



Government of Lesotho

LESOTHO

Health Sector Strategic Plan 2012/13-2016/17

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LIST OF ABBREVIATIONS

ARI	Acute Respiratory Infection
ART	Antiretroviral Therapy
CHAL	Christian Health Association of Lesotho
CPR	Contraceptive Prevalence Rate
DHMT	District Health Management Team
DHMIO	District Health Management Information Officer
DMO	District Medical Officer
EMU	Estate Management Unit
GDP	Gross Domestic Product
GoL	Government of Lesotho
HMIS	Health Management Information System
HRH	Human Resources for Health
HRMIS	Human Resources manage Information System
HSS	Health Systems Strengthening
HSSP	Health Sector Strategic Plan
ICT	Information Communication and Technology
IMR	Infant Mortality Rate
LDHS	Lesotho Demographic and Health Survey
LNSP	Lesotho National Strategic Plan
LRCS	Lesotho Red Cross Society
MAF	MDG Accelerated Framework
MCA	Millennium Challenge Account
MCST	Ministry of Communication, Science and Technology
MDG	Millennium Development Goals
MDR	Multi-Drug Resistance
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoU	Memorandum of Understanding
MMR	Maternal Mortality Rate
MTEF	Mid Term Expenditure Framework
NEPI	Nursing Education Partnership Initiative
NGO	Non-Governmental Organisation
NHTC	National Health Training Institute
NMR	Neonatal Mortality Rate
NSTG	National Standard Treatment Guidelines
OPD	Outpatient Department
PAU	Project Accounting Unit
PSC	Public Service Commission
PHC	Primary Health Care
PPP	Public Private Partnership
QA	Quality Assurance
RCU	Research Coordination Unit
SACU	Southern Africa Customs Union

STI Sexually Transmitted Infection
SRH Sexual and Reproductive Health
TFR Total Fertility Rate
U5MR Under five Mortality Rate
VCT Voluntary Counselling and Testing
VHW Village Health Worker
WHO World Health Organisation

1. INTRODUCTION

1.1 Population, geography and administrative system of Lesotho

Lesotho is a small, mountainous and landlocked country situated in Southern Africa and is entirely surrounded by the Republic of South Africa. The country is divided into 10 administrative districts with a total area of about 30,355 square kilometres as shown below:

Figure 1: Map of Kingdom of Lesotho



Less than 10% of the land is arable and the country is divided into four ecological zones: Lowlands, Foothills, Mountains, and Senqu River Valley. The mountainous terrain that characterises Lesotho makes ground travel very difficult. Nearly all of Lesotho's people are Basotho and Sesotho and English are the national languages for the country. Lesotho is predominantly a Christian country and 90% of its population are Christians.

According to the 2006 Population and Housing Census the population of Lesotho was estimated at 1.8 million and 26.9% of the population live in urban areas. The four largest districts of Maseru, Leribe, Berea and Mafeteng hold 62.2% of Lesotho's population and this need to be taken into consideration in allocation of resources. There are more females in Lesotho at 54% compared to males at 46%. Forty percent of the people in Lesotho are under the age of 15 years and 7% are aged 65 years and over. Under-fives constitute 24% of Lesotho's population while those under one constitute 11.8% of the

population. It is estimated that 21.8% of Lesotho's population are adolescents. The 2009 Lesotho Demographic and Health Survey (LDHS) found that 36% of the households are headed by women.

1.2 Educational attainment

The literacy rate among women in urban areas is estimated at 98.8% and in rural areas at 96%. The corresponding proportions among men are 93.8% and 75.8%, respectively. Nearly 15% of the people of Lesotho have never gone to school and there are more men at 17.3% than women (6.7%). It is estimated that 5% of the women and 15% of the men aged 6 and above have not been to school. This demonstrates that in Lesotho women are more likely to attend school compared to men. Ninety four (94%) of the children of primary school age attend school. The introduction of free and compulsory primary education has improved enrolment and in 2010 school completion rate was estimated at 87.5%. A significant proportion of the Basotho people, especially men, are illiterate and this might impact on the implementation of the strategic plan mainly because men are the decision makers in most households. The level of education is an important determinant of health seeking behaviour as demonstrated in the 2009 Lesotho Demographic and Health Surveys (LDHS) in which prevalence of diseases such as diarrhea and acute respiratory infections (ARIs) decreases the higher the educational attainment.

1.3 Lesotho's economy

With a Gross National Income per capita of 1,055 US dollars, the country was ranked number 156 out of 177 in the 2009 Human Development Index. Lesotho's GDP per capita is estimated at US\$516.00 and real per capita GDP growth averaged 3.3% over the period 1991-2007. It is estimated that 50% of the population of Lesotho live below the poverty line. Lesotho's economy is largely influenced by its location with respect to South Africa which supplies 80% of imported goods and purchases about 25% of Lesotho's exports. The migration of the Basotho people to South Africa for jobs is quite common and remittances constitute a significant source of income for Lesotho. This has, however, fallen sharply as the number of mine workers has dropped from 120,000 in the 1980s to less than 50,000 now¹. Customs revenue from the Southern African Customs Union (SACU) and the sale of water to South Africa constitute major sources of income for Lesotho. While SACU is a major income source this again is being threatened with decline. The economy also relies on a small manufacturing base and the rapidly expanding apparel industry as well as on subsistence agriculture especially cattle. Over the years the contribution of the agricultural sector to Lesotho's GDP has been declining from about 24.5% in 1982/83 to 13.1% in 2010/11. While agriculture still plays an important role, Lesotho's economic growth will significantly be driven by the growing mining industry and the textile and garment manufacturing initiatives currently being implemented.

¹ GoL. (2012). *Lesotho national strategic development plan 2012-2017*. Maseru: GoL

2. Lesotho's health system

2.1 Background to the development of the health sector strategic plan

As early as 2000 the Government of Lesotho (GoL) recognized that while gains had been achieved in the health sector these were however being eroded. A number of reasons were given at the time for the erosion of these gains and these included the general lack of a comprehensive and clear policy framework, the lack of appropriate management and planning expertise, insufficient financial and human resources, fragmented and uncoordinated delivery of health services, the advent of the HIV and AIDS epidemic (exacerbated by the resurgence of tuberculosis) and high population growth rate. The health sector reforms were therefore designed in order to achieve sustainable increases in access to quality health care services at all levels and achieve universal coverage and equity in the process. In order to achieve this GoL aspired to strengthen the institutional capacity of the MoH to effectively deliver the health services including expansion of HIV services to all people in Lesotho². The achievements during the health sector reforms period are described elsewhere in this document. The development of the Health Sector Strategic Plan (HSSP) 2012-2017 building on the initiatives of the health sector reforms implemented in Lesotho between 2000 and 2011. The development of this strategic plan has been largely informed by the Ouagadougou Declaration on PHC and Health Systems in Africa which calls on African Countries to rededicate themselves to PHC as a model to delivering health services.

2.2. Lesotho's health care system

2.2.1 Health services delivery

The MoH is the line GoL Ministry that is responsible for health issues in Lesotho including the development of health policies, development of standards and guidelines, mobilization of health resources and monitoring and evaluation of health sector interventions. It is also responsible for providing a legal framework within which health services are delivered. The process of decentralization however has not made significant progress and this has affected delivery of services. In order to successfully implement the strategic plan there will be a need to effectively implement the Decentralisation Plan developed by the MoH in 2005 which provides guidance on what it implies to decentralize health services delivery.

2.2.2 Levels of health care

The delivery of health services in Lesotho is done at three levels namely primary, secondary and tertiary levels. There are 372 health facilities in Lesotho: 1 referral hospital, 2 specialty hospitals, 18 hospitals, 3 filter clinics, 188 health centres, 48 private surgeries, 66 nurse clinics and 46 pharmacies. Health centres are the first point of care and this is aimed at making the patient load at district and referral hospitals lighter. In total 213 of these facilities belong to MoH and Christian Health Association of Lesotho (CHAL).

² Ministry of Health. (2012). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

Forty two percent (42%) of the health centres and 58% of the hospitals are owned by the MoH. Thirty eight percent (38%) of the health centres and the same proportion (38%) of the hospitals are owned by CHAL. The remaining facilities are privately owned. About 90% of the private for profit health facilities are situated in the four large districts of Maseru, Berea, Mafeteng, and Leribe³. There are non-governmental organizations (NGOs) which provide health services. These include (i) Lesotho Planned Parenthood Association which has nine clinics located in urban centers around Lesotho; (ii) Lesotho Red Cross Society (LRCS) which operates four clinics; and (iii) Population Services International (PSI) operates five voluntary counseling and testing (VCT) centers⁴.

