Quithing	☒	☒	☒	☒	☒	☒
Machabeng	☒	☒		☒	☒	☒
Mokhotlong	☒	☒		☒	☒	☒
Butha-Buthe	☒	☒		☒	☒	☒
Leribe	☒	☒	☒	☒	☒	☒
Berea		☒		☒	☒	☒
Maluti	☒	☒	☒	☒	☒	☒
Mamouhau		☒		☒	☒	☒
Seboche	☒	☒	☒	☒	☒	☒
Paray	☒	☒		☒	☒	☒
St. James	☒	☒	☒	☒	☒	☒
St. Joseph	☒	☒	☒	☒	☒	☒
Scott	☒	☒	☒	☒	☒	☒

Source: MOHSW (2009)

The availability of laboratory technologists has also improved with the addition of four newly trained and qualified laboratory cytotechnologists and the absorption of two laboratory technologists after their donor-supported contracts expired. In addition, the MOHSW has created the new position of laboratory quality manager and has trained quality officers from each laboratory to assess and supervise health centers.

In the period 2007/08 to 2008/09, the use of the government central laboratory increased, particularly for HIV/AIDS-related services. The number of tests conducted for CD₄ increased by 30 percent and those for full blood count and blood chemistry increased by 19 percent and 11 percent, respectively.

However, the long-term sustainability of gains made in laboratory services is threatened by the overwhelming dependence on external support. The provision of TB reagents and consumables to all laboratories occurs with the support of the Global Fund. Furthermore, although the GOL supports ART monitoring services in part, the Global Fund and the Clinton Foundation continue to provide significant input, as they do with cultures and line probe assay.

Other significant challenges affecting the quality of laboratory services are related to procurement, contracting, and payment for services. The procurement system often leads to long delays, resulting in stock-outs in laboratories. Exacerbating this situation is the interruption in services caused by the failure to execute service contracts for chemistry analyzers and the delays in payment to providers for services rendered.

4.5.7 NATIONAL-LEVEL (VERTICAL) PROGRAMMING

With the introduction of the PHC strategy in 1979, the MOHSW began to shift its focus from a centrally controlled service delivery system to a more decentralized approach. This led to the creation of various PHC programs with the mandate to coordinate the planning and budgeting functions for PHC.

The programs that currently exist under the PHC Department and that control activities, both in the MOHSW and nationally, include the following:

1. *National AIDS Prevention & Control Program*: This program's key objective is to coordinate the strengthening of the national response to the HIV/AIDS pandemic, especially the capacity of the MOHSW to provide leadership. The program's key products are (1) the development of guidelines for HIV clinical management, PMTCT, VCT and home-based care; and (2) coordination with respect to the strengthening of VCT, PMTCT, pediatric AIDS, and ART services, at all levels of the health system. Activities are implemented through four units: Counseling and Community-based Programs, Behavior Change and Communication, Clinical Care Services, and Research and Surveillance.
2. *Family Health Division*: The division is made up of four subprograms: Reproductive Health (RH), Child Survival, Nutrition, and Community-based Health, and its goal is the reduction of infant, child, and maternal morbidity and mortality rates.
3. *Disease Control*: At its inception, the program's focus was on TB (considered to be the biggest health challenge facing the country), sexually transmitted diseases, and leprosy. The mandate was later expanded to include HIV/AIDS and noncommunicable diseases. The AIDS program, however, was eventually delinked from disease control, with a separate directorate being created within the MOHSW.

The other two programs under the PHC Department are Environmental Health and Health Education programs.

In the last five years significant progress in improving service delivery has been made, especially by the HIV/AIDS and TB programs. However, the increase in the level of noncommunicable diseases, especially diabetes, cancer, and hypertension, has placed great strain on the system's capacity to respond to needs and underscored the inadequacy of HR capacity (numbers, training, etc.) and other challenges, some of which cut across programs. These challenges are mainly related to coordination and communication between various key MOHSW stakeholders and the individual programs.

Interviews with senior MOHSW personnel revealed that, recently, the level of integration, both between programs and within the mainstream of MOHSW, has improved. However, there remains an underlying concern that the vertical programs are not properly aligned with the holistic vision of the rest of the MOHSW/sector. In addition, the greatly increased level of partner support to particular vertical programs has led to their becoming more attractive to health workers than others areas of the health sector, creating both a geographical and sector-discipline distortion in health workers.

Interestingly, the concern was also voiced within the ministry that organizational restructuring and implementation of sector reforms could lead to a decreased level of attention to vertical programs and, thus, result in a loss of the significant gains achieved through the programs. Those interviewed believed this constituted a "relatively serious threat," considering the significant role vertical programs play, especially in the key HIV/AIDS and TB sectors.

4.5.8 COMMUNITY-LEVEL SERVICE DELIVERY

Following a national primary care conference in 1978, the MOHSW established voluntary CHWs as part of the health system; however, the sector did not develop any formal policies to define the CHWs' role within the system or guidelines concerning the issues of training, recruitment, remuneration, retention, supervision, and other issues related to engaging CHWs. As a result, to date, there are no official mechanisms in place to ensure active engagement of the community in the management of the health

system and the delivery of services. The ability, therefore, of the health sector to elicit the population's priorities, clients' perceptions of the quality of service delivery, and the barriers clients face in seeking care is limited. (This is also discussed in the governance section.)

Voluntary CHWs, estimated in 2004 to constitute 56 percent of the total formal and informal personnel in the health sector (Schwabe et al. 2004), were intended to provide the first line of contact for basic health care services to the community at the village health post level. However, in the last decade there has been a steady decrease in focus on the functions for which the CHWs were established, and they are not included in policy and planning discussions. The level of GOL financial support is also inadequate (World Bank 2009).

This lack of formal policies, guidelines, and central coordination has resulted in a number of crucial and unresolved challenges, which have led to the country's current inability to harness what is potentially one of the most significant resources available. At the primary level of the health system, the link between the community and the 'formal' health system is undefined. As a result, CHWs are not catered for within the context of broader health sector operations and the implementation of activities. Support supervision for the community system is inadequate, as is financial assistance for the CHWs' operations, such as transport allowances when carrying out their duties. Community-based facilities and workers are also faced with frequent stock-outs of drug kits and other commodities, which greatly affects their ability to serve the community and, as a result, impedes the level of trust the community has in their ability to deliver services.

Inadequate funding, among other challenges, has dramatically decreased the level of GOL-led training since the 1990s and has resulted in a poorly coordinated and less efficient system. The training that does occur is conducted by the various NGOs and is ad hoc, albeit well-intentioned. The capacity at the central level to monitor and supervise the quality of these community programs, their relevance and applicability to the country's needs, and their sustainability is minimal.

The lack of recruitment and replacement of CHWs in the last 10 years has resulted in another threat to the health delivery system at the district and community level. Nonreplacement of the original 'stock' of CHWs trained during the 1980s and 1990s, whose current average age is 54 years (Kimane 2008), suggests that the majority are now near retirement. The country is thus faced with the urgent need to replace thousands of sector personnel to avoid the certain losses that will occur in less than 10 years.

Although most of the older CHWs were recruited on the agreed understanding of voluntary work, it is unlikely that the same terms and principles of engagement will be found acceptable nowadays. Studies have shown that the average income of CHWs is only about half (53 percent) of the average community member's income (Kimane 2008). Unless the government focuses on developing realistic and sustainable recruitment, remuneration, and retention plans, the country will soon be faced with the loss of the largest HR component in the health sector that is closest to the vast majority of the population.

4.5.9 HEALTH SERVICE DELIVERY INDICATORS

The health sector has made concerted efforts in recent years to improve service delivery and has registered some success, evidenced by the improvement of service delivery indicators over the last decade. However, despite these successes, Lesotho's health statistics still compare unfavorably with those of neighboring countries of similar size and/or economic development. Tables 4.5.1 and 4.5.6 summarize select health indicators for Lesotho, the region, and neighboring countries. Of key interest is the very high levels of maternal mortality and low levels of births attended by a health professional, both of which are affected by access to and utilization of health facilities.

TABLE 4.5.6. COUNTRY COMPARISON OF SELECTED HEALTH INDICATORS

	Source	Lesotho	Botswana	Mozambique	Swaziland
Hospital beds per 10,000	WHO	13	24	8	21
Births attended by skilled health personnel (%)	WDI 2010	55%	94%	47%	69%
DTP3 immunization coverage (% of 1 year olds)	WHO	91%	96%	75%	68%
Contraceptive prevalence (% women aged 15–49)	WDI 2010	37%	48%	16%	50%
Pregnant women who received at least 1 ANC visit (%)	UNICEF	90%	97%	85%	85%
Life expectancy at birth, total (years)	WDI 2010	44.99	54.24	47.89	47.55
Infant mortality rate, deaths per 1,000 live births	WDI 2010	63.10	25.95	90.40	58.80
Maternal mortality ratio per 100,000 live births (adjusted)	WDI 2010	960	380	520	390
Prevalence of HIV, total (% of population aged 15–49)	UNAIDS	23.2%	23.9%	12.5%	26.1%

4.5.10 SERVICE DELIVERY ACCESS, COVERAGE, AND UTILIZATION

Although statistics for access, coverage, and utilization of services in Lesotho have improved in the last five years, especially in the HIV/AIDS and TB sectors, they are still very poor.

- 79.5 percent of the national population lives within two hours' walking distance of a fixed facility, but much of the travel is over rough terrain.
- Utilization rates are some of the lowest in the world. The World Bank Health Sector Expenditure Review reported a per capita outpatient visit ratio of 0.75 in 2009. This correlates to less than one visit per year, per Basotho and is well below the WHO norm of 3.5 visits per capita per year (Strachan 2007).
- Average bed occupancy rate for GOL and CHAL hospitals was 38 percent and 42 percent, respectively, in 2008, well below the 80 percent efficiency level.
- Although no significant change has occurred in the number or relative accessibility of facilities, efforts are underway to further improve the existing structure through an extensive, MCC-supported renovation and construction activity.

Individual disease or topic specific programs have relayed the following information on access, coverage and utilization:

HIV/AIDS: HIV/AIDS is one area in which visible progress has been made and success in health outcomes seen and reported. The MOHSW has completed the national behavior change and communication strategy and a countrywide 'Know Your Status' campaign is now being implemented. Between 2006 and 2007, Lesotho experienced a marked increase (177 percent) in the number of people who tested for HIV, rising from 79,394 to 220,296; between 2007 and 2008, the increase was about 31 percent. In 2009, the number of PMTCT sites also increased significantly, from 35 (17 percent) facilities to 180 (88 percent) facilities, out of a target 205 facilities.

The number of HIV-positive pregnant women who are on Zidovudine (AZT), are receiving the minimum package, or are on Highly Active Antiretroviral Therapy (HAART) has also increased significantly in the two-year period (2006 to 2008), from 15 percent to 56 percent.

In 2007/08, Lesotho experienced vast improvements in the ART rollout program, although uptake by districts has been relatively poor. The cumulative number of all patients increased by about 78 percent (33,613 to 59,958) and the cumulative number of children increased by 90 percent. However, nearly one-half (30,000) of that total were living in urban areas and/or in relatively more urbanized districts (i.e., Maseru, Leribe, and Mafeteng). Seven district hospitals had fewer than 100 pregnant women on ARV prophylaxis in 2008.

The rapid expansion of HIV/AIDS programming, however, has resulted in new challenges. The tremendous increase in donor-funded support, resulting in the greatly increased demand for HIV/AIDS-related services, has strained the country's delivery system. The increased focus and financial resourcing of HIV/AIDS has also resulted in a shift in health workforce distribution. Higher-level cadres have left other disease sectors for HIV/AIDS-related programs, resulting in a distortion of implementation capacity within the country.