2.2.2.1 Primary or community level

The primary level of health care includes health centres, health posts and all community level initiatives including all staff working at this level. This network of clinics each serves between 6,000 and 10,000 people provide basic health services. These facilities are staffed by clinicians, nurses or nursing assistants who diagnose and treat common conditions⁵. The GoL and CHAL health centres provide services free of charge after the abolition of user fees in 2008 which has subsequently led to a significant increase in the utilization of health services by clients. CHAL provides services to at least 30% of the population and its facilities are situated in remote rural areas where coverage by public facilities is limited. There is a Memorandum of Understanding (MoU) between CHAL and MoH which aims at harmonizing service provision, provide salaries and user fees and the need for GoL to register and certify CHAL facilities⁶.

At community level there is also a network of more than 6,000 village health workers (VHWs) who man health posts. There are also other categories of community-based health workers such as traditional birth attendants, community based condom distribution agents and water minders⁷. VHWs are volunteers and receive an incentive from the GoL. They mainly provide promotive, preventive and rehabilitative care. Nurses at health centres supervise and train VHWs. VHWs also organize health education gatherings and immunization efforts within the communities they serve. The link between community and health centres provided by VHWs has remained informal despite their huge contribution. The VHWs program is coordinated by the Division of Family Health at the MoH headquarters⁸. Inadequate funding and acute shortage of health personnel to adequately train and supervise VHWs has hampered the growth of this community initiative⁹. VHWs refer cases to health centres. Health centers are the first point of professional care.

³ Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010*. Maseru: Ministry of Health and Social Welfare.

⁴ Ministry of Health. (2009). *National Reproductive Health Commodity Security Strategic Plan 2008-2012 for Lesotho*. Maseru: Ministry of Health.

⁵ Ministry of Health. (2012), *National Tuberculosis and Leprosy strategic plan 2013-2017*. Maseru: Ministry of Health.

⁶ Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010*. Maseru: Ministry of Health and Social Welfare.

⁷ Ministry of Health. (2012), *National Tuberculosis and Leprosy strategic plan 2013-2017*. Maseru: Ministry of Health.

⁸ Ministry of Health and Social Welfare. (2011). *National health policy*. Maseru: Ministry of Health and Social Welfare [Still in Draft Form].

⁹ Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010*. Maseru: Ministry of Health and Social Welfare.

2.2.2.2 District or secondary level of care

In each district there is a district hospital which is a referral facility for all health centres in the district. In Maseru, however, there is no district hospital hence the National Referral Hospital also acts as a district hospital and congestion of clients is inevitable. Clients who go to the district hospitals to access services pay user fees. All the district hospitals, instead of offering specialized services, are still offering primary health care (PHC) services which are supposed to be offered by health centres and health posts. This is partly because those people living in towns do not have access to free primary level health services and they are accessing hospital services and hence they are paying. District hospitals refer cases to the National Referral Hospital for further management.

2.2.2.3 Tertiary level of health care

At tertiary level there is only one National Referral Hospital and two specialized hospitals namely Mohlomi Mental Hospital and Bots'abello Leprosy Hospital. If this does not work then patients are referred to South Africa for quaternary care through the national tertiary referral hospital. There are other specialized health care facilities like Senkatana for HIV and AIDS Management, Botšabelo for MDR TB and Baylor's Paediatric Centre of Excellence¹⁰.

3. SITUATION ANALYSIS

The Strategic Plan for the Health Sector Reforms covering the period 2000-2010 guided the implementation of various interventions in the health sector. This plan, however, expired in 2010 and initiatives to develop a successor plan started soon after it expired. The major concern of the MoH, development partners and stakeholders is that over the health sector reforms period instead of health indicators improving they actually worsened and it is only now that some of the indicators are picking up. This section looks at the status of the health of the people of Lesotho starting with impact level indicators, then disease specific indicators and then health systems support interventions.

3.1 Impact level indicators

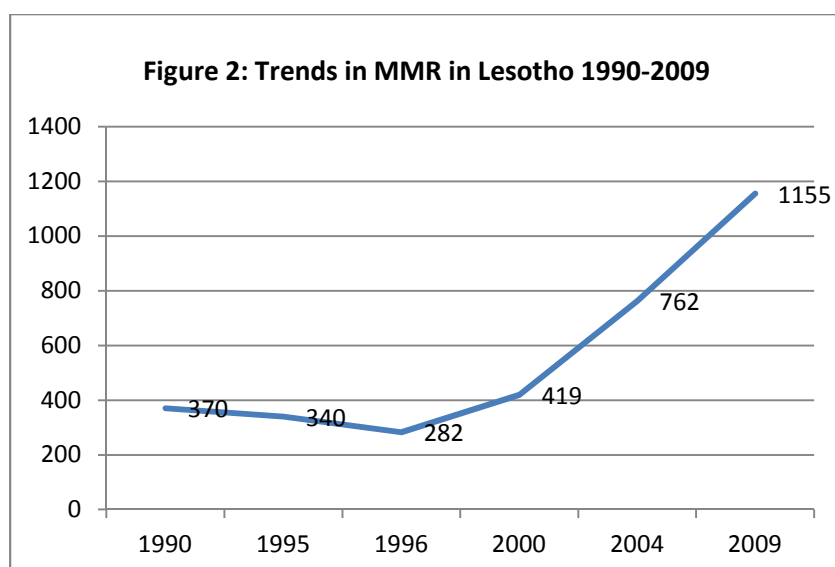
Life expectancy in Lesotho decreased from 50 years in 2000 to 47 years in 2008¹¹ and this, as is the case with other countries in Southern Africa, was mainly due to the HIV and AIDS epidemic. In terms of childhood mortality, the 2009 LDHS shows that infant mortality rate (IMR) in Lesotho was estimated at 94 deaths per 1,000 live births and this was an increase from 72 in 1996. Instead of going down the IMR increased and this was the first time for this to happen since 1986. According to the LDHS the increase in IMR was due to factors such as poverty, malnutrition and HIV. The under-five mortality rate (U5MR) was estimated at 71 in 2000 and this increased to 90 in 2004 and in 2009 it was at 117. The neonatal mortality rate (NMR) has also been increasing over the past decade or so: it was at 35 in 2000 and 2004

¹⁰ Ministry of Health. (2009). *National Reproductive Health Commodity Security Strategic Plan 2008-2012 for Lesotho*. Maseru: Ministry of Health.

¹¹ <http://apps.who.int/ghodata/>

and it increased to X in 2009. These trends in IMR and U5MR demonstrate that there is a need for further significant investments in child survival interventions in order for Lesotho to reach the MDG targets¹².

The total fertility rate (TFR) for Lesotho reduced from 4.1 to 3.5 between 1996 and 2006. The TFR in urban areas is lower at 2.1 compared to 4 in the rural areas. The contraceptive rate (CPR) for Lesotho has increased significantly from 37% in 2004 to 47% in 2009. This CPR is higher than most southern African countries with an exception of Zimbabwe (60%), Namibia (55%) and Swaziland (51%). The National Strategic Development Plan (NSDP) for Lesotho (2012-2017) puts a target for CPR as 80% in 2015; hence more efforts need to be made in order for this to be realised. Maternal mortality rate (MMR) has increased from 762/100,000 in 2004 to 1,155/100,000 live births in 2009. Figure 2 below shows the trends in MMR in Lesotho between 1990 and 2009:



With such trends in MMR it is unlikely that Lesotho will reach the MDG target of 300 by 2015¹³ unless significant investments are made in maternal health interventions. The main causes of maternal deaths in Lesotho are postpartum sepsis, complications of abortion, obstructed/prolonged labour, pre and eclampsia and haemorrhage¹⁴.

3.2 Progress in delivery of the Essential Services Package

One of the major reforms in the health sector was the removal of user fees in health centres belonging to CHAL and MoH in 2008. The average OPD contact per capita has increased because of removal of these user fees from about 0.5 in 2007 to 0.7 in 2009. This is well below the WHO norm of 3.5 visits per capita per year (Strachan 2007). The average bed occupancy rate in 2009 for GOL and CHAL hospitals

¹² Bureau of Statistics. (2010). *Lesotho demographic and health survey 2009*. Maseru: Bureau of Statistics.

¹³ GoL. (nd). *MDG acceleration framework Action Plan for Lesotho*. Maseru: GoL

¹⁴ GoL. (nd). *MDG acceleration framework Action Plan for Lesotho*. Maseru: GoL.

were 38% and 42% respectively. It is estimated that approximately 80% of the people of Lesotho live within two hours' walking distance of a fixed health facility. Access to such services is however made difficult due to the fact that much of the travel is over rough terrain. A good proportion of clients are satisfied with hospital services and those who are dissatisfied gave reasons such as long waiting time and unavailability of medicines¹⁵.