Tuberculosis: Lesotho, which remains one of the most poorly performing TB countries in the world (fifth among the 15 countries with the highest per capita incidence), reported 635 TB cases per 100,000 in 2006 (WHO 2008). Unfavorable TB-related factors in the country have remained much the same: high death rate (10 percent) and high numbers not evaluated (14 percent). However, the TB/Leprosy Program, which was merged to improve implementation, has made significant strides in the last few years. In 2008 the MOHSW reported 13,163 TB cases, of which 11,436 (approx. 87 percent) were new cases.

In 2007, the MOHSW reported a case detection rate of 77 percent against the WHO-recommended rate of 70 percent. There was, however, a decline by 6 percent in the treatment success rate, from 73 percent to 67 percent, this is well below the global target of 85 percent.

HIV/AIDS – TB Collaboration: Increased funding and improved coordination among vertical programs has seen an increase in the level of collaboration-specific activities between the HIV/AIDS and TB sectors. In all 10 districts, TB/HIV collaborative activities have scaled up, and the MOHSW has established a TB/HIV working group, which is now active. As a result, a subworking group was established to review the referrals system in accordance with the WHO guidelines for strengthening HIV counseling and testing.

Surveillance data for 2008 indicate a 4 percent reduction in the proportion of TB patients who tested positive for HIV (from 80 percent in 2007 to 76 percent in 2008), but the number of HIV-positive patients on ARVs remains low at 24 percent. Co-trimoxazole Preventative Therapy has seen a great improvement, with a 12-percent increase in the proportion of TB patients on this type of therapy, increasing from 3,490 patients (70 percent) in 2007 to 5,592 patients (82 percent) in 2008.

Reproductive Health: Performance of the RH sector has been very poor. Maternal morbidity and mortality remain unacceptably high, fuelled in great part by the severe lack of capacity at the health center level. Although utilization of services and the number of institutional deliveries are expected to increase due to the abolition of user fees at the health center level, this has not yet been evidenced. The number of deliveries in 2008 decreased from 2007 in all but two districts (Berea and Thaba Tseka), and reasons for this have not yet been established.

Overall, the quality, utilization, and coverage of ANC services in the country remain poor. The proportion of women who know where to go in the event of complications was reportedly good, but only a small proportion actually knew at least two danger signs in pregnancy. The percentage of pregnant women who attended ANC at least once was high at 92 percent (MOHSW 2009), but only 48 percent made the recommended four ANC visits—22 percent less than the 70 percent reported by WHO in 2005. The macerated stillbirths rate, an effective measure of the quality of services and care

received by pregnant mothers during the antenatal period, was recorded in seven facilities nationwide to be 66 percent, a very high figure.

Performance with respect to safe delivery is also poor, especially in the public sector where the maternal case fatality rate is much worse than in CHAL facilities. Although the maternal case fatality rate recorded in all facilities in the country was less than 1 percent of total deliveries in 2008, the majority of GOL facilities (77 percent) reported maternal deaths. This compared very poorly with CHAL, which recorded no maternal deaths in 75 percent of its facilities. Facility-based estimates of safe delivery, however, mask the true magnitude of the problem as many women are not delivering in facilities. The assessment team was not able to discover if this is due to cultural barriers, concerns about quality, or unavailability of services, but emergency obstetric care was only available at 61 percent (11 out of 18) of the district-level hospitals at the time of this assessment. Taking into consideration the poor roads, inaccessibility of vehicles for referrals, and the unavailability of emergency obstetric care at many of the hospitals that women would be referred to from the health centers, accessibility, availability, and quality are likely significant factors in the high maternal mortality rates.

As part of ongoing efforts to improve RH-related service delivery and address the high maternal mortality, the MOHSW has implemented a number of initiatives. The technical capacity of the Reproductive Health Unit has been strengthened by two consultants, with the support of development partners. The MOHSW has established a Committee on Confidential Enquiry into Maternal Deaths and distributed copies of the obstetric record to all facilities for the proper management of labor. No evidence exists, however, that the obstetric record is being used with a focus on continuity of care, and the patient retention level of the 'maternal record page' post-delivery is only 45 percent.⁵³

Child Survival: Malnutrition is the highest cause of institutional deaths among children in the country (22 percent) and the third highest cause of institutional admissions (11 percent). In response, the MOHSW has instituted steps to increase the coverage, access, and utilization of services (MOHSW 2009).

The MOHSW has established 60 Integrated Management of Acute Malnutrition pilot sites, under the Child Survival Program, with distribution of 'Plumby Nut' and other supplements/products to hospitals and health centers. The ministry has also developed an Infant and Young Child Feeding Curriculum to standardize feeding practices.

Diarrhea in children is the highest cause of childhood admissions at 14 percent and the second highest cause of institutional deaths (17 percent) after malnutrition, posing a very serious challenge to the health sector. Access to knowledge and levels of awareness seem to play a big role in combating this illness. The EPI and Quality Assurance Sampling surveys reported that knowledge about managing the danger signs of this childhood illness was limited. The surveys further reported that during diarrhea episodes, children were given less to eat and drink than their usual intake, and in a recordable number of cases, diarrhea episodes were managed with antibiotics.

In 2008, the MOHSW introduced the pentavalent vaccine (DPT-HB) in all districts and trained health workers and communities in measles and polio surveillance. The country also experienced an improvement in the DPT3 immunization coverage, from 83 percent in 2008 to 91 percent in 2009 (WHO 2009). Performance in this decade, however, has been relatively stagnant, with no change from the 83-percent coverage recorded in 2003 until the increase recorded in 2009.

⁵³ The 'maternal record page' is meant to be retained by the mother to maintain a personal record of events.

In the five districts that participated in the Quality Assurance Sampling Survey 2004, BCG⁵⁴ coverage was 80 percent and coverage of other vaccines was less, varying between 73 percent and 76 percent. However, all reported or identified cases of measles in 2008 were investigated.

4.5.11 QUALITY ASSURANCE OF CARE

The MOHSW is in the process of developing and updating tools and guidelines, and has conducted a number of trainings to facilitate decentralization of services to improve quality of care. Overall, however, the efficiency and quality of the delivery of services remains a big challenge to the MOHSW and the country. An important issue raised during interviews was that despite the improvement in physical access, access in terms of quality of services has remained poor. Major reasons identified include the inadequacy of trained personnel and drug stock-outs. The health sector's inability to address an HR crisis and ensure reliable delivery of medicines and medical supplies has led to a reduction in the coverage of, and access to, quality health services by the population.

One of the key initiatives the MOHSW took to improve the quality of health care was to establish a Quality Assurance unit in 2008, mandated to ensure all health service sectors in the country, irrespective of ownership, comply with standards set by the MOHSW.

Since its inception, the QA unit has conducted a nationwide quality assurance sensitization exercise for facilities and introduced Quality Assurance Steering Committees in all districts; it is not clear, however, whether these committees are functional. The QA unit has also completed a situation analysis and baseline study and, with the assistance of COHSASA, which provides facilitated capacity building, conducted trainings on how to enforce quality assurance standards and M&E.

The unit, however, is under-resourced. With only two staff members (manager and assistant), the QA unit is implementing activities in the absence of a national QA policy. Currently, the unit uses the national standards developed in 2006 with the assistance of MCDT and to date has managed to conduct two national facilities' assessments, one in 2007 and one in 2009. The final (round 3) accreditation exercise is due in 2010.

The results of the two assessments reflect the low quality of service delivery in the country. Of the eight GOL hospitals, eight CHAL hospitals, and 147 health centers assessed, none passed the accreditation standards. It should be noted that the QA unit considers the 2006 national standards used during the assessment to be inadequate, as the standards assess only 11 domains rather than the 38 elements considered necessary to adequately capture quality performance and assurance.

The 2007 accreditation exercise found that noncompliance to standards was very high. The fact that the 2009 exercise also failed to pass any facilities indicates that little progress had been made and, perhaps, an inadequate level of attention had been given to the situation. The final accreditation exercise to be carried out under the unit's current mandate is planned for 2010. In preparation for this, the QA unit is revising the existing tools (merging the COHSASA standards with the Lesotho standards) to develop a more comprehensive tool that will capture the desired 38 elements.

The main challenge the unit faces to implementing a functional, efficient, and sustainable QA program is HR related, both in its own capacity and the capacity within the health sector. The high burnout and attrition rates suffered throughout the health sector are, in part, the reason for the non-institutionalization of the standards, protocols, and skills required to maintain QA. Interviews revealed

⁵⁴ Baccille Calmette Guerin vaccine.

that doctors and nurses trained by the QA unit remain in their positions no more than six months before they leave the station for which they were trained. Since the dissemination of the accreditation exercise report and the training of district doctors, nearly all health workers in CHAL facilities who received QA training have left the Lesotho health sector⁵⁵.

Application of QA methods and standards is not harmonized throughout the country. The GOL and CHAL still use different QA tools and management systems, despite the MOU signed in 2007. Interventions NGOs involved in service delivery have implemented also use their own tools and standards for quality assurance and M&E, an example being ICAP's⁵⁶ use of tools developed by Columbia University. In many cases, the utilization of separate tools is due to the lack of MOHSW-developed tools and its current inability to do so. That notwithstanding, it is felt that the current situation perpetuates a lack of harmonization within systems, the creation of silos, and effective fragmentation of critical data that are necessary to monitor and evaluate performance and ensure the centrally coordinated quality of service delivery.

The MOHSW has performed well in the area of policy development for promoting the quality of care, especially in the HIV sector. Major policies and/or guidelines that the MOHSW has developed/implemented in the last few years include: a behavior change communication strategy, a male circumcision policy, an ANC register, a delivery register and the revision and distribution of the TB register.

Laboratory Services: The QA of care with respect to laboratory services has improved at the central level, and steps have been taken to strengthen district service delivery. However, much of the focus has been on HIV/AIDS and TB-related services.

In addition to training personnel, the MOHSW has focused on strengthening the laboratory services policy framework. With the support of development partners, the ministry approved the National Laboratory Policy and Laboratory Strategic Plan. The ministry has also reviewed and approved the Laboratory Quality Manual and Client Handbook and developed and approved a laboratory safety manual.

⁵⁵ Information obtained through key informant interviews with the MOHSW QA unit.

⁵⁶ ICAP supports 34 GOL and CHAL facilities (five hospitals, including Queen Elizabeth II, one filter clinic, and 28 health centers). Its mandate is to reduce pediatric HIV infection and HIV morbidity and mortality.

4.5.12 SUMMARY OF FINDINGS

Table 4.5.7 presents a SWOT analysis of service delivery in the Lesotho health system.