3.2.1 Childhood vaccinations

Lesotho has a comprehensive nationwide program which is being coordinated by the Expanded Program on Immunisation (EPI) in the Division of Family Health of the MoH. The 2009 LDHS reports that 62% of the children aged 12-23 months were fully vaccinated and this represented a decline from 68% in 2004. Fifty three percent (53%) of the children in this age group were vaccinated by their first birthday. Only 3% of the children had never been vaccinated. Coverage for individual vaccines is quite high for example for children aged 12-23 months 95% received BCG, 96% received DPT1 and for Polio 1 it was at 94%. What has been observed is that subsequent doses of DPT and Polio tend to drop off. The 2012 DQS also observed the declining trends in immunisation coverage which is a worrying trend¹⁶. The delivery of immunization services is mainly done at static clinics belonging to CHAL, LRCS and the MoH. The delivery of immunization services through outreaches is very limited. The MoH also arranges NIDs depending on availability of financial resources and the last one was conducted in 2010. Lesotho has also introduced the pentavalent vaccine and the GoL is planning the introduction of new vaccines namely pneumococcal vaccine in 2013 and rotavirus in 2014 which would require additional storage space.

3.2.2 Acute respiratory infections

Pneumonia is major cause of hospital admissions and deaths among under five children in Lesotho. The proportion of children with ARIs two weeks prior to the surveys increased from 6% to 19% between 2004 and 2009. About 66% of the children who had ARIs in 2009 were taken to a health facility. The prevalence of ARI is linked to the mode of cooking used in households. Forty four percent (44%) of the households in Lesotho use firewood to cook and there are more households in rural areas at 60.4% who do this compared to urban areas at 5.2%. Fifty eight percent of the households use solid fuels for cooking and 79.5% in rural areas do this compared to urban areas at 6.8%. The proportion of children with ARIs is highest at 10% among children living in households that use animal dung for cooking and this is followed by those who use wood/straw at 6.2%. The majority of the households use solid fuels which put children at higher risk of ARIs if the rooms are not well ventilated.

3.2.3 Diarrhoeal diseases

Diarrhoea is the second common cause of admissions among children under the age of 5 years. Eleven percent (11%) of the children were reported to have some form of diarrhoea 2 weeks prior to the survey

¹⁵ MoH 2010. Annual Joint Review Report 2009/10 FY

¹⁶ Ministry of Health. (2012). *Lesotho in-country RED DQS training and DQS*. Maseru: Ministry of Health.

in 2009. Of those who reported having had diarrhoea 53% were taken to health facilities and 18.3% received no treatment. The prevalence of diarrhoeal diseases is closely linked with availability of safe water and access to sanitary facilities. In 2009 76.7% of the people of Lesotho had access to improved sources of water. More people in urban areas at 90.1% have access to improved sources compared to rural areas at 72.5%. In terms of sanitation facilities it is estimated that 33% of the households in Lesotho do not have toilets. There are more households in rural areas (44.9%) who have no toilets compared to urban areas at 4.4%. It is also estimated that 24% of the households have improved sanitation facilities while 43% have non-improved facilities¹⁷.

3.2.4 Malnutrition

The problem of malnutrition remains high in Lesotho. Thirty nine percent (39%) of the children aged less than 5 years are stunted and 15% of the children are severely stunted. Females (35%) are less likely to be stunted compared to males (43%). The prevalence of stunting among under five children has remained stable since 2004.

3.2.5 Maternal health

One in 32 women in Lesotho dies of pregnancy and child birth related conditions¹⁸ and such deaths can be avoided. The antenatal care coverage by skilled providers increased slightly between 2004 and 2009 from 90% to 92%, respectively. The coverage is higher in rural areas at 95.7% compared to urban areas at 90.5%. In 2004 52.4% of the pregnant women delivered in a health facility and this increased to 58.7% in 2009. Most women delay in initiating attendance at ANCs and about 9% do not attend ANCs at all¹⁹. The proportion of pregnant women delivering in health facilities was 85.6% and 50.5% for urban and rural areas, respectively. In 2004 it was estimated that 55% of the pregnant women delivered with assistance of skilled personnel and this increased to 62% in 2009. Fifty one percent (51%) of these deliveries were done by nurse midwives. A significant proportion of pregnant women (23%) delivered with assistance from relatives, other people or without any assistance at all. With regard to coverage of tetanus toxoid, the 2009 LDHS shows that 60% of the pregnant women received 2 or more doses of tetanus toxoid vaccine during the last pregnancy. This figure did not change since 2004. The coverage of these maternal health interventions is inadequate.

3.2.6 Family planning services

The knowledge about family planning among persons aged 15-49 is almost universal: 98% of both men and women know at least 1 method of family planning. Male condoms constitute the most widely known method of family planning. Among women the most commonly used contraception are the injectables (19%), pill (13%) and male condom (9%). There is significant unmet need of contraception as indicated in the 2009 LDHS which found that more than 20% of the currently married women in Lesotho

¹⁷ This refers to a piped source within the dwelling or plot, public tap, tube well or borehole, protected well or spring, or rainwater.

¹⁸ GoL. (nd). *MDG acceleration framework Action Plan for Lesotho*. Maseru: GoL.

¹⁹ GoL. (nd). *MDG acceleration framework Action Plan for Lesotho*. Maseru: GoL.

have an unmet need for family planning. The LDHS also reports that 58.8% of the women did not want to have anymore more children. Therefore there is need to increase the availability of family planning services to reach the 80% MDG target as stipulated in the MDG accelerated framework Action Plan for Lesotho²⁰.

3.2.7 Adolescent health

Adolescents constitute 21.8% of the total population in Lesotho and they experience a lot of challenges. By the age of 17 years 50% of adolescents have already started sexual activities. Teenage pregnancy is estimated at 25%²¹. The 2009 LDHS found that among never married women aged 15-19 who reported they had had sex within the past 12 months, 62.3% said they used condom at last sex and the corresponding proportion among men was 62.5%. According to MoH 16.7% of all hospital deaths for females aged over 14 years were due to abortion complications. Facility based surveys indicate that 13% of all abortion cases were among adolescents. Rape is quite common among adolescents: one study showed that 53% of all inpatients attended were adolescents that had been raped. This demonstrates that adolescents experience a number of sexual and reproductive health challenges which need to be addressed.

3.2.8 Major communicable diseases

3.2.7.1 Tuberculosis

Tuberculosis is a major communicable disease in Lesotho. The TB incidence in the world estimated at 696 tuberculosis²² patients per 100,000 populations. In 1990 the prevalence of tuberculosis was at 75/100,000 in 1990 and this increased to 454/100,000 by 2009. The case detection rate for tuberculosis in Lesotho is estimated at 72% against a WHO target of 70%. The target for treatment of notified TB cases is 85%. There was an increase in treatment success rate from 47% to 74% in 2008 and in 2009 it dropped to 70%. The treatment target rate of 85% has never been reached in Lesotho. The country has achieved universal facility coverage with TB DOTS services. The failure to reach this target has been attributed to patient deaths, defaulting, failure, transfers and cases that were not evaluated. Seventy eight percent of the individuals with tuberculosis were also tested for HIV. Challenges in the fight against tuberculosis in Lesotho remain²³.

3.2.7.2 Sexually transmitted infections including HIV and AIDS

The prevalence of HIV in Lesotho is still high at 23% among persons aged 15-49. This is a slight drop from 26% in 2004. There are approximately 290,000 people living with HIV in Lesotho and 138,500 are in

²⁰GoL. (2013). *MDG acceleration framework Action Plan for Lesotho*. Maseru: GoL.

²¹Ministry of Health. (2006). *National adolescent health policy*. Maseru: Ministry of Health.

²²WHO Report 2011 Global Tuberculosis Control. Surveillance, Planning, Financing. Geneva. 2011

²³Ministry of Health. (2012), *National Tuberculosis and Leprosy strategic plan 2013-2017*. Maseru: Ministry of Health.

need of treatment²⁴. In 2009 HIV prevalence among women was higher at 27% compared to men at 18%. HIV prevalence among men is higher in urban areas at 21% compared to rural areas at 17% and the corresponding proportions among women are 31% and 25%, respectively. The HIV prevalence among ANC clients is 27.7% and it is 54.5% among STI clients. Among youth aged 15-24 9.3% are HIV positive and the prevalence among females is higher at 13.6% than men at 4.2%. There are an estimated 62 new HIV infections and about 50 deaths due to AIDS each day in the country²⁵. There are 21,000 new adult infections and new infection among children each year in Lesotho. In terms of HIV transmission the modes of transmission data shows that the bulk of new infections (48.5%) are likely to come from individuals with one sexual partner²⁶.