TABLE 4.5.7. SERVICE DELIVERY SWOT ANALYSIS

Strengths • Health Sector Reforms: ◦ The new MOHSW (flat functional) structure • Planning and Implementation: ◦ Implementation of activities according to a developed sector plan. ◦ Implementation of the Health Systems Strengthening Project through MCA-PIU embedded within the MOHSW • Established QA system in place • MOU between GOL and partners such as CHAL, Red Cross, and private practitioners • HIV/AIDS and TB Programs: ◦ Strong HIV/AIDS and TB policy framework ◦ High level of donor funding and technical support ◦ Use of the health system primary level in the rolling out of the PMTCT program through health centers ◦ Some level of collaboration between the HIV/AIDS and TB programs • AfDB support for mental health infrastructure development • Strong logistical support for service delivery (Riders for Health)	Opportunities • Strong partnership between GOL, CHAL, Red Cross, and private practitioners • Health sector reforms and decentralization processes • High level of donor goodwill and support • MCC support for laboratory and health facility infrastructure • Strong relationship between MOH and COHSASA
Weaknesses • Service Access, Coverage, Utilization, and quality: ◦ Poor access to services in the highlands ◦ Continued existence of the primary level health posts outside of the formal health system ◦ Decline of all health indicators ◦ Weak referral system • Leadership and Management Capacity: ◦ Poor planning, coordination, and monitoring mechanisms ◦ Nonuse of data for planning and decision making ◦ Private sector facilities not included in planning for service delivery • Policy Framework: ◦ No policy framework formalizing the roles, responsibilities, and status of voluntary/community health workers ◦ No national QA policy ◦ Weak policy framework regarding maintenance • Human Resources for Health: ◦ Scarce competent HRH	Threats • No facilities passing the accreditation exercise • Health Sector Reforms & Decentralization: ◦ Slow progress of implementation of the decentralizations and health sector reforms processes. • MOU • HIV/AIDS: ◦ Greatly increased demand for services at district level, well in excess of capacity to deliver ◦ High level of community focus on HIV/AIDS (vertical) programming, to the exclusion of other community priorities • Increasing level of noncommunicable diseases • Low morale throughout the health sector • High level of dependence on external HR capacity

4.6 HEALTH INFORMATION SYSTEMS

Accurate, complete, and timely health information is fundamental to ensuring the public's health. A recent WHO report emphasizes that reliable information is particularly necessary in resource-constrained settings, where optimal allocation of resources can mean the difference between life and death (WHO 2008).

Unfortunately, it is most frequently the countries with the greatest health needs and fewest resources that have the weakest HIS (WHO 2008). Over the years, such factors as weak capacity, financial constraints, and political decisions have resulted in low levels of investment in HIS (WHO 2008) and lack of evidence that compromises policymakers' ability to be good stewards of their health systems. Where multi- and bilateral-donor programs operate, they often create their own vertical reporting systems. These separate systems mean there are both gaps and redundancies in the national health information picture.

For the purposes of this assessment, a HIS is defined as a "set of components and procedures organized with the objective of generating information that will improve health care management decisions at all levels of the health system."

HIS have four functions: (1) data generation, (2) data compilation, (3) data analysis and synthesis, and (4) data communication and use (WHO 2008). That is, HIS collect data from the health sector and other relevant sectors; analyze the data and ensure their overall quality, relevance, and timeliness; and convert the data into information for health-related decision making. Regularly updating the information allows policymakers to judge if those decisions are being implemented correctly, are achieving the intended results, or need to be modified.

In addition to performing this M&E function, HIS provide early warning systems, support direct delivery of care to patients and management of health facilities, inform planning and enable research, permit health situation analysis and global reporting, and communicate health information to diverse users (WHO 2008). HIS operate at four levels: individual, health facility, population, and public health surveillance.

Lesotho compares well to its peers with respect to the availability of information on key indicators. The country is capable of reporting on international obligations in a timely and systematic manner.

4.6.1 RESOURCE POLICY AND REGULATION

Lesotho has a national HMIS policy (2003) and a draft strategic plan (2004-2008). Key legal instruments governing statistics and information include the National Statistics Act (2001) and the Registration of Births and Deaths Act (1973). Because reporting of births and deaths is not mandatory, implementation of the Registration of Births and Death Act is not effective, and the vital registration system performs poorly (HMN & MOHSW 2007). The Bureau of Statistics delegates collection, processing, analysis, and use of health and social welfare data to the MOHSW. With respect to facility-based routine reporting, the CHAL/GOL MOU supports routine reporting, and CHAL facilities use the standardized data collection tools developed by the MOHSW. Policies and regulations governing health information have been updated given the provisions of the decentralization law (Local Government Act, 1997), especially as relates to local government responsibilities for delivery and management of health and social welfare services.

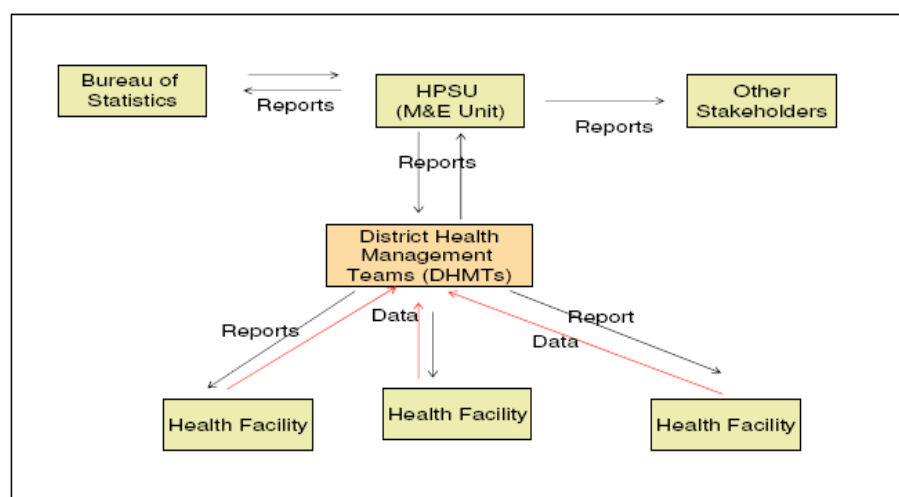
The MOHSW of Lesotho has a dedicated statistics unit (within the Department of Planning). The mandate of the unit covers the following:

1. Collection of relevant and reliable statistics on health service delivery, health status, utilization of health services, and distribution of health resources.
2. Timely production and dissemination of health statistics reports.
3. Promotion of collaboration among producers of health information (for production and use).
4. Training of health workers in health statistics to enhance use of data in management, planning, and research.

Lesotho has a hybrid HIS, with a mix of integrated and stand-alone data systems. The integrated data system covers outpatient, inpatient, delivery, maternal health, ANC, and oral health data. Conversely, the major disease control programs (HIV, TB), as well as notifiable diseases, immunization, and social welfare and human resources, have separate, vertical data systems. Lesotho currently has no systems for tracking financial data, managing human resources for health, or managing logistics (i.e., distribution and management of drugs and essential supplies).

Figure 4.6.1 depicts the levels of reporting, as detailed in the Activity Outline for Decentralization of Health Data Processing and Utilization to District Levels for the MOHSW. The HMIS decentralization plan calls for this structure to be implemented (MOHSW 2006).

FIGURE 4.6.1. LEVELS OF REPORTING: CENTRAL, DISTRICT, AND FACILITY



Source: MOHSW (2006)

Key informants indicated that there was a certain degree of confusion concerning roles and responsibilities with respect to HIS at the district level. The central level wants districts to take charge of HIS activities at their level, whereas districts complain that transportation is a challenge.

Structures or committees charged with reviewing, adapting, or changing HIS indicators are typically convened on an ad hoc basis. No standing committee or task force is charged with organizing periodic reviews of indicators. The emergence of large vertical disease programs has led to a proliferation of ad hoc committees on M&E/HIS. In addition, the MOHSW-led M&E technical working group is not functional because the central level unit is chronically understaffed.

Given that Lesotho is only now embarking on effective decentralization and that District Health Information Officer (DHIO) positions were unfilled until late 2009, it is not surprising that district-level M&E committees do not exist or are not operational.

4.6.2 ROUTINE HEALTH DATA

Routine health activity data are recorded daily in all GOL and CHAL health facilities using standard registers and record forms. As CHAL and GOL facilities account for more than 95 percent of service provision in Lesotho, these data provide a fairly comprehensive picture of the HIS in Lesotho. No information was available on HIS in other (non-CHAL) private sector facilities.

In terms of procedures, health posts submit monthly reports to their supervising health centers. Health centers and hospitals report to the central level, through the DHIO. DHIO's are responsible for managing data at the district level, as well as submitting reports to the DHMT, which then submits the data to the central level (HMIS information that excludes data from vertical programs such as TB, HIV, and EPI). All facilities that receive data are expected to verify completeness, accuracy, and relevance.

National minimum core indicators, which account for most Millennium Development Goals (MDGs), have been developed for national and district levels. However, these are not survey based, and information on most of these indicators is not available. The USAID Enhancing Strategic Information project is currently providing assistance to districts to determine district catchment area population.

The HMIS at the central level has a data warehouse, but it has no reporting capacity. The system does not have any built-in validation or data-checking functionality. Data are transmitted from district to central level on flash disks/memory sticks. Districts do not have data warehouses. They merely play a data compilation and verification role prior to sending information to the central level. The current data warehouse is built on an MS-Access platform. The ETR.Net is used for TB data management at district and national levels.

Data that CHWs collect on paper forms should be validated and transmitted by health posts/centers to supervising clinics. Key informants suggested that this seldom occurs as CHWs frequently run out of forms. Inadequate access to transportation and communication infrastructure also impedes CHWs' ability to transmit timely information. Additionally, the substantial workload tied to data collation causes facilities to report late, which in turn affects the timeliness of district reports.

An HR Information System (HRIS) is being developed with the assistance of PEPFAR through SAHCD to improve HR management. An Access-based database is already in place and statistics are available for the MOHSW. IFMIS software, developed by the MOFDP, is also in place for health finance information.

Existing systems are unevenly resourced, and, consequently, perform at uneven levels. As to be expected, vertical disease program data systems are substantially better resourced than the routine health information data system. For example, the HIV data system has dedicated infrastructure and staff at the national and district levels. All 10 districts in Lesotho have a district AIDS officer who is in principle responsible for the collection, compilation, and analysis of HIV data, although these are not performing their duties with respect to data management at the district level. International partners involved in the provision of HIV/AIDS treatment at service outlets routinely hire data collection managers for HIV programs. No other facilities other than HIV/AIDS treatment outlets have dedicated data management staff.

Despite having a hybrid information system, Lesotho made great strides in improving its monitoring capacity, as evidenced by the limited number of indicators measured quarterly in the M&E reports, which form the basis of the AJR. The decentralization policy will require that a similar approach be rolled out to the district level (district scorecard) to monitor the implementation of decentralization and district performance.

Table 4.6.I illustrates the hybrid nature of the Lesotho HIS.

TABLE 4.6.I. LESOTHO DATA SYSTEMS

Integrated systems (routine)	Outpatient Inpatient Delivery Mental Health ANC Oral Health
Vertical systems	HIV TB EPI Social Welfare Notifiable Diseases Family Planning Nutrition
Partial/no systems	Finances Human Resources Drug and Logistics Management

4.6.3 FINANCIAL RESOURCES TO SUPPORT HIS

Similarly to many countries in the region, the Lesotho HIS unit at the central level falls under the general administration budget of the Department of Planning; this has been the case for the last four year (2005 to 2009). As such, the unit does not have a specific line item within the MOHSW budget. Key respondents indicated that the level of resources available is typically only sufficient for “basic performance,” and that resources for supervision, training, and monitoring are seldom available. This is attributed in large part to delays in budget allocation from the MOFDP and the low budget utilization rate of the MOHSW due to bottlenecks in the system. According to the MOHSW Finance Department, the budget execution rate of the Department of Planning as of November 2009 was 17 percent (M976,218 spent from a total budget of M5,559,858). District-level budgets follow a similar pattern to their central-level counterparts’ in as far as they do not have specific budgets for HIS expenditures.

Support for the Lesotho HIS has significantly increased over the last three years. The major health partners (USG–PEPFAR and MCC) and the World Bank have provided resources for HIS strengthening. Enhancing Strategic Information is the main PEPFAR partner providing technical and financial support for HIS strengthening in Lesotho. Additionally, the World Bank-funded health sector reform project provided equipment and seconded personnel to health districts (DHIOs). The MCA is strengthening HIS through training, supporting recruitment of data clerks, and designing and implementing a new electronic data HIS. Other partners, such as the Clinton Foundation and the Global Fund (round 8, capacity building), are paying for HIS personnel (data clerks) in facilities in which they provide ART.

Although opportunities and goodwill abound, support for HIS in Lesotho is fragmented and uneven. Key respondents indicated that government has an impression that donors “cherry pick” HIS initiatives to support. Therefore, support is uneven and the overall system is not strengthened.