The 2009 LDHS found that 66% of the women and 37% of the men reported having ever been tested and there were no differences between rural and urban areas. A total of 737,813 people aged 12+ were tested in 2009. In 2009 1,442,427 male condoms and 82,044 female condoms were distributed in Lesotho. In 2009 71.6% of women attending ANCs received ARV prophylaxis and HAART. Ninety percent of the women attending ANCs had tested for HIV. In 2009 186 health facilities were providing PMTCT services from 37 facilities in 2006²⁷. The number of people enrolled on ART in 2009 was 49,642 and 7% of these were children aged less than 14 years. By end of 2009 62,190 adults and children had been enrolled on ART²⁸. HIV remains a leading cause of institutional deaths among both men and women in Lesotho. Other sexually transmitted infections (STIs) remain among the top 10 causes of OPD attendance and in 2009 of the 1,321,838 new OPD contacts 69,093 (5.2%) were STI clients. This was a decrease from 119,539 clients in 2008. In 2010 there were 85,962 STI clients in Lesotho²⁹. The 2009 LDHS found that 4% of the men and women who have ever had sex reported having had an STI 12 months prior to the survey. These figures demonstrate that STIs are a major public health problem in the country.

3.2.8 Non-communicable diseases

Just like other countries in Southern Africa, Lesotho is experiencing a double burden of both communicable and non-communicable diseases (NCDs). The STEPS survey published in February 2013 identified a significant proportion of people with high blood pressure and some of these are not even on medication. Thirty one percent (31%) of the participants in this survey had raised BP and this was higher among women at 35.6% compared to men at 26.3%. These were on medication. The prevalence of smoking was also quite high at 24.5% and among males it was at 48.7% while among women it was 0.7%. In terms of drinking alcohol 48.1% of the respondents were identified as life time abstainers: there were more females (65.3%) compared to males at 30.6%. About 31% of the respondents were currently drinking alcohol; 47.3% were males and 14.4% were females. About 35% engage in heavy episodic drinking while 9.4% of the females do this and Lesotho has just developed a national alcohol policy.

²⁴ MoH. (2011). *Strategic plan for elimination of mother to child transmission of HIV and for paediatric HIV care and treatment*. Maseru: MoH.

²⁵ Ministry of Health. (2012), *National Tuberculosis and Leprosy strategic plan 2013-2017*. Maseru: Ministry of Health.

²⁶ Ministry of Health. (2011). *National HIV and AIDS Strategic Plan 2012-2017*. Maseru: Ministry of Health.

²⁷ Ministry of Health. (2011). *National HIV and AIDS Strategic Plan 2012-2017*. Maseru: Ministry of Health

²⁸ Ministry of Health. (2011). *National HIV and AIDS Strategic Plan 2012-2017*. Maseru: Ministry of Health

²⁹ Ministry of Health. (nd). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

Drinking of alcohol is associated with an increased risk of chronic diseases, acute health conditions including injuries and road traffic accidents.

Lastly 41.5% of the respondents were overweight and more women were overweight at 58.2% compared to males (24.8%). These figures generally show that NCDs are a major public health problem in Lesotho³⁰. Another significant NCD in Lesotho is mental health. In 2007/08 60,696 mental health patients were seen at OPDs and 2,081 were new cases, 19,488 were relapses, 33,907 came as follow ups, and 5,220 were defaulters. Between 2007 and 2010 epilepsy and schizophrenia were the top two mental disorders reported at OPDs in Lesotho. The delivery of mental health services is mainly hampered by the shortage of human resources and other challenges include lack of funds, shortage of transport for community services, lack of equipment and the poor conditions of Mental Health Observation and Treatment Units at most hospitals³¹. These challenges need to be addressed in order to improve service delivery.

3.2.9 Gender based violence

Wife beating to some extent is acceptable to both men and women and there are a number of situations when this is acceptable. According to the 2009 LDHS the most commonly accepted reason for wife beating were as follows: 27% of the women and 34% of the men said wife beating was acceptable if the wife was arguing with her husband; 24% of the women and 31% of the men said that this is acceptable if the wife neglected the children; and 14% of the women and 24% of the men said that this was acceptable if the wife went out without informing her husband. Only 15% of the men felt that it is justifiable if a man beat his wife after refusing him sexual intercourse. While data on prevalence of gender based violence is scarce, it seems that gender based violence is common in Lesotho. One recent study found that 31% of health providers saw victims of assault and domestic violence at least weekly while more than 50% saw such cases at least once monthly. The challenge however is that most health workers did not have training on how to care for victims of gender based violence³².

3.3 Health systems challenges

3.3.1 Medicines and medical supplies

The National Drug Services Organization (NDSO) is responsible for the procurement, storage, and distribution of medicines and other health and medical supplies for CHAL and GoL but it also serves private health facilities and pharmacies. The NDSO delivered orders to the main hospitals and these have the responsibility of distributing medicine to the health centres. The lack of transport and other administrative problems sometimes deterred hospitals from delivering medicines to health centres; hence creating shortages at health centre level. Although staff from the MoH report that drugs, as

³⁰ Ministry of Health. (2013). *Lesotho STEPS Survey 2012: fact sheet*. Maseru: Ministry of Health

³¹ Ministry of Health. (nd). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

³² Pentj, B. and S. Malope. (2012).

Sexual Assault & Gender Based Violence in Lesotho: Survey results of healthcare providers experience dealing with victims of gender-based violence. Maseru: WONCA Conference.

contained in the MoH Essential Medicines List (EML), are in most cases available in the health facilities, a 2012 evaluation of the health sector reforms found that there were two major challenges namely that a shortage of drugs and supplies still prevail in most health facilities in Lesotho mainly due to maladministration and, secondly, the critical shortage of pharmacy staff particularly at the district level and PHC level. . At health centres in 2010 key tracer items for obstetric care were out of stock for more than 6 months on average and ARVs for more than 5 months³³. As a result of shortage of staff waiting times for obtaining medication was exceedingly long. These challenges have also been reported at recent Annual Joint Reviews (AJRs) organized by the MoH.

MCA has constructed new health facilities in Lesotho but the major problem is that there is no adequate space for pharmaceuticals: storerooms are small and not according to specifications. The other problem is that there are inadequate management systems in the medicines supply chain and that some Departments with MoH do request medicines without even consulting the Pharmacy Division which is supposed to know so that it can plan how these drugs shall be managed. The 2010 HSS report also found that the National Standard Treatment Guidelines (NSTGs) are not widely used for training and supervision of requisite health personnel. NSTGs and other key documents in the pharmaceutical sector are also not regularly updated. Other challenges include weak procurement systems, inadequate supportive supervision for facilities, non-adherence to guidelines for donations of medicines and poor adherence to standard treatment guidelines. Currently there is no a medicines regulatory authority in Lesotho which can monitor and regulate the procurement and distribution of medicines. There is also lack of quantification skills by health facilities resulting in orders that are simply estimates. The 2009 AJR also showed that the warehousing facilities were still inadequate and needed further expansion³⁴.

3.3.2 Human resources for health

Lesotho faces an acute human resource for health (HRH) crisis. No recent data exists on HRH in Lesotho as acknowledged by MoH staff during consultations. In terms of HRH, there are 8,600 personnel working in the health sector: 44% work in the formal sector comprised of GOL, CHAL, NGOs (such as LRCS), and the private health sector³⁵; 75% work in government, 22% in CHAL, and 3% in NGOs and the private-for-profit sector. A third of MoH labour force consists of support staff. Nurses constitute 73.3% of the workforce in MoH followed by physicians at 6% with other health cadres constituting a low percentage of the workforce. While there is a general shortage of staff, it should be emphasized that Lesotho generally experiences an acute shortage of specialized health cadres. Professional council such as the Lesotho Nursing Council and the Medical, Dental and Pharmacy Council also generally lack appropriate staffing levels for them to carry out their work of ensuring that professional health workers carry out their work professionally. The Nurses Council also faces challenges in areas of capacity for developing coherent regulatory and administrative systems and ensuring competency based curricula for nurses and midwives³⁶.

³³ Ministry of Health and Social Welfare. (2010). *Lesotho health system assessment 2010*. Maseru: Ministry of Health and Social Welfare.

³⁴ Ministry of Health. (nd). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

³⁵ Ministry of Health. (2005). *Human resource strategic plan 2005-2025*. Maseru: Ministry of Health.

³⁶ Ministry of Health. *Lesotho nursing and midwives strategic plan 2011-2016*. Maseru: Ministry of Health.

At community level there are Village Health Workers who in 2004 constituted 56% of total formal and informal health sector and these provide first line of contact for basic health care services. Inadequate funding has decreased level of GoL led training of VHWs since the 1990s. Such trainings are now being conducted on an ad hoc basis by NGOs and other stakeholders. The ratio of doctors to population is at 0.5 per 10,000 population while that of nurses is at 6.2 per 10,00 population. Both ratios are far below the WHO Afro region of 2.4 and 10.9, respectively³⁷. On average, Lesotho's total health workforce is equivalent to a third of the African average (.850/1000 versus 2.626/1000). There is maldistribution of the health workforce: less than 20% of the health workforce is employed at PHC level even though 60% of health care are delivered at that level; 46% of the formal sector labour force is employed at the secondary level and 24% at the tertiary level. District and lower level facilities are severely understaffed: for example at district hospital level only 50% of their nursing requirement is filled and for filter clinics only 31% of them had full time equivalent personnel they required. This generally demonstrates that there is gross shortage of HRH in Lesotho especially at district and lower levels. It seems that the MoH has not engaged adequately with PSC to create additional positions at district level. The absence of incentive to attract health workers to hard to reach areas is a challenge as well.

In terms of production of HRH, there is no medical school currently in Lesotho. All doctors are being trained outside the country. There are health training institutions owned by GoL and CHAL. The National Health Training College (NHTC) offers training programs at diploma level in the areas of nursing, environmental health, medical laboratory technology and pharmacy. It also offers certificate level course in nursing assistance and auxiliary social work. The post basic courses are in psychiatric mental health³⁸, ophthalmic nursing, anesthetic nursing³⁹, dental therapy⁴⁰, midwifery and nurse clinicians⁴¹. All the 4 CHAL health training institutions offer nursing courses. Most programs' intake is about 20 students but the general nursing program enrolls between 40 and 60. The total enrolment is at approximately 500. The major challenges as mentioned by NHTC include lack of facilities for practical training, inadequate classrooms and lack of examination halls. The MoH may demand that the NHTC increase intake but they are limited by classroom space. There is only one teaching hospital which has the capacity to host students on internship. While health training institutions produce about 40 nurses, recruitment of these nurses is really a challenge as the process is long. Library space at the NHTC is limited and needs expansion including improving staffing levels. There will therefore be a need to strengthen health training institutions for them to produce adequate and quality health workers.

A number of organizations are currently involved in strengthening and expanding the training of health workers for example the Nursing Education Partnership Initiative (NEPI) is helping the GoL to transform nursing education to address critical shortage of HR in order to improve health related MDGs. These initiatives aim at providing quality nursing education, increasing enrolment and that nursing education should address priority health conditions in Lesotho.

³⁷ Ministry of Health. (2012). *National Strategic Development Plan 2011/12-2015/16*. Maseru: Ministry of Health.

³⁸ Currently not running but will start again in future.

³⁹ This is a new program.

⁴⁰ This will start soon.

⁴¹ The NHTC has just restarted this programs.

3.3.3 Laboratory services

Laboratory services in the health sector remain grossly understaffed and laboratory personnel who are specialized are very few in the system. As a result of this shortage, at health centres level health centre staff collect specimen for processing at the district hospital. In addition to lack of personnel, there are interrupted supplies of commodities and some gaps are being filled by development partners who purchase laboratory reagents among other things. As far as large laboratory equipment is concerned, the MoH rents such equipment. There is, however, a shortage of small equipment at all levels and this affects the effective delivery of laboratory services. Maintenance of such small equipment is also a challenge for the MoH. Over the years the laboratory section has mainly focused on clinical side and not much is being done for public health services.

3.3.4 Quality assurance

The MoH aims at providing quality health care at all levels for the benefit of all people in Lesotho. In order to achieve this the GoL designed a certification and accreditation system for quality assurance (QA). All standards, indicators and methods of scoring were approved by the MoH's QA committee and MoH for use in district hospitals and health centers in Lesotho. All GoL and CHAL facilities meeting the standards are certified. Two certification/accreditation surveys have been carried out in CHAL and GoL facilities. Eleven domains are used in order to assess whether a facility should be accredited or not and an overall threshold of 80% must be attained for certification. A QA policy and a QA strategic plan have been developed. While a QA Unit has been established to monitor compliance of health facilities to established standards, there are challenges that are being experienced and these include shortage of funding, lack of transport to visit health facilities, shortage of staff, shortage of office space and that a lot of authorised structures have not been put in place making difficult for the Unit to run as well as implement its activities⁴².

3.3.5 Infrastructure and equipment

Although no significant change has occurred in the number or relative accessibility of health facilities, efforts are underway to further improve the existing structure through an extensive, MCC-supported renovation and construction activity. The major expectation is that the MoH will be able to maintain and repair these facilities as need arises. With decentralization, health centres are now under local government. However, the challenge is that local governments do not have the capacity for repair and maintenance of health centres. Technicians from MoH are still being used. These technicians are only in district hospitals and they have to oversee that all satellite clinics are being maintained. As is the case with other programs in the MoH the Estate Management Unit (EMU) is understaffed and most of its personnel are on contracts. The EMU therefore lacks the institutional capacity to manage infrastructure

⁴² Ministry of Health. (2012). *Quality assurance in the health sector strategic plan 2012-2017*. Maseru: Ministry of Health.

planning, programming, design, procurement and maintenance⁴³. The infrastructure needs assessment was conducted in 2004 and it is based on this that the MCA and other development partners are basing their support. Staff accommodations, while being addressed by MCA, a short fall still exists.

The equipment assessment was done in 2005. MCA is supplying new equipment to all the health centres they are constructing or refurbishing but the gaps in hospitals remain. In several financial years over the health sector reform period, the budget available for maintaining and purchasing new equipment was unable to cover costs. There is also a problem in that the MoH does not have personnel who can competently maintain specialized equipment. For example there are no people who can maintain dental equipment and when a machine breaks down it takes a long time to be repaired; hence affecting service delivery. A number of departments also mentioned that they do not have vehicles or the vehicles they have are quite old. They fail to provide services for example at community level or supportive supervision is not being done according to schedules or they fail to mentor people at lower levels because of lack of transport.

2.3.6 Health financing

There are two major sources of funding for the health sector namely the GoL and development partners. Other funds come from out of pocket direct payments to health services providers and contributions to private health insurance schemes and some employees also enjoy insurance schemes arranged by their employers. Lesotho allocates a significant proportion of its financial resources to the health sector. Between 2004/05 the GoL spent 7.7% of its GDP on health and this is above WHO Afro region average of 5.6% in 2006. Over the same period GoL spent US\$54.6 per capita per annum which was also above the US\$34 per capita per annum recommended by WHO for providing a minimum package of cost effective interventions in African countries.

With such levels of funding GoL therefore has the capacity to provide quality health care services to its people. The concern is that while GoL invests heavily into the health sector these levels of funding have not translated into positive health outcomes. Over the period 2004/05-2009 the GoL expenditure on health as a percentage of total GoL expenditure averaged 9.6% and this reached 14% in 2010/2011 which demonstrates that Lesotho is one of the countries which have made a lot of progressing towards reaching the 15% Abuja target. The GoL is a major source of health financing contributing 60.7% of total health spending between 2004/5 and 2008/9. This is followed by private sources namely households and companies at 25.1% and donors ranked third at 14.2%. Government expenditure as a percentage of total health expenditure averaged 43.9% over the period 2004/5-2008/09. Out of pocket spending as a percentage of private health spending has been estimated at 95.7%. Health services at health centre level are provided free of charge and this is one way that encourages people to go to facilities where services are free as compared to hospitals where people pay user fees.

⁴³ Ministry of Health. (nd). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

Currently Lesotho does not have a Medium Term Expenditure Framework (MTEF) as the last one expired in 2011. The GoL plans to develop another MTEF in the 2013/2014 financial year. While resources in the health sector appear to be adequate for provision of a basic package the last MTEF showed that there was a funding gap of M5 billion (about US\$59 million); hence support from donors is required. It should be mentioned that Lesotho has never conducted a National Health Accounts; there is therefore a need that such an activity should be done regularly in order to know the flow of resources within the health sector. There is also a need for GoL to explore the establishment of a national social health insurance scheme. The other challenge is that while the MoH can budget at the end of the day the Ministry of Finance sets a ceiling for each GoL ministry and department hence cuts are done in line with the ceiling; hence budgets are based on ceiling and not on planned activities.