4.6.4 PHYSICAL RESOURCES TO SUPPORT HIS

The availability of recording forms, papers, pencils, and other supplies needed for recording health services and disease information is not an issue in Lesotho. Facilities seldom experience shortages and stock-outs of registers or patient cards. All facilities visited at the district and subdistrict level did not report any shortages or stock-outs of forms; however, appropriate use of forms, particularly recording forms (monthly reports) remains problematic in selected facilities.

The HIS unit at the central level has a computer laboratory containing 20 computers. As of February 2009, only 10 (50 percent) of these data entry stations were operational. In addition, the four-person team of the central HIS unit (M&E coordinator, chief statistician, statistician, and M&E technical advisor) had functional information technology (IT) kits (laptop, desktop, printers, and Internet connectivity). With respect to infrastructure, 80 percent of districts reported having a computer for HIS data compilation, and 70 percent of districts (7 out of 10) reported having software to facilitate compilation of data. It should be noted that the assessment did not evaluate the adequacy of the current HIS software.

With respect to HIS, a major issue facing health facilities in Lesotho is lack of adequate communication infrastructure. Fewer than 50 percent of districts reported having adequate information and communication technology (ICT) infrastructure (access to telephone, email, and Internet). This has significant repercussions on the ability to transmit data and communicate with health facilities. Maintenance of ICT infrastructure is highly problematic, with only 10 percent of districts having a dedicated budget and access to competent maintenance support. Given the rugged terrain, the government made significant efforts to provide two-way radios to health facilities to ease communication between clinics and district hospitals and improve use of the referral system. This equipment was not functional in any of the health facilities visited by the assessment team. The rapid expansion of the mobile telephony network, in addition to the establishment of the GOL data link, jointly open up a number of possibilities to the MOHSW to improve communication among health facilities.

4.6.5 GUIDELINES FOR HIS

Standards and guidelines for reporting are in place. When questioned, key respondents stated that facilities are informed on the reporting calendar. The guidance stipulates that facilities are to submit their monthly reports on or before the seventh day of the following month to their district office. Subsequently, the district office has three weeks to compile and submit the data to the national level (by the seventh day of the following month). However, a standard operating procedure document or formal manual/guideline on reporting is not available. The only semi-official guidance documentation provided are the presentation handouts distributed to DHIOs at their training sessions with the MOHSW.

Lesotho does not have standard guidelines for data QA or verification. No information was available on whether the HMIS unit at the central level conducts regular or ad hoc data quality assessment exercises.

Several international partners are implementing electronic data systems in facilities. Similar systems are being deployed in various departments of the MOHSW, and at other levels of the health system. The MOHSW does not have any technical standards for electronic databases.

Key respondents indicated that guidelines for reporting on HIV are lacking. This is largely due to the frequency of revising and changing forms. This affects quality insofar as forms do not necessarily reach their designated destinations and because guidelines are lacking.

The HMIS unit uses a step-down training approach for training on indicators; this is not functional mainly because of a lack of documentation (training manuals, slides, etc.).

4.6.6 DATA ANALYSIS (TIMELINESS OF REPORTING/COMPLETENESS, FEED BACK LOOPS AND PROCESSING/DISSEMINATION OF DATA)

Great variations on reporting exist between the districts, and they routinely report late to the national level. According to key informant interviews at the MOHSW, all districts submitted reports each quarter in 2009, but all 10 districts submitted their reports late to the MOHSW HMIS unit. The degree of lateness varied by district, but none was able to submit its reports on time. This is, to some degree, linked to the turnover with DHIOs. The GOL has recently concluded recruitment of DHIOs. Most DHIOs are newly installed and not adequately trained on reporting procedures.

Data on completeness of reports were not available. The MOHSW does not routinely conduct data quality assessments or data completeness analyses. The DHIO typically compiles and transmits data from facilities in their catchment area. Little analysis is conducted of the information garnered for use at the district and facility levels. It should be noted that Lesotho is in the early phases of effective decentralization in the health sector, and as this initiative ramps up, DHIOs will be expected to play a greater role in analysis and use of information at the local level.

The rate of reporting from private facilities is routinely high (>80 percent) because CHAL facilities are considered to be private sector facilities. There are currently no legal provisions requiring private facilities to report on any diseases. The MOHSW is envisaging to update the Public Health Act to require that all facilities (public and private) report on notifiable diseases, at a minimum (HMN & MOHSW 2007).

The MOHSW has data feedback mechanisms in place, such as the AJR, national and district level quarterly reviews. Although synthesized reports are submitted to the districts, respondents showed a need for data feedback from the central level. There is a discrepancy between the types of feedback reports sent to the districts and those expected/desired. International partners that support selected facilities for provision of specific services (EPI, HIV, etc.) regularly use data for supervision and monitoring purposes. The lack of timely reporting, alluded to previously, has a negative impact on feedback. As discussed in the governance section, information on health sector performance is seldom, if ever, shared with the public.

A national health statistics compendium was produced in 2006. The chief statistician reported that the annual statistical report has not been drafted since 2006 because of a shortage of staff and a change of indicators in the TB program. With the exception of the AJR and reporting for international conventions (MDGs, UNGASS⁵⁷, etc.), quarterly, semiannual, or other routine reports are not produced for external audiences. Data can be obtained upon request.

4.6.7 USE OF DATA

According to the Lesotho Health Metrics Network (HMN) assessment and key respondents, decisions on resource allocation and planning are not driven by information products of the HIS. Rather, budgeting is largely informed by historical trends and overall resource availability. There are no procedures or systems that link HIS information products to budgeting procedures.

All districts fared poorly on the use of data generated for decision making, either through HIS fora, standing meetings, HIS committees, or HIS review groups. This raises questions about how relevant the data collected is to the district level. Although Lesotho is in the early stages of its decentralization push,

⁵⁷ United Nations General Assembly Special Session.

it is imperative that data collected from health facilities are relevant, timely, and useful to DHMTs, which are progressively taking on a greater role in district management.

4.6.8 HUMAN RESOURCES FOR HIS

Lesotho's chronic HRH challenges have been widely researched and documented. The country suffers personnel deficits across all categories, and HIS is not spared. HIV care and treatment facilities that receive direct or embedded donor support frequently have dedicated records and data management officers. Data management at all other facilities (GOL and CHAL) is conducted by nurse assistants or other support staff. The number of reports that facilities have to submit can have a negative impact on provision of care, as heavy reporting burdens take time away from provision of care. On average, facilities report having to submit between five and seven reports per month. This number fluctuates depending on the type of facility (health center, clinic, hospital) and the service mix.

However, it should be noted that human resources for HIS at district level remains a challenge. Until 2009, there were no HIS dedicated staff at the district level; now, the routine HIS is supposed to have one dedicated staff member (DHIO) who is a statistician/demographers (at the bachelor's level). In addition, every district has a district AIDS officer who has responsibility for the collection and analysis of HIV/AIDS information. Although 10 district-level HIS staff had been recruited under the World Bank health sector reform project, these positions were discontinued at the end of the project and, after recreating these positions, only eight districts have hired DHIOs.

The central-level HIS unit is staffed by four people and supported by one international technical advisor. The unit has core skills in epidemiology and statistics (one epidemiologist and two statisticians). The unit does not have any core IT competencies (database management). The HIV directorate has its own dedicated M&E staff (two M&E advisors, five data entry staff). EPI and the national TB control program have their own staff available. With the exception of responding to ad hoc requests for information, very little collaboration exists across programs at the central level with respect to data analysis and processing.

4.6.9 VERTICAL SYSTEMS

Lesotho has the third highest HIV prevalence rate in the world. Approximately 23 percent of the Basotho people are infected with the virus. Management of chronic diseases, such as HIV, requires information systems capable of tracking patients over the long term (longitudinal tracking systems). Additionally, information on essential supplies, such as drugs and laboratory commodities, is critical for long-term management of HIV and other chronic diseases.

Each disease program (TB, etc.) at the central level has its own M&E staff. Additionally, each program has a separate reporting flow. For example, routine HIS reports are prepared by facilities, submitted to the DHIO, who subsequently submits the reports to the MOHSW Department of Planning for analysis. For HIV/AIDS, reports are prepared by facilities and submitted to a district AIDS officer. This person in turn submits the report to the DHMT, which submits a compilation of district HIV/AIDS reports to the central-level HIV/AIDS directorate. This parallel, uncoordinated, and unevenly resourced structure greatly impedes coordination of data collection, limits use of data, and creates duplication. The Clinton Foundation has offered to hire 60 data clerks for HIV care and treatment sites, and the Global Fund round 8 proposals include provision for 60 data clerks.

Lesotho has made great strides in instituting harmonized reporting forms for HIV. A national patient card is available and all monthly reports have been standardized. However, the sheer number of forms and reports that staff are expected to complete is overwhelming. For example, the national HIV program has three registers (pre-ART, ART, and counseling and testing register); three reporting forms

(HTC, ART, and pre-ART); multiple referral forms (chronic HIV, community-based counseling, HTC, PMTCT, etc.); and each subprogram has a specific patient card.

Several partners, including PIH (OpenMRS), MSH (RxSolution) and ICAP (Careware), have implemented electronic systems to ease data management and facilitate reporting at the facility level. However, Lesotho has no standards for electronic patient monitoring systems. As such, exchanging data across systems, implementing automated reporting (for production of monthly statistics), and harmonizing support for these systems is currently not possible.

4.6.10 DISCUSSION

As is the case in most developing countries, use of data remains challenging. Data are collected essentially for reporting to the national and international levels. Facilities do not have the autonomy to make programmatic decisions based on the data they collect. At the national level, a significant interest in data use exists, but a lack of a dedicated data management group within the MOHSW or other means of coordination impedes systematic use of data by MOHSW senior management. The lack of coordination also prevents the HIS unit from having systematic access to data produced by the vertical programs (e.g., HIV, TB, etc.). Data are most frequently made available on an ad hoc basis.

A major issue facing the Lesotho HIS is the linkage between the routine HIS and M&E efforts. Data used to monitor major health sector reform activities under the framework of the AJR are collected on a quarterly basis. Although the AJR collects selected data elements that fall outside the scope of the routine HIS (such as staff and client satisfaction), it also engages in separate collection of routine data elements. This is reflective of either a performance issue, or a lack of confidence with the data produced by the routine HIS. The MOHSW's quarterly and annual monitoring activities should, wherever possible, rely on the routine HIS for their data needs.

In addition, data on drugs, reagents, and dressings are not collected through a routine system. Therefore, quantification exercises involve costly, time-consuming, national-level data collection efforts.

4.6.11 SUMMARY OF FINDINGS

The Lesotho HIS has the potential to build on its strengths derived from harmonized reporting formats and a high level commitment to HIS within the MOHSW. Another strength of the Lesotho HIS is its technically competent core HIS staff at the central level.

The political and administrative decentralization underway in Lesotho offers an opportunity to strengthen the HIS from several perspectives. First, data needs of district health management teams will inform the revision of indicators and routine HIS reports. This, in theory, will allow the central-level HIS team to devote its attention to higher-level coordination/policy/data use issues. Second, the GOL and its development partners are investing, and will continue to invest, substantial resources in decentralized structures. The country is currently building a national data link that will connect all districts to the government data network. Third, the MOHSW has recruited eight (eventually a total of 10) DHIOs who will be responsible for the collection, analysis, and reporting of health information to the central level. This presents opportunities to strengthen the use of data for supervising, monitoring, and making decisions at the district level.

Lesotho has benefited from a substantial influx of resources for health development in the last five years. Official development assistance for health has increased from 10 percent to 30 percent of the overall health budget. Lesotho is in the midst of implementing a sectorwide approach for health. As such, availability of increased resources for health development offers opportunities to strengthen HIS.