3.3.7 Monitoring and evaluation

Lesotho developed the National HMIS Policy in 2003 and has just drafted an HMIS Strategic Plan covering the years 2-13-2017. The collection of data is guided by the National Statistics Act (2001). Lesotho's HMIS is a hybrid with a mix of integrated and stand-alone data systems. The integrated HMIS software is a web-based system hosted by Ministry of Communications, Science and Technology (MCST). The system is accessible by all Districts⁴⁴. The MoH and CHAL, which account for 95% of service provision, collect routine data from facilities using an established Health Management Information System (HMIS) using standard registers and forms. Data from the community level including from health posts is sent to health centres where all data from its catchment area is aggregated and sent to the DHMT. While VHWs play an important role in collecting data at community level they frequently run out of forms and they lack transport and communication; hence they report data quite late. With support from development partners some health centres have data entry clerks whose responsibility is to aggregate data at these health centres. The data sent to the DHMT from health centres is in paper form and it is entered at the district level into a web-based data entry template. The District Health Management Information Officer (DHMIO) is responsible for managing data at the DHMT and submitting it to the MoH headquarters. The data excludes vertical data such as tuberculosis, HIV and EPI as separate data collection systems exist for each one of these. Quarterly reports are produced and shared in the health sector and that at the end of the year an annual joint review meeting is conducted where progress in the implementation of interventions in the health sector are shared and discussed. As a way of monitoring and evaluation of progress in the health sector, the DHS is conducted after every 4 years.

The major challenge experienced in the running of the HMIS is lack of human resources at health centre, district as well as at central level. This system is mostly being run by temporary staff. Currently 4 districts have vacant positions of DHMIOs and it is taking long for these positions to be filled. There is a need to have more than one person at the DHMT level to deal with data workloads so that when one leaves there should be continuity and the capacity to handle all data. Data verification at facility and at the DHMT is not being done due to inadequate staffing levels. There are challenges with data accuracy and

⁴⁴ Ministry of Health. (2013). Health management information system strategic plan 2013-2017. Maseru: Ministry of Health.

in some cases data is not even available. Other challenges include untimely reporting of data from lower levels, existence of poor data analysis and use culture and existence of parallel data collection system which places a lot of pressure on the few HRH which are there⁴⁵.

3.3.8 Supervision

The HSS project together with MoH developed supportive supervision manuals together with checklist tools that people at different levels can actually use when they go for supervision⁴⁶. Although these manuals exist some MoH headquarters did mention that such tools either are old or do not exist demonstrating lack of awareness of the tools that were recently developed. Informants in the MoH did mention that the conduct of supportive supervision is haphazard, not integrated and each department plans for supervision on its own. There is also lack of the conduct supportive supervision and the MoH staff added that health workers at lower levels also complain that they are not being supervised adequately. The other challenge is that the Lack of adequate manpower both at central and district levels have in many occasions hampered program implementation and supervision even when funds are available.

3.3.9 Research

A Research Coordination Unit has been established in the MoH whose responsibility is to coordinate research. A strategic plan to guide the conduct of research in Lesotho has been finalised. A National Research Ethics Committee and National Institutional Review Boards have been established. This Unit currently does not have a budget for research and it relies on other programmes and the staffing levels are low. Research skills in the Unit are also limited. The Unit has not yet started monitoring the conduct of approved studies mainly due lack of staff levels as well as financial constraints. Results of studies done in Lesotho sometimes are not communicated back to stakeholders. Program managers in the health sector at all levels also lack skills to conduct research that would be meaningful to addressing problems prevailing in the health sector. There is also lack of capacity at national and district level to use existing data to inform programming and policy. In addition to this, the MoH does not have a library in which documents and research reports can be deposited. Currently there is no national health research agenda which can guide the type of research that the MoH and stakeholders can conduct to inform policy and programming. Lastly there is no institution dedicated to health research in Lesotho.

3.3.10 Partnerships and donor coordination

A number of public private partnerships have been formed during the health reform period. These include the partnership between MoH and CHAL and LRCS in which user fees at health centre level have been abolished, the provision of a grant to *purchase* services from CHAL and the use of a common quality assurance system to accredit health facilities. A PPP has also been signed for the management of the National Referral Hospital. The GoL has also partnered with the private sector to implement the

⁴⁵ Ministry of Health. (nd). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

⁴⁶ Ministry of Health. (2012). *Annual report 2011-2012 HSS project*. Maseru: Ministry of Health.

DOTS program and offer ART services. These partnerships are informal due to absence of a public-private partnership (PPP) framework for the health sector. There is currently no policy or strategic plan guiding the public private partnerships in Lesotho's health system. However a PPP Unit has been established within the MoH which coordinates PPP activities. The challenge however is that partnerships with NGOs have not been explored to support health promotion at community level.

An MoU between MoH and South Africa has been signed strengthening collaboration with South Africa on cross-border referrals, HIV/AIDS and disease surveillance. For development partners a common funding mechanism has been developed that enables major partners to channel their financial support through the Project Accounting Unit (PAU) using the GOL disbursement and procurement procedures in line with the Accra Agenda. A lack of institutional structures or guidelines for partnership coordination or collaboration between the MoH and its partners impelled this reform area.

3. Policy context

3.1 National policy and legal context

A Public Health Bill including regulations has been drafted and awaits enactment by Parliament. This Bill provides for the establishment of the national health system in Lesotho and has been discussed widely among different stakeholders including at cabinet level. Once this Bill is passed there will be adequate legal environment for the provision of health services in Lesotho. In terms of policy, Lesotho has the National Health Policy approved in 2012 which guides the implementation of interventions in the health sector. There are also policies that have been developed by individual departments within the MoH and these include the Quality Assurance Policy, the Adolescent Health Policy, Mental Health Policy, the EPI Policy and the National Medicines Policy. Some of these policies need to be revised as they have outlived their life spans.

3.2 International and regional policies

Lesotho is a signatory to a number of international conventions and declarations. For example the country signed the 2000 Millennium Declaration and the country has an obligation to report on the progress it is making in terms of achieving the MDG targets by 2015. For health related MDGs, it is evident that Lesotho is off track in achieving reduction of child mortality, improving maternal health and combating AIDS and tuberculosis. Other health related international agreements that Lesotho has signed include the Abuja Declaration, Libreville Declaration on Health and the Environment, the Paris Declaration on Aid Effectiveness and the Accra Agenda for Aid Effectiveness and the Ouagadougou Declaration on Primary Health Care (PHC) and Health Systems in Africa. The Ouagadougou Declaration calls for rededication of African countries to PHC as a strategy for delivering health services as promoted by the World Health Report of 2008. While Lesotho is committed to achieving the targets challenges remain as discussed in Chapter 3 of this strategic Plan.

4. The process of developing the health sector strategic plan

This HSSP covering the period 2012-2017 is a successor plan to the 2000-2010 National Health Sector Plan which expired in 2010. The process of developing this strategic plan started towards the end of 2010 with the formation of a Technical Working Group to work on the development of the National Health policy and the Health Sector Strategic Plan. This process involved interviewing key informants, the review of relevant literature. All the major stakeholders in the health sector including development partners, civil society organizations and the private sector were involved in these consultations. By early December 2010 draft versions of the National Health Policy and the National Health Sector Plan were produced. The National Health policy was completed in 2012.

In April 2012 the process of developing the Health Sector Strategic Plan re-started. Even though a lot of consultations were done in 2010 there was a need for more consultations and these were made with the members of staff in the MoH, development partners, CHAL and health training institutions. Literature was also reviewed and the documents that were reviewed included monitoring and evaluation reports, the AJR reports produced for the health sector, some evaluations conducted in the health sector for example the impact of health sector reforms, the 2009 LDHS, health sector policies and strategic plans from different departments and Units in the MoH, the LNSD, the MDG acceleration framework for Lesotho and the Framework for the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems in Africa among others. A stakeholders' meeting was held on 16th April 2013 at the MoH to discuss the Draft Strategic Plan. Comments from this meeting were incorporated into the Plan.

5. Some lessons from the Health Sector Reforms 2000-2010

While the health sector reforms were aimed at addressing the critical shortage of HR in the sector among other things, this objective was not met; hence it affected the implementation of other outcomes of the reforms. Chapter 3 clearly shows that key health indicators worsened over the period of the reforms. In summary it has been observed that that the reforms did not succeed: MMR and IMR increased over this period; tuberculosis prevalence increased; STI prevalence was stable; and HIV prevalence slightly decreased. The following recommendations have been made by the team that reviewed the health sector reforms:

- Human resource is still a major challenge which should be addressed and this would impact on service delivery. The HSR evaluation call for an assessment to be carried out that will clearly identify staffing needs in terms of positions that need to be filled, positions with high turnover and reasons for that, and positions currently funded by donors. The assessment should also look at evaluating staff in terms of skills and knowledge.
- Salary scales should be reviewed and incentives put in place for recruiting and retaining high quality staff and encouraging placement in rural areas.

- The MoH does not have a plan for absorbing staff being funded by development partners or health workers who have just finished their training programs; hence there is a need to develop and implement a health workers absorption plan for staff being funded by development partners as well as those who have just finished their trainings.
- There is a need to strengthen inter-sectoral collaboration with other government ministries and departments as well as NGOs.
- GoL should see to it that its strategic plans and policies are implemented and when need arises they are reviewed to attain expected outcomes.
- A client-centred approach to service delivery should be adopted.
- Service delivery protocols should be reviewed in order to prioritize client-centred practice over efficiency.
- The development of policies and programs should be strongly informed by research evidence and that strong leadership is a prerequisite for ensuring that research results are utilised.
- Decentralisation should be adopted as a way of improving health services delivery and strong management structures as recommended in the Decentralisation Plan for the health Sector should be put in place for effective decentralization.

While MoH and stakeholders developed the ESP challenges in the delivery of this package have also been noted and these include:

- Inadequate HR both in terms of skills and numbers.
- Inefficient human resource management system.
- Limited outreach facilities.
- Non-rational use of medicines due to lack of explicit policy guidelines and an efficient management system.
- The efforts of GoL and NGOs are not harmonized and well coordinated.
- Limited community participation in decision making in design and delivery of services.
- Centralised decision making processes.
- Incomplete data generated by the HMIS hence it cannot be used to inform decision making.
- Unregulated and unsupervised private health facilities posing a challenge to quality care.
- Lack of supportive supervision.

The development of the Health Sector Strategic Plan took into consideration these recommendations from the review of the health sector reforms.

6. SWOT Analysis

Table 1 below presents the strengths, weaknesses, opportunities and threats that might affect the implementation of health interventions as detailed in this strategic plan:

Table 2: SWOT analysis

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> ○ GoL strong track record of financing the health sector. ○ Availability of key documents for addressing HR issues. ○ Existence of basic infrastructure for all cadres except medical doctors. ○ Existence of VHWs to facilitate community participation. ○ Key documents such as HIV strategic Plan, TB strategic Plan, SRH Policies and strategic plans, Nutrition policy and plan are in place. ○ Restoration of health infrastructure is on-going. ○ The existence of the ESP. ○ The existence of a Public Health Bill. ○ Existence of HMIS, AJR and other mechanisms for collecting data. ○ Strong partnerships with health development partners. ○ Capacity to mobilize resources. 	<ul style="list-style-type: none"> ○ Low risk pooling mechanism with high household expenditures for health. ○ Low absorption capacity of budget. ○ Limited implementation of policies and plans such as the HRD strategic plan. ○ Weak coordination between MoH, PSC and health training institutions. ○ Weak regulatory frameworks for pharmaceutical commodities and professionals. ○ Low capacity to discharge procurement functions. ○ Inadequate replacement of VHWs in the past decade. ○ Absence of HSC to address HRH specifically. ○ Shortage of human resource and inequitable distribution. ○ Inadequate health service coverage and utilization. ○ Poor transport systems. ○ Weak M&E system and lack of utilization of data for decision making. ○ Non-implementation of decentralization.
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> ○ Substantial international good will to support the health sector. ○ Abolition of user fees in health centres. ○ Government's commitment to the health sector. ○ Strengthened governance through the decentralization process. ○ Existence of public-private partnerships in health service delivery. 	<ul style="list-style-type: none"> ○ The burden posed by HIV and AIDS and TB MDR. ○ Shortage of human resources. ○ High attrition of health personnel. ○ High level of dependency on expatriates in service delivery. ○ Climate change. ○ High levels of illiteracy among men.. ○ Donor dependency.

7. Health sector priorities

The following are the priorities of the health sector and this was arrived at by examining contributions to the heaviest burden of disease and periodically updated essential health package⁴⁷.

- HIV and AIDS care, treatment and prevention tops the list.
- TB detection and treatment.
- Raising and sustaining immunization.
- Managing childhood illnesses (neonatal conditions, ARI and diarrhoeal diseases).
- Ensuring safe motherhood, newborn, child and adolescent health.
- Addressing non-communicable diseases (hypertension, diabetes, trauma, heart disease and cancer etc)
- Sanitation and hygiene.
- Disease prevention through health education and promotion.
- Addressing severe health systems weaknesses.
- Making available strategic information.

8. VISION, GOAL, MISSION AND GUIDING PRINCIPLES OF THE PLAN

8.1 Vision

- To have a healthy population, living a quality and productive life by 2020.

8.2 Mission

- To enhance a system that will deliver quality health service efficiently, effectively, and equitably to all Basotho.

8.3 Goal

- To contribute to the attainment of improved health status and quality of life for socio-economic development of Lesotho.

8.4 Purpose

- To consolidate the health systems that will guarantee quality health care to the poor, vulnerable and disadvantaged.

8.5 Core Values

- The following are core values articulated in the Constitution of Lesotho, Vision 2020 and other International and Regional Conventions that guide the health sector policies:
 - Integrity
 - Responsiveness
 - Innovative
 - Public accountability

⁴⁷ This is from the National Health Policy (2012) Page 16.

- Commitment to high quality services

8.6 Guiding Principles

- **Political Commitment:** The GoL is committed to poverty reduction with emphasis on economic growth. This commitment will provide the critical guidance in priority-setting and resource allocation. Commitment to this policy will be required at all levels of political, civil and cultural leadership.
- **PHC Approach:** In accordance with Alma Ata declaration of 1979 and the Ouagadougou Declaration 2008, the Government of Lesotho shall provide essential health care services that are universally accessible and affordable to all Basotho. Emphasis will continue to be put on effective application of its principles and elements as well as Health Systems Strengthening.
- **Equity:** In accordance with the Constitution of Lesotho, all Basotho shall have equal access to basic quality health care services. Particular attention shall be paid to resource distribution patterns in Lesotho to identify and accelerate the correction of any disparities.
- **Accessibility and Availability:** Services shall be progressively extended to reach all communities in Lesotho. Special attention shall be given to the disadvantaged regions and underserved communities in the country. Services shall be community based taking into consideration special socio-cultural circumstances.
- **Affordability:** The Essential Health Package shall be free of charge or highly subsidized. Other services shall be obtained for a fee. The fee structures for such services shall take into consideration the wide range (variation) abilities of Basotho to pay. Alternative options for health financing shall be explored.
- **Community participation:** Communities shall be actively encouraged and supported to participate in decision-making and planning for health services. Through ownership of community projects, communities will be masters of sustainable primary health care programmes in their own areas.
- **Integrated Approach:** This lays the ground for a common approach and for a common front to improve the quality of life. The health sector will continue to use an integrated approach to service provision.
- **Sustainability:** The ability for a service to continue into the future is referred to as sustainability. New and ongoing programmes will be subjected to sustainability assessment.
- **Efficiency in use of resources:** As much as possible, resources shall be used where the greatest benefit to an individual or community is envisaged. Periodic cost- effectiveness analysis shall be carried out to identify cost effective interventions.

- **Inter-sectoral Collaboration and Partnership:** Government and non-Government sectors will be consulted and will be involved in the implementation, monitoring and evaluation of health service provision using effective collaborative mechanisms.
- **Quality:** Efforts will be made to ensure that all Basotho receive quality health care services. National norms and guidelines and standards of services shall be reviewed, formulated and applied to ensure that good quality services are provided.
- **Gender Balance:** Gender sensitivity and responsiveness shall be applied in health service planning and implementation. Special consideration shall be accorded to women due to their culturally constructed lower status in the society and their special role in reproduction. Where men have been disadvantaged, special effort will be made to support them.
- **Ethical consideration:** Health workers shall exhibit the highest level of integrity and trust in performing their work. They will observe ethical conduct guided by ethical guidelines as enforced by professional councils. Health service consumers and health workers shall be protected by legislation specifying their rights and channels of appeal. Both service consumers and providers shall be oriented to and shall apply the human rights based approach in health.
- **Evidence-based decision making:** The development and implementation of health interventions programs shall be based on research evidence, cost-effectiveness and where appropriate international best practice.
- **Decentralization:** In line with the Local Government Act health services delivery shall be delivered to the people of Lesotho using a decentralized approach where local governments shall be responsible for services delivery at district and lower levels.

9. EXPECTED OUTCOMES AND OBJECTIVES OF THE HSSP

9.1 Expected outcomes of the HSSP are as follows

- Reduced morbidity, mortality and human suffering among the people of Lesotho.
- Reduced inequalities in access to health care services.
- Strengthened health system.