The most promising opportunity for HIS development derives from the rapid and widespread expansion of ICT in Lesotho, particularly with respect to infrastructure and solutions. As indicated earlier, geographical considerations (i.e., rough terrain) have historically posed a major challenge to the delivery of social services and have impeded the ability to provide timely data. Lesotho has two major wireless telecommunications providers that cover over 50 percent of the national territory. These networks are rapidly expanding and are deploying technologies that can support data transfer (WiMAX, 3rd generation, Global System for Mobile Communications, etc.). Additionally, the GOL is extending its national data network to all 10 districts. This high-speed data link will cover district hospitals (including DHMTs), district headquarters, and major specialized/referral hospitals.

As indicated earlier, several electronic information systems are being implemented in Lesotho by the government (DHIS, CRIS), service provision partners (Open MRS, RxSolution and Careware), development partners (iHRIS) and NGOs. Lesotho needs to develop standards for electronic systems to ensure a level of interoperability between systems. An IT architecture should also be developed to guide investments in electronic systems.

Table 4.6.2 presents a SWOT analysis of the health information systems in Lesotho.

TABLE 4.6.2. HEALTH INFORMATION SYSTEMS SWOT ANALYSIS

Strengths • Harmonized reporting forms and use of patient cards • HIS and planning department are in place and functional • Highly competent (but insufficient) staff in HIS unit	Opportunities • Decentralization • Increased financial resource availability • HSS firm in place to support the HIS through MCA • ICT (connectivity and mobile platforms)
Weaknesses • Insufficient human resources for HIS • Poor data use culture • Lack of a broad vision/strategy for HIS • Low budget execution rate • Excessive parallel reporting systems • Untimely reporting by health facilities	Threats • Excessive donor reporting requirements • Lack of harmonization/duplicative/redundant IT systems

5. HEALTH SYSTEM PERFORMANCE CRITERIA

This section identifies key issues and discusses the performance of the Lesotho health system with respect to equity, efficiency, access, quality, and sustainability.

5.1 EQUITY

Equity is a normative issue that refers to fairness in the allocation of resources or the treatment of outcomes among different individuals or groups. In Lesotho, persistent inequities in resource allocation and in the distribution of all cadres of staff among districts have led to inequalities in the service provided.

If the population per capita is used as the principal determinant of health care needs and adjusted for poverty levels (one of the main factors affecting demand for health care), per capita MOHSW recurrent budgets differ by a factor of 2.2 between Maseru district and Quthing district, despite the fact that Quthing district has a slightly higher proportion of poor compared to Maseru. Related to this, outpatient visits per capita are negatively correlated with the percentage of poor in the district. This suggests there are financial barriers to care, and, therefore, implies that if the recurrent budget were allocated according to health needs of the population, Quthing district would have received more financial resources. These additional resources could have been used to improve the quality of MOHSW facilities and health care services in Quthing, thus reducing the probability of the population seeking care from alternative sources where fees are charged. The assessment team also observed a glaring discrepancy in the MOHSW budget per capita by a factor of 7.2 between the lowest and the highest district.

With respect to the equitable distribution of human resources, the assessment revealed that while 60 percent of health care is supplied at the PHC level, less than 20 percent of the formal sector labor supply (nurses, doctors, pharmacists, etc.) is employed at that level; the largest share of the labor supply works at the secondary (46 percent) and tertiary (24 percent) levels. This inequitable distribution of HRH causes strains on service delivery (including the provision of care, the collection of health data for HIS, the appropriate use of medicines, etc.). Because patients do not receive the care they require or expect at the PHC level, self-referral to secondary level care causes strain on an already insufficient labor force and infrastructure. Lesotho should take measures to improve distribution of HRH, based on population, epidemiology, and income.

Weak engagement of the CSOs, the limited capacity of CSOs, NGOs, and clients, and a lack of health advocacy are impediments to improving the equitable distribution of health resources (financial and human) throughout the country. Local organizations do not have the capacity or space to engage with the GOL to advocate for a more equitable distribution of health resources. Nevertheless, the ongoing decentralization offers communities opportunities to improve equity because it offers more opportunities for communities and local organizations to participate in decision-making processes at the local level.

5.2 EFFICIENCY

Efficiency concerns how well resources are used to produce the desired outcomes and could be defined as the ability to obtain the best possible value for the resources used. *Technical efficiency* means producing the maximum possible sustained output from a given set of input. *Allocative efficiency* refers to the allocation of resources in such a way that any change to the amount or type of output currently being produced (that could improve an individual's health) would deteriorate an individual's situation.

The MOHSW spent only 9 percent of its budget on primary care and 51 percent on secondary and tertiary care, with the remaining 40 percent on central programs in 2006/07. Even adjusting for the fact that hospitals provide primary outpatient care, this percentage appears low. It can be clearly seen that the MOHSW funds a hospital-based and centrally organized health care system, and this could be said to be an allocative inefficiency of limited financial resources.

The MOHSW's sector plans are not results based, nor are they adequately coordinated with the donor community. This means that certain health sector activities are being conducted that are not contributing to the overall goals of the health system and are not contributing to easing systemic bottlenecks. Results-based strategic and operational plans could dramatically improve the efficiency of the health sector, as well as facilitate implementation by defining clear roles and responsibilities—in order to hold individuals accountable for results.

Additionally, poor planning and coordination of HRH prevents the efficient use of human resources. The MOHSW does not have a HRIS to inform decisions on deployment of scarce staff, there are poor linkages between institutions tasked with the production of HRH and the MOHSW, and the ministry is not able to absorb trained workers, further exacerbating the HRH situation. Indicators on uptake of cadres (i.e., percentage of newly trained workers/cadre absorbed into the civil service) would be useful to measure improvements in this area.

NDSO faces efficiency challenges in procurement. NDSO's product catalogue contains well over 3,000 line items for a relatively small population, and the organization is crippled by payment back-logs from the district sub-accountancies. The institution faces capacity challenges such as lack of a laboratory, lack of capacity to fully evaluate suppliers, weak regulatory controls in the country, lack of sufficient storage space, and small procurement volumes, which prevent it from achieving economies of scale and/or implementing international competitive bidding as a standard practice. These challenges lead to an unacceptably high number of emergency procurements as a percentage of total procurements annually.

Despite significant resources being spent on the routine HIS (staff, infrastructure, etc.), the HIS remains inefficient insofar as it is not capable of informing annual monitoring exercises in a timely and reliable manner. This results in parallel data collection efforts, focusing on data elements that the routine health information, if performing efficiently, would be able to provide. In addition, vertical program HIS staff at the facility and district levels are not used in an efficient manner. Lesotho has the potential to leverage these resources to improve data management at the facility and district levels. For example, requiring data clerks and district-level AIDS information officers to collect, manage, and verify data from priority programs would greatly increase HR available for HIS, as well as improve availability of data. The lack of standards and uncoordinated roll-out of electronic information systems are also indicative of HIS inefficiency.

5.3 ACCESS

Access is a measure of the extent to which a population can reach the health services it needs. It relates to the presence or absence of economic, physical, cultural, or other barriers that people might face in using health services.

With regard to financial access, evidence abounds that user fees were suppressing demand for health care services in Lesotho. To this end, user fees were abolished in GOL and CHAL health centers. As previously noted, the latest AJR (2008/09) reported an increase in utilization of health services in health centers, and this was attributed to the removal of user fees. However, access to health services in the country remains uneven due to regional inequities in terms of distribution and coverage of both health facilities and health workers.

Access to information and planning/policy processes is also limited in Lesotho. First, information on health systems performance is not readily accessible to stakeholders. This is partially due to difficulties in disseminating information (because of cost, terrain, etc.) and partially due to CSOs not seeking this information. Second, access is weak in terms of opportunities to provide input into policymaking and strategy-making processes. However, this factor is attributable to the low capacity of national NGOs and CSOs to effectively engage with the health sector.

5.4 QUALITY

Different concepts define quality of care. In the HSA framework, quality is defined as the characteristic of a product or service that bears on its ability to satisfy stated or implied needs. Quality can be observed in terms of the individual's perceived needs or in terms of society's perceived needs.

The assessment data indicate that the system's performance is less than adequate with respect to quality in pharmaceutical management. The three southern region districts of Mafeteng, Mohale's Hoek, and Quthing were the worst-performing districts in the country.

Most refrigeration units at the facilities, especially health centers, countrywide were for a specific vertical program, EPI. This meant that the quality of other essential pharmaceuticals, such as insulin, would most likely be compromised due to inadequate storage facilities. Although several functional mechanisms to improve rational use of drugs, such as NPTC, HPTCs, NSTGs, and NEML, exist at both the hospital and central levels, NSTGs are not consistently used for basic and in-service training of health personnel. This adversely affects the quality of care as well as the efficiency and equitability of care as different prescribers who have been trained in different countries and schools will usually have different approaches to the treatment of the most common illnesses in Lesotho. This inadequate performance also affects efficiency, as it will most likely increase the value of inventory loss due to expiry.

Similar to other performance criteria, the quality of the service delivery in Lesotho is severely affected by resource allocation including systemic bottlenecks in use of allocated resources, critical shortages of HR, drug stock-outs, lack of information, and challenges in implementing strategies at the central level.

5.5 SUSTAINABILITY

With regard to financing, the assessment found that the Lesotho health system is sustainable in the short term since the government is the major source of funding for health. This means that in the event donor aid is withdrawn, the system could still continue with its health activities. However, in the medium term, the Lesotho health system will likely be unsustainable if general government revenues, in particular

SACU, which is the major source of government revenues, decrease. Such a decline has already led to reduced forecasted allocations to the MOHSW. In addition, with regard to HIV/AIDS funding, especially for HIV/AIDS prevention, mitigation, and support services, the Lesotho health system is seriously unsustainable as it is largely dependent on donor support. In the event of donor withdrawal, HIV/AIDS activities could no longer be sustained in the short to medium term.

6. HSA CONCLUSIONS AND RECOMMENDATIONS

6.1 CONCLUSIONS

Lesotho is at a crossroads. HIV/AIDS has affected every facet of life, confronting the country with a public health crisis of catastrophic proportions. To address this crisis, Lesotho must revamp its health system by making more rational and efficient use of resources, improving coordination of services, seizing upon international goodwill, and improving coordination among partners. From a planning perspective, it is imperative that Lesotho move away from a “fire-fighting” paradigm, which results in addressing challenges in an isolated and uncoordinated manner, to a comprehensive, long-term approach. This is all the more necessary because the major challenges facing the health sector can only be addressed in the medium to long term. From a disease perspective, slowing the spread of HIV and providing comprehensive treatment and support to all persons in need is a long-term endeavor, increasing availability of HRH is a long-term endeavor, and setting up sustainable financing schemes such as national social insurance programs is also long term. In summary, the major health challenges Lesotho faces warrant a long-term, comprehensive approach. This HSA provides a foundation on which to craft such a vision and plan.

6.2 RECOMMENDATIONS

6.2.1 HEALTH FINANCING RECOMMENDATIONS

- Improve public finance management systems and technical capacity at all levels so as to improve the flow of funds between various levels of the system.
- Increase GOL funding for health and HIV/AIDS services and goods.
- Consider recentralizing the payment system for drugs and medical supplies—the MOHSW should pay for drugs at NDSO on behalf of the districts until capacity for processing payments is developed at the district level.
- Develop and implement a rational resource allocation methodology that includes indicators of health needs.
- Develop a full-fledged health SWAp, with common planning, funding, and M&E procedures.
- Expand risk pooling mechanisms, in particular medical aid schemes, and develop a social health insurance scheme so as to reduce out-of-pocket spending.
- Undertake an evaluation of the impact of abolition of user fees in GOL and CHAL health centers.
- Undertake National Health Accounts so as to fully understand the total amount of health care resources in Lesotho and their distribution between different uses
- Engage the private sector employers (companies) to contribute more funds for health services.
- Follow up on the recommendations made by partners during the AJR.

- Address bottlenecks between MOFDP and MOHSW in the flow of funds.

6.2.2 HRH RECOMMENDATIONS

- Establish a system for monitoring the implementation of the various strategic plans aimed at strengthening HRH (emergency hiring plan, continuing education plan, etc.). Indicators on uptake of cadres (i.e., percentage of newly trained workers/cadre absorbed into the civil service) would be useful to measure improvements in this area.
- Take urgent measures to reinvigorate the CHW system through updating and large-scale training
- Expand use of skilled birth attendants within health facility radius and providers of home-based care.
- Revamp CHW supervision mechanisms (through DHMTs)
- Use CHWs to collect community health data to strengthen HMIS at all levels.
- With SAHCD assistance, operationalize the HRIS system (i-HRIS) at the district levels, as well as within the nursing council, before the end of 2010.
- Engage with the GOL Cabinet and Parliament and propose the establishment of a health service commission to streamline recruitment of health sector personnel.
- Establish twinning arrangements with NHTC and NUL, and explore the possibility of establishing formal cooperation mechanisms between these training institutions and PEPFAR (cooperative agreements) to ramp up production of health workers.
- Rapidly identify and address blockages (absorption, low budget execution rates, etc.) causing poor absorption of health workers and propose solutions.
- Engage active, retired HRH on contract basis to address critical HRH shortages.

6.2.3 PHARMACEUTICAL MANAGEMENT RECOMMENDATIONS

- To facilitate procurement and to comply with STGs, the MOHSW should review the NEML every five years. Availability of a current list, which clearly identifies items as vital, essential, or nonessential (VEN analysis), would assist all stakeholders to better manage drugs. A national quantification exercise involving all the critical clinical programs and vertical programs should be facilitated by a task team led by MOHSW, with the pharmaceuticals directorate assuming the role of secretariat.
- Urgent attention also needs to be placed on the facilities' timely payment to NDSO, as this has the biggest impact on the ability of NDSO to run efficiently. Key informant interviews at NDSO indicated that late disbursement of funds from district sub-accountancies resulted in NDSO failing to honor debts from its own suppliers.
- Professional practice regulation should be strengthened such that the technical quality of pharmaceutical services is ensured and sustained. This should involve collaboration between the PSL and the Lesotho Medical, Dental and Pharmacy Council, as well as the training institutions:

- *Rationalization of the pharmacy training curricula* toward national needs. This should involve assessment of curriculum relevance at the two training institutions. The PSL should take the lead role in this.
- *Strengthening professional practice regulatory frameworks.* This should involve urgent review of the current law that regulates pharmacy practice: The Medical, Dental and Pharmacy Order No 13/1970. The law needs to be revised to strengthen and better regulate pharmaceutical practice. Some of the key areas of weakness in the current legislative framework that would need urgent attention are the lack of clear regulatory structures within the current frameworks for pharmacy technicians and technologists; the lack of clear and concise accreditation guidelines for training programs; the lack of a framework for internship for pharmacy graduates; and the lack of a continuing education framework in relation to continued retention on the registers. The project is already rightfully under the stewardship of the Director General of Health Services, and the pharmaceuticals directorate, together with the PSL, should take an active role in the review of pharmaceutical components of the law.
- The HRH strategy should be implemented for deployment of pharmacy personnel to remote areas of the country, such that accessibility and quality of pharmaceutical services are equitable throughout the country.
- NSTGs and the NEML should be published and distributed efficiently and effectively throughout the country across all health care levels.
- In-service training and orientation programs should be established for prescribers and pharmacy personnel at all levels of health care throughout the country. The monitoring, evaluation and reporting component of these programs should be quite robust so as to inform forward decision-making processes in terms of standardization and rationalization of treatment.
- An assessment of the MNP and its strategic action plan should be conducted. This assessment should give an indication of progress in terms of the planned activities for the sector.
- The central pharmacy administration needs to be strengthened by implementing the following:
 - Formalize the establishment of the post of the director of the department of pharmaceuticals.
 - Allocate funds for the pharmaceuticals program.
 - Deploy appropriate number of human resources to the directorate.
 - Provide training and manpower development, as well as mentoring and succession plans.
- The process of assessing curriculum relevance needs to be expedited in order to facilitate production of pharmacy personnel who are appropriately trained and prepared to address the critical needs of the sector.
- Improve management of transport at the district level

6.2.4 GOVERNANCE RECOMMENDATIONS

- Implement a results-based strategic planning process for the health sector, which includes the participation of representatives from the lowest levels of the health

system, vulnerable groups, NGOs, CSOs, and donors active in health service delivery. This strategy should be linked to country priorities identified through a criteria-based participatory process, a sound situational and response analysis, and realistic cost estimation. This strategy should then feed into a rational budget allocation and donor coordination process. The JANS tool⁵⁸ is available for health strategy guidance through the International Health Partnership website⁵⁹.

- Enhance civic engagement by strengthening the capacity of chiefs, CSOs, NGOs, and community councilmen to advocate on behalf of their constituents, members, and clients. Although this is happening somewhat through the Global Fund activities, a round 10 Global Fund HSS proposal could request funds for health sector CSO/NGO strengthening to complement existing disease-specific CSO/NGO strengthening already occurring in earlier Global Fund rounds.
- Strengthen the functions at the decentralized levels to communicate with community-level stakeholders about health issues/topics, as identified through community councils in the decentralization plans. Enhancing this information flow will not only enrich the discussions of client needs but will also enable the MOHSW to respond more quickly to service delivery challenges.
- Encourage stakeholder input into the planning and policymaking processes at the national and decentralized levels. More formalized health planning forums is one way to encourage stakeholder participation at the district level. Another would be to establish bylaws that include representatives from stakeholder groups to participate in inter-ministerial committees and reviews, such as the annual joint review.
- Conduct budget allocation to the districts based on a set criteria, taking into account population dynamics and needs as well as district health priorities. The DHMT structure needs to be strengthened to take on these planning and budgeting functions. Lesotho would benefit from allocating resources through a strategic planning process that takes into account the geographic distribution of the health system's needs.
- Empower and capacitate districts to take on their technical oversight role by providing them with staff, communication, and transportation resources to reach facilities on a regular basis.
- Pilot the provision of incentives for providers to improve service delivery in the areas in which HIS is stronger and the MOHSW and DHMTs are able to monitor health indicators.
- Increase information flow out of the ministry by making ministry policies, plans, and reports publicly available.
- Conduct review and update operational laws (i.e., 1970 Public Health Law).
- Ensure better and more systematic implementation of the public service code of conduct.
- Empower and capacitate the central level to take on its technical and policy oversight role.

⁵⁸ Joint Assessment of National Strategies.

⁵⁹ http://www.internationalhealthpartnership.net/en/about/j_1253621551.

6.2.5 SERVICE DELIVERY RECOMMENDATIONS

- Construct/rehabilitate maternity wards in all health centers.
- Strengthen referral system through installation/rehabilitation of telephone facilities in all health centers and in all ambulances.
- Conduct health sector reform and decentralization through the following:
 - Define and formalize the roles and responsibilities of the structures created by the health sector reform and decentralization processes.
 - Strengthen and formalize logistics, equipment, procurement, and maintenance policies.
- Formalize the roles of the health posts within the health system.
- Strengthen the leadership and management capacity of the health sector.
- Develop/strengthen internal performance assessment mechanisms.
- Develop/strengthen outreach programs in remote and hard-to-reach areas.
- Maintain an up-to-date national health facility inventory.
- Strengthen the integration of services within vertical programs, and between vertical programs and general health services.
- Standardize the role of the health post.
- Conduct high-level advocacy for health services.

6.2.6 HIS RECOMMENDATIONS

- Develop standard operating procedures/guidelines on health information management for facility- and district-level staff.
- Develop standardized training materials on management of health information to enable districts to provide step-down training to facility-based staff.
- Develop national standards for electronic HIS to ensure interoperability, data exchange, and national ownership. Information systems should be adaptable and extensible, and preferably should be an open source, easy to maintain in country, and capable of exchanging data with district- and national-level databases.
- Develop a national health information architecture or vision.
- Leverage the expansion of IT infrastructure (district networked to national backbone) to improve connectivity and facilitate transmission of data at facility level.
- Strengthen the routine HIS system at the district level and systematically use routine health data for quarterly and annual monitoring activities (versus engaging in parallel data collection efforts).
- Strengthen human resources (especially health information officers/statisticians) at the district levels.
- MOHSW should reinforce the policy that partners should not run their own vertical data systems but rather support the Ministry's HIS.

ANNEX A: METHODOLOGY NOTE

Description of the Facilities Sampled

The objective of the Lesotho Health System Assessment was to obtain data on health service delivery, health information systems, human resources, governance, pharmaceutical management, and health financing from a sample of hospitals and health centers in Lesotho. The sampling design adopted for the selection of the sample is described below.

Sampling Design

The target population for this survey is all hospitals and health centers in Lesotho.

The population consists of 21 hospitals and 195 health centers⁶⁰. The objective is to select a representative probability sample of hospitals and health centers. The sampling frame for the selection of the sample, which is a complete list of hospitals and health centers with information required for stratification of the population, was provided by the Lesotho MOHSW. Using this list for selection of a probability sample will lead to a known probability of selection for each selected hospital and health center.

To conduct a sampling design, it is necessary to have representation of hospitals and health centers from each of the 10 districts. Lesotho has 21 hospitals, with only one or two hospitals in some districts. Therefore, all 21 hospitals were included in the sample with certainty. A sample of 55 health centers was selected from the total health center population for a total sample of 76 health facilities. The sample size for health centers was determined based on the time and cost of collecting data from the health centers. The sample of 76 facilities will provide estimates of population percentages of characteristics of interest (yes/no type) with a margin of error of at least plus or minus 9.6 percentage points at a 95-percent confidence level.

For the selection of health centers, the population of health centers was stratified by districts and the total sample of 55 health centers was allocated to each district in proportion to the number of health centers in the population in that district. This allocation provided representation for each district in the sample and provided estimates for each district. Table A.1 shows the distribution of hospitals and health centers in each district in the population and the number of health centers to be selected from each district.

⁶⁰ Note: This number differs from the number in the health system overview. The sample was calculated based on an MOHSW health center estimate, which included 195 facilities and also included filter clinics.

TABLE A.1. DISTRIBUTION OF HOSPITALS AND HEALTH CENTERS BY DISTRICT

District	Total Number of Hospitals	Total Number of Health Centers	Number of Health Centers in the Sample	Total Sample Hospitals and Health Centers
Maseru	7	50	14	21
Berea	2	21	6	8
Leribe	2	27	8	10
Botha-Bothe	2	12	3	5
Mokhotlong	1	12	3	4
Thaba Tseka	2	17	5	7
Qacha's Nek	2	12	3	5
Quthing	1	9	3	4
Mohale's Hoek	1	15	4	5
Mafeteng	1	20	6	7
Total	21	195	55	76

Selection of Health Centers

In each district, a list of health centers was prepared. The size of the health center was not available but information on type was available. The list was sorted by type of health center. An equal probability systematic sample was selected. The size of the sample is as shown in Table A.1. Table A.2 shows the ownership of the facilities selected.

Sampling Weights

For producing population-based estimates and for all statistical analyses, each responding health center and hospital will be assigned a sampling weight. This weight combines a base weight and an adjustment for nonresponse. The base weight is the inverse of the probability of selection. All facilities selected with certainty like hospitals will be assigned a base weight of 1.00. The health centers will be assigned a sampling weight in each stratum based on the number in the population and the number in the sample. These weights should not differ very much because of proportional allocation of the sample.

These weights will be adjusted if there is any nonresponse to the survey.

Estimates at the national level will be obtained by aggregating the district level estimates

TABLE A.2. OWNERSHIP OF HOSPITALS AND HEALTH CENTERS INCLUDED IN THE HSA SAMPLE

District	Number of Hospitals (all sampled)	Ownership of Hospitals				Number of Health Centers in the Sample	Ownership of Facilities Sampled			
		GOL	CHAL	Red Cross	Private		GOL	CHAL	Red Cross	Private
Maseru	7	4	2		1	14 (includes 1 GOL filter clinic)	4	5		5
Berea	2	1	1			6	2	3		1
Leribe	2	1	1			8	3	4		1
Botha-Bothe	2	1	1			3	2			1
Mokhotlong	1	1				3	1	1		1
Qacha's Nek	2	1	1			3	2	1		
Thaba Tseka	2		2			5	3	2		
Quthing	1	1				3	2	1		
Mohale's Hoek	1	1				4	3	1		
Mafeteng	1	1				6	3	2	1	
Total	21	12	8	0	1	55 (28% of total health centers)	25 (29% of total GOL)	20 (28% of total CHAL)	1 (25% of total RC)	9 (26% of total private)

ANNEX B: LIST OF NATIONAL-LEVEL KEY INFORMANTS

TABLE B.I. NATIONAL-LEVEL KEY INFORMANTS

Organization	Interviewee #1	Title interviewee #1	Interviewee #2	Title interviewee #2
Association of Nurses	Lineo Malataliana	HR officer		
Baylor COE	Dr. E. Q. Mohapi	Executive Director	Dr. L.K. Thahane	Associate Director
Blue Cross	Matsepo Letlola	Director		
CDC	James Creighton	Country Director		
CHAL	Mrs. Ntholi	Executive Secretary	Bolila Ramashamole	Senior Economic Planner
Delegation of the European Union to the Kingdom of Lesotho	Dr. Amaury Hoste	Attaché (Operations)		
Development for Peace Education (DPE)	Mosala Mokhotlu	Community Animator		
Global Fund	Mrs. Nkhala Sefako	National Coordinator Global Fund	Mr. Mokhothu Makhamanyane	Deputy National Coordinator
Health Systems Strengthening (HSS) Project	Dr. Kelello Lerotholi	Decentralization Advisor		
HSS/HMIS	Dr. Kelello Lerotholi	Decentralization Advisor		
ICAP	Dr. Raphael Ntuny	Country Director	Danielle Morris	Program Coordinator
Irish Aid/DFA	Dr. Semakaleng Phafoli	Programme Advisor	Ms Mapaseka Selikane	Economic Advisor
Irish Aid/DFA	Edward Nko	Governance Advisor		
Irish Ambassador/Donor Partner Coordination Forum	Paddy Fay	Ambassador, Embassy of Ireland	Patrick Curran	Head of Development
Enhancing Strategic Information (ESI)	Keke Ntoi	HMIS officer		
Lesotho Council of NGOs	Sekonyela Mapetja	Grants Manager		
Lesotho Flying Doctors	Linda Morakabi	Nursing Officer	Thapelo Phomane	Public Health Nurse
Lesotho Medical Association (LMA)	Dr. C.K. Hoedofia	President of the LMA		
Lesotho Medical Dental Pharmacy Council (LMDPC)	Dr. 'Musi Mokete	Chairperson	Deborah Ntsaba	Registrar
Lesotho Nursing Council	Tlaleng Mabereng Elizabeth Letsie	Councilor	Flavia 'Mamohapi Moetsana-Poka	Registrar

Organization	Interviewee #1	Title interviewee #1	Interviewee #2	Title interviewee #2
Lesotho Planned Parenthood (LPPA)	Dan Mofokeng Makhetha	Chief Executive	Malineo Lebina	Monitoring & Service Delivery Coordinator
Mamoth - Insurance	Mpho Ramokgopa	Managing Director	Thato Moshoeshoe	General Manager
MCA Project Implementation Unit (MCA-PIU)	Tsepang Mohlomi	Chief Executive Officer		
Millennium Challenge Account (MCA) Lesotho	Morongoenyane Tlali	HSS Coordinator		
Millennium Challenge Corporation	Gene MacDonald, PhD, MPH	Resident Country Director		
Ministry of Local Government and Chieftainship	Mapitso Panyane	Principal Secretary		
Ministry of Finance	Mr. Griffiths Thakhisi	Budget Officer/Health Desk Officer		
MOHSW Bureau of Statistics	Ms. Malehloa	Economics Department		
MOHSW Clinical Services	Dr. McPherson	Director, Clinical Services		
MOHSW Decentralization	Mpopo Tšoele	Health Decentralization Coordinator		
MOHSW Department of Health Planning and Statistics	John Nkonyane	M&E team leader		
MOHSW Department of Health Planning and Statistics	Mrs. Mahlapane	M&E lead, HIV/AIDS directorate		
MOHSW Department of Health Planning and Statistics	Ms. Mahlape	Chief Statistician (HMIS)		
MOHSW Director General	Dr. Mpolai Moteetee	Director General of Health Services		
MOHSW Director of Health Planning and Statistics	Mrs. Makhakhe	Director of Health Planning and Statistics	Dr. Kyaw Thin	Public Health Specialist
MOHSW Directorate of Pharmaceuticals	Mrs. Masoko Ntšekhe	Director Pharmaceuticals		
MOHSW Drug Regulation Unit	Mrs. Lirontšo Matšoara	Head: Drug Regulation Unit		
MOHSW Finance	Mrs. Thato Mokhutšoane	Finance Manager	Mr. Mmolaoa Maqhama	Financial Controller
MOHSW HR Staff (HRH Presentation & Discussion)	MOHSW/HRH Staff			
MOHSW Public Private Partnership Coordination	Mathuntsane Mohapi (Zondy)	Public-Private Partnership Coordinator		

Organization	Interviewee #1	Title interviewee #1	Interviewee #2	Title interviewee #2
MOHSW Quality Assurance	Dr. Tetteh	Director of Quality Assurance		
MOHSW STI/HIV/AIDS Department	Ms. Maud B. Boikanyo	Director, SHAD		
Pharmaceutical Society of Lesotho	Ms. Teboho Khelesi	President		
National AIDS Commission Lesotho (NAC)	Motlalepula Shadrak Khobotlo	Director of Policy Strategy and Communication	Nthathi Lebona	Section Head, Stakeholders, Coordination & Support
National Drug Services Organization (NDSO)	Matebele G. Sefali	General Manager	T. Khetsekile	Procurement Manager
National Drug Services Organization (NDSO)	N. Leopa	Quality Assurance Manger		
National Health Training College (NHTC)	Me' Nthabiseng Molise	Director		
National University of Lesotho (NUL)	A. Ranotsi	Dean, FOHS	Momo Tlali	Lecturer, Head of Pharmacy
National University of Lesotho (NUL)	Patrick Gwambi	Department of Environmental Health		
Partners in Health (PIH)	Dr. Hind Satti	Country Director		
Southern Africa Human Capacity Development Coalition (SAHCD)	Dr. Phiny Hanson	Country Director		
UNFPA	Dr. Lillian Dipuo Marutle	UNFPA Representative	Nestor Owomuhangi	International Program Specialist
United States Ambassador	Robert Bernard Nolan	Ambassador of the United States of America	Elizabeth C. Power	Deputy Chief of Mission
USAID/PEPFAR	Tsenolo Moruthoane	Strategic Information officer		
WHO	Angela Benson MD, MPH	WHO Representative Lesotho	Mr. Mohlakola Hlabana	Health and Environment Officer

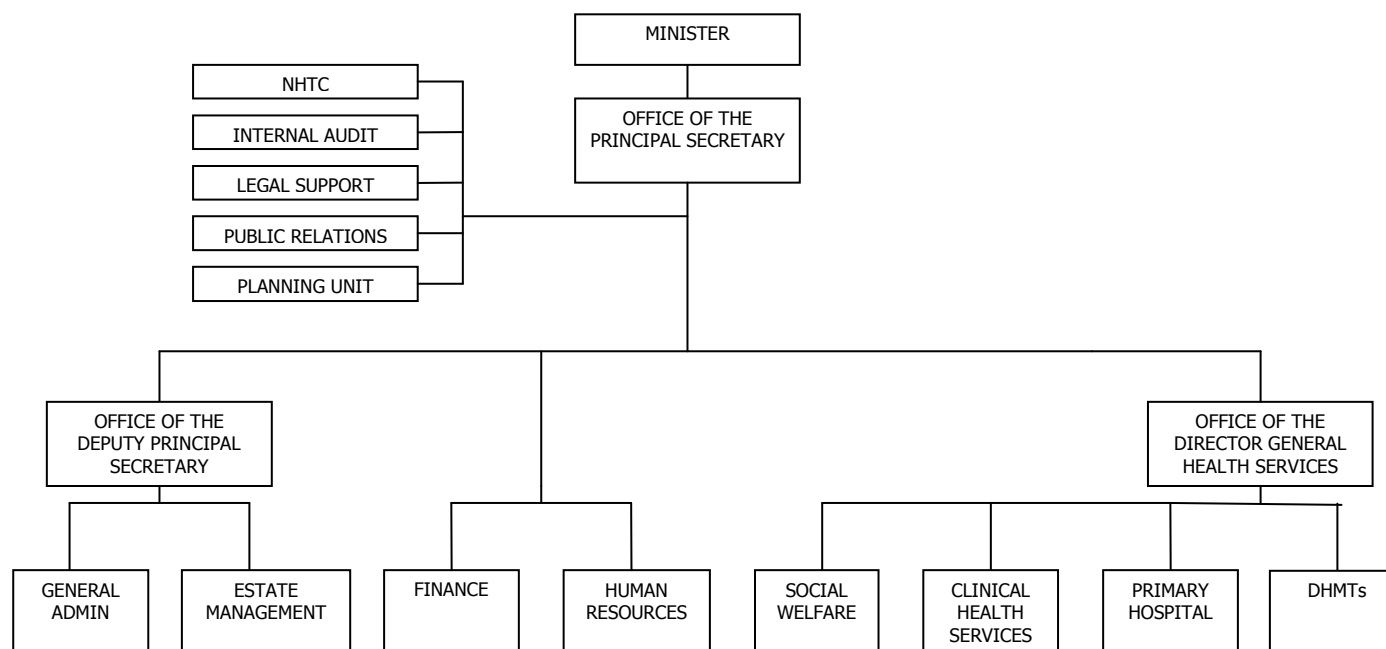
TABLE B.2. FACILITIES VISITED

District Name	Facility Name	Ownership	Facility Type
Berea	Mabote	GOL	Filter Clinic
Berea	Maqhaka	CHAL/Catholic	Health Center
Berea	St. Theresa	CHAL/Catholic	Health Center
Berea	St. Magdalena	CHAL/Catholic	Health Center
Berea	Pilot	GOL	Health Center
Berea	Willes Hospital	Private	Hospital
Berea	Maluti	CHAL/Seventh Day	Hospital
Berea	Berea	GOL	Hospital
Bothe Bothe	Motete	GOL	Health Center
Butha-Buthe	Thusanang	Private	Health Center
Butha-Buthe	Ngoajane	GOL	Health Center
Butha-Buthe	Butha-Buthe Hospital	GOL	Hospital
Butha-Buthe	Seboche	CHAL/Catholic	Hospital
Leribe	Fobane	CHAL/Seventh Day	Health Center
Leribe	Seshote	GOL	Health Center
Leribe	Matlameng	GOL	Health Center
Leribe	Pontmain	CHAL/Catholic	Health Center
Leribe	St Anne	CHAL/Catholic	Health Center
Leribe	Springfield	Private	Health Center
Leribe	Little Flower	CHAL/Catholic	Health Center
Leribe	Palama	GOL	Health Center
Leribe	Motebang	GOL	Hospital
Leribe	'Mamohau	CHAL/Catholic	Hospital
Mafeteng	Malelea	GOL	Health Center
Mafeteng	Tsakholo	GOL	Health Center
Mafeteng	Samaria	CHAL/Catholic	Health Center
Mafeteng	Thaba-Tsoeu	GOL	Health Center
Mafeteng	St Andrews	CHAL/Catholic	Health Center
Mafeteng	Mafeteng Hospital	GOL	Hospital
Maseru	Likotsi	GOL	Filter Clinic
Maseru	LCS (prison HC)	GOL	Health Center
Maseru	NUL	Private	Health Center
Maseru	SDA (Seven Day Adventist)	CHAL/Seventh Day	Health Center
Maseru	Masianokeng	Private	Health Center
Maseru	Molopi	Private	Health Center
Maseru	Tsepang		Health Center
Maseru	Matube	Private	Health Center
Maseru	St. Leo	CHAL/Catholic	Health Center
Maseru	St. Peter Claver HC	CHAL/Catholic	Health Center
Maseru	Thamae	GOL	Health Center
Maseru	Matukeng	CHAL/Bible Convent	Health Center
Maseru	Likalaneng	GOL	Health Center
Maseru	St. Joseph	CHAL/Catholic	Health Center
Maseru	Kena	Red Cross	Health Center
Maseru	Mohlomi	GOL	Hospital

District Name	Facility Name	Ownership	Facility Type
Maseru	Queen II	GOL	Hospital
Maseru	Makoanyane	GOL	Hospital
Maseru	Botsabelo	GOL	Hospital
Maseru	St. Joseph's	CHAL/Evangelical	Hospital
Maseru	Scott Hospital	CHAL/Catholic	Hospital
Mohale's Hoek	Lithipeng	GOL	Health Center
Mohale's Hoek	Mpharane	GOL	Health Center
Mohale's Hoek	Ha-Tsepo	CHAL/Catholic	Health Center
Mohale's Hoek	Ntsekhe	GOL	Hospital
Mokhotlong	Linakaneng	GOL	Health Center
Mokhotlong	St Martins Health Centre	CHAL/Catholic	Health Center
Mokhotlong	Naleli (Letseng Diamond Mine Clinic)	Private	Health Center
Mokhotlong	Mokhotlong Hospital	GOL	Hospital
Qacha'Nek	Machabeng hospital	GOL	Hospital
Qacha's Nek	Hermitage	CHAL/Catholic	Health Center
Qacha's Nek	Mohlapiso	GOL	Health Center
Qacha's Nek	Melikane	GOL	Health Center
Quthing	Maqokho	GOL	Health Center
Quthing	St. Mathews	CHAL/Catholic	Health Center
Quthing	Mphaki Clinic	GOL	Health Center
Quthing	Quthing	GOL	Hospital
Thaba Tseka	Paray School of Nursing	CHAL/Catholic	Hospital
Thaba-Tseka	Khohlo-Ntso	GOL	Health Center
Thaba-Tseka	Auray clinic	CHAL/Catholic	Health Center
Thaba-Tseka	Bobete	GOL	Health Center
Thaba-Tseka	Popa	CHAL/Anglican	Health Center
Thaba-Tseka	Paray	CHAL/Catholic	Hospital
Thaba-Tseka	St. James Mission Hospital	CHAL/Anglican	Hospital

ANNEX C: MOHSW ORGANOGRAM

FIGURE C.1. ORGANOGRAM OF THE MINISTRY OF HEALTH AND SOCIAL WELFARE



ANNEX D: DONOR ASSISTANCE FOR HEALTH

TABLE D.I. DONOR ASSISTANCE FOR HEALTH*

Donor	Field of Intervention/ Activities	Timeline/ Duration	Amount/ Commitment	Project Location	Counterpart
USG (PEPFAR)	PMTCT	2009-2010	\$2,935,000	National level	Implementing partners
	Sexual Prevention	2009-2010	\$2,120,000		
	Blood Safety	2009-2010	\$200,000		
	Male Circumcision	2009-2010	\$1,000,000		
	Counseling and Testing	2009-2010	\$2,650,000		
	Adult Care	2009-2010	\$1,675,500		
	Pediatric Care	2009-2010	\$272,000		
	TB/HIV	2009-2010	\$2,175,000		
	OVC	2009-2010	\$1,475,000		
	Adult Treatment	2009-2010	\$483,000		
	Pediatric Treatment	2009-2010	\$302,000		
	Laboratory	2009-2010	\$2,220,000		
	Strategic Information	2009-2010	\$2,020,000		
	HSS	2009-2010	\$5,577,075		
	Management and Operations	2009-2010	\$1,595,425		
	PEPFAR Total, fiscal 2009	2009-2010	\$26.7M		
	Projected PEPFAR, fiscal 2010	2010-2011	\$29M	National level	Implementing partners
USG (MCC)	Health Sector Project (HSS, infrastructure development and health care waste management) (5-year total \$1.22B)	2010	\$24M	National level	MOHSW
		2011	\$20M		
		2012	\$14M		
World Bank	HIV	2010	\$12M	National level	MOFDP
	Health	2010	\$5M		
Global Fund	Round 6 – TB	Year 3 2009/2010	\$1M	National level	
	Round 7 – HIV/OVC	Year 2 2009/2010	\$5.75M	National level	
	Round 8 (from round 5) – HIV/HSS	Year 1 2010	\$25M	National level	
	Round 8 – TB	Not signed	\$25M (requested, life of grant)		
	Round 9 – HIV/OVC	Not signed	\$30.7M (requested, life of grant)		

EU	Empowerment of OVC	2007-2011	12,000,000€	National level	Implemented by the department of social welfare with assistance from UNICEF
	Empowering people with disabilities		675,000€	National level	Skillshare, through the GOL
	Community-based care for PLWHA		744,000€	Berea and Leribe districts	German Red Cross with Lesotho Red Cross
	Food security activities for households affected by HIV and AIDS		570,000€	Berea and Leribe districts	Red Cross
	Enabling/supporting women and OVCs to access resources for HIV prevention and mitigation		750,000€	National level	CARE
UNICEF	HIV	2010	\$2,905,020	National level	
GTZ	HIV	2010	\$250,000		
WHO	Communicable Diseases (EPI, Polio, surveillance, outbreak response, neglected diseases,	2010-2011	\$1,017,000	National level and district level	Biennium plan of action with MOHSW
	HIV/TB	2010-2011	\$379,000		
	Chronic noncommunicable diseases	2010-2011	\$58,000		
	Reproductive, Maternal and Child Health	2010-2011	\$1,239,100		
	Emergency Preparedness	2010-2011	\$744,900		
	Health Promotion	2010-2011	\$87,000		
	Health data	2010-2011	\$32,600		
	Environmental Health	2010-2011	\$52,000		
	Nutrition and Food Safety	2010-2011	\$86,000		
	Service Delivery	2010-2011	\$330,000		
	Pharmaceutical Management	2010-2011	\$73,000		
	WHO TOTAL Fiscal 2010	2010-2011	\$4,098,600		
Irish Aid	CHAL District Health Services	2009	50,000€	District level	MOHSW
	DHS	2009	200,000€	National level	MOHSW
	HRH	2009	600,000€	National level	MOHSW
	Access to HIV/AIDS services in the health sector	2009	3,500,000€		Clinton Foundation

*Information collected through key informant interviews and project and program documents

ANNEX E: HEALTH SYSTEMS INDICATORS DATABASE DATA NOTES

NOTES:

** Averages are not calculated due to small sample size of the annual DHS data.

NC: Not Calculated because the regional comparator includes both high-income countries as well as some countries that have a population of less than 30,000, which are not classified by the World Bank.

--: Data Not Available

- : No specific year is noted here since the average is calculated across different countries, where the data are reported in different years

5- Estimates derived by regression and similar estimation methods for the following countries: Afghanistan, Albania, Algeria, Angola, Armenia, Bhutan, Bolivia, Botswana, Burundi, Cape Verde, Comoros, Congo, Cote d'Ivoire, Democratic Republic of Korea, Democratic Republic of Congo, Djibouti, Dominican Republic, El Salvador, Equatorial Guinea, Fiji, Gambia, Georgia, Ghana, Guinea Bissau, Indonesia, Iraq, Kazakhstan, Kyrgyzstan, Lao People's Democratic Republic, Lebanon, Lesotho, Liberia, Libyan Arab Jamahiriya, Maldives, Mozambique, Myanmar, Namibia, Nicaragua, Niger, Nigeria, Oman, Pakistan, Papua New Guinea, Senegal, Sierra Leone, Solomon Islands, Somalia, South Africa, Sudan, Swaziland, Syrian Arab Republic, Tajikistan, Timor-Leste, Turkey, Turkmenistan, United Arab Emirates, Uzbekistan, Viet Nam.

6- Ranges from -2.5 to 2.5. Higher values indicate better governance ratings.

7- Percentile rank indicates the percentage of countries worldwide that rate below the selected country (subject to margin of error)

10- The interpretation of the first six indicators in the HIS component is not based on the indicator's value but on the timeliness of reporting. It should be noted that timeliness is not the only one criterion for measuring the quality of data. Other criteria, not included here, are data collection quality, periodicity of measurement, consistency of data, representativeness of data, disaggregation of data and data estimation methods. The indicators presented in HIS module are a selected group of indicators. A more extensive list was developed and is available in the following publication: Health Metrics Network. 2007. Framework and Standards for Country Health Information Systems. Second edition. Geneva: World Health Organization.

11- Timeliness is defined as "for the most recently published estimate, number of years since the data were collected." The standards for each indicator for timeliness of reporting were taken from the following source: Health Metrics Network. 2007. Framework and Standards for Country Health Information Systems. Second edition. Geneva: World Health Organization.

12- The timeliness standards set by the HMN for this indicator are highly adequate if 0-2 years; adequate if 3-5 years; present but not adequate if 6-9 years; not adequate at all if 10 years or more.

13- The timeliness standards set by the HMN for this indicator are highly adequate if less than 2 years; adequate if 2 years; present but not adequate if 3-4 years; not adequate at all if 5 or more years.

14- The HMN does not provide a standard for timeliness of reporting of the number of hospital beds. Instead, the standard for when the national database of facilities was last updated was used: highly adequate if less than 2 years; adequate if 2-3 years; present but not adequate if more than 3 years; not adequate at all if there is no national database or if no data are available.

15- The HMN does not provide a standard for timeliness of reporting of contraceptive prevalence. Instead, the standard for timeliness of reporting of condom use with higher risk sex was used: highly adequate if 0-1 year; adequate if 2-3 years; present but not adequate if 4 years or more; not adequate at all if there are no data.

16- The HMN does not provide a standard for reporting of percentage of surveillance reports received at the national level from districts compared to number of reports expected. Instead, the standard for a percentage of districts submitting weekly or monthly surveillance reports on time to the next higher level was used: highly adequate if 90 percent or more; adequate if 75 percent-89 percent; present but not adequate if 25-74 percent; not adequate at all if less than 25 percent. This indicator is used by the HMN to assess the dimension of Capacity and Practices (Defined as: Does capacity in country exist to collect the data, and analyze and manage the results? Are standards applied for data collection? Is documentation available, accessible and of high quality?) of the Health and Disease records (including disease surveillance systems).

** Averages are not calculated due to small sample size of the annual DHS data.

Source: Health Systems 20/20 Health Systems Database (<http://healthsystems2020.healthsystemsdatabase.org/>)

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