9.2 Objectives of the strategic plan 2012-2017

- To contribute to improved health status through equity and access to quality health care in both public and private domains guided by the principles and strategies of primary health care and health systems strengthening.

- To attain and maintain deployment of right numbers and skills mix of appropriately trained and motivated HRH.
- To ensure availability and management of financial resources for improved access to health services and utilization of health facilities.
- To ensure that essential, safe, efficacious, acceptable quality and affordable medicines and other therapeutic products, medical devices and technologies are available all the times in health facilities and are accessible to all.
- To provide timely, relevant, accurate and complete health information on a sustainable and integrated basis using ICT.
- To improve delivery of health services by tapping into expertise and skills from the private sector, focusing on the output based partnerships and ensuring an optimal allocation of risk between the private and public sectors
- To ensure health physical infrastructure are properly designed and constructed and that equipment are properly procured, installed and maintained in accordance with health

10. DEFINING STRATEGIC DIRECTIONS FOR THE HEALTH SECTOR IN LESOTHO

10.1 Delivering an Essential Services Package

In 2005 the GoL defined an Essential Services Package (ESP) for Lesotho. An ESP is a set of the most cost effective, affordable and acceptable interventions for addressing conditions, diseases and associated factors that are responsible for the greater part of the disease of a given community. It therefore represents those health interventions that address priority health and related problems that result in substantial health gains at a relatively low cost. The selection of these interventions was based on the disease profile of Lesotho, cost effectiveness of the health interventions, affordability of the interventions the extent to which the outcomes is a public good or has positive externalities. Lesotho has not carried out the burden of disease study; hence reliance on the disease profile⁴⁸. The disease profile for Lesotho has not changed much over the last decade; the major change being that, as demonstrated by the STEPS survey, non-communicable diseases have become more important. Table 2 below shows the top 10 causes of death in Lesotho among men and women:

⁴⁸ Ministry of Health. (2005). *Essential services package*. Maseru: Ministry of \health.

Table 2: Causes of death 2008/09 and 2009/10 males and females

Cause	Male		Females	
	2008/09	2009/10	2008/09	2009/10
HIV and AIDS	771 (28%)	676 (32%)	850 (34%)	858 (46%)
Pulmonary TB	383 (14%)	330 (17%)	242 (10%)	216 (12%)
All forms of meningitis	215 (8%)	148 (7%)	143 (6%)	157 (8%)
Pneumonia	165 (6%)	103 (5%)	129 (5%)	95 (5%)
Trauma (head injury, assault, other injuries)	146 (5%)	87 (4%)	-	
Heart failure and stroke	144 (5%)	104 (5%)	186 (8%)	144 (8%)
Diarrhoea and gastroenteritis	104 (4%)	69 (3%)	124 (5%)	100 (5%)
Pneumoconiosis	60 (2%)		51 (2%)	28 (2%)
All forms of anaemia	48 (2%)	33 (2%)	90 (4%)	60 (3%)
Dehydration	43 (2%)	35 (2%)	-	
Diabetes mellitus	-	31 (2%)	63 (3%)	58 (3%)
Hypertension	-	-	50 (2%)	25 (1%)
Other diseases	-	385 (19%)	519 (21%)	126 (7%)

Table 2 shows that HIV is a major cause of death in Lesotho and this is followed in the distant second by tuberculosis. One thing that can also be observed in Table 1 is that NCDs constitute common causes of death among people in Lesotho. Based on these factors, over the period of the HSSP there will be 4 components of the ESP as follows:

- (i) **Essential public health interventions:** Health Education and Promotion; Environmental Health; child survival including immunisations; and Nutrition.
- (ii) **Communicable Diseases Control:** STIs, Tuberculosis and HIV.
- (iii) **Sexual and reproductive health:** antenatal care; management of deliveries; postnatal care; family planning; adolescent health; cancer screening (cervix and breast cancers).
- (iv) **Essential clinical services:** NCDs (diabetes, hypertension, cancers; and trauma); common illnesses (ear, eye and skin infections), oral health; and mental health.

One other consideration in the choice of the HSP was that it was supposed to cover 80% of common health problems especially those that cover the majority of the poor in Lesotho. A recent review of the health sector reforms also found that the definition of the HSP was also based on a community needs assessment, an analysis of various sets of information by technical advisors (TA), and consultations with different stakeholders⁴⁹. The delivery of a comprehensive package of health services requires substantial resources and, for Lesotho and other developing countries, resources are scarce and it is difficult to support all the country's health needs. Having an ESP is therefore advantageous in that within the prevailing financial and human resources constraints, the people of Lesotho can at least have access to basic health services. In terms of implementation of the ESP, services shall be free at health centre level belonging to MoH, CHAL and LRCS and services shall be delivered in an integrated manner at all levels. This will ensure that an efficient way of ESP services delivery as the use of a vertical approach uses more HRH and it is expensive. Annex X shows the ESP services that will be delivered at different levels and that disease programmes shall be responsible for delivering these services.

In order to address issues of equity to accessing ESP services the GoL will continue offering these services free of charge at health centre and community level and that where there are no health centres in towns, these will be constructed in order to ensure that people living in town are also able to access free health services. The conduct of outreach clinics shall be promoted especially in hard to reach areas so that people do not fail to access services because of distance or other reasons. Since poverty is widespread, the waiver of user fees in health centres which belong to MoH, CHAL and LRCS will continue so that people are not denied access to health services because of failure to pay.

Lesotho is off track in terms of achieving the health related MDGs. The emphasis shall be to strengthen the national response to the HIV and AIDS epidemic, expand coverage of tuberculosis interventions to achieve global treatment rate and care notification rate and address the emerging NCDs.

⁴⁹ Ministry of Health. (nd). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

In order to reduce infant and child mortality rates a number of key interventions have been spelt out in the MAF and these include eliminating MTCT of HIV, scaling up of cost effective interventions such as immunization and community case management of diarrhea and ARIs, making available skilled birth attendants at health centres, improving access to emergency obstetric care services, scaling-up essential nutrition package for pregnant and lactating mothers among other interventions. For MMR reduction the focus shall be improvement of Skilled Service Delivery (deliveries attended by skilled personnel); strengthening provision of emergency obstetric and neonatal care (EmONC); improving quality of antenatal (ANC) and postnatal cares (PNC); and increasing access to family planning services⁵⁰.

10.2 Medicines and medical supplies

During the implementation of the Health Sector Strategic Plan, the MoH with support from development partners, will ensure that there are adequate quantities of safe and affordable medicines in the health sector as contained in the EML. The EML shall be revised from time to time to ensure that it is in line with the prevailing disease burden in Lesotho. The MoH shall ensure that guidelines for donations of medicines and national standard treatment guidelines (NSTGs) are adhered to. Where possible, local production of modern medicines shall be promoted. The MoH shall also establish a Medicines Regulatory Authority as is the case in other countries in the region. This authority shall be an autonomous and functional organization outside the MoH. Since pharmacy work at lower levels is being done by non-pharmacy staff the Department of Pharmacy shall work with health training institutions to review curriculum for training health professionals to incorporate training modules in drug management for non-pharmacy health professionals particularly nurses, who often take on the role of drug management at the health centres. In addition to this the curricula for training health workers shall be reviewed in order to incorporate issues on rational use of medicines. The Department shall continue mentoring staff at facility level so that they comply with the Drug Supply Management Manual and Standard Operating Procedures. The MoH shall also implement pooled procurement payment systems for drugs and medical supplies and expand integrated electronic Drug Supply Management. Lastly, since forecasting and quantification is a challenge at health facility level, the MoH shall build the capacity among health workers to be able to do this.

10.3 Human resources for health

As has been mentioned earlier, Lesotho continues experiencing critical shortages of HRH to cope with the HRH needs of the country. In order to address this crisis, a functional review of the MoH and CHAL shall be made in the first year of the strategic plan in order to identify the HRH needs at each level of health care. The functional review exercise shall also help in establishing optimal staffing norms for health centres, hospitals and referral hospitals for effective delivery of the ESP. These positions once established will be filled as a matter of urgency. The functional review will create positions and a full compliment staff will be available at all levels as recommended by the Decentralisation Strategy developed by the MoH. In order to facilitate the recruitment of human resource an HSC shall be

⁵⁰ GoL. (nd). *MDG acceleration framework Action Plan for Lesotho*. Maseru: GoL

established and operationalised and shall be responsible for recruitment of HRH. The rationale for establishing the HSC is that the Public Service Commission (PSC) takes a long time to recruit health workers. In addition to this the MoH and stakeholders has developed a career path for health workers at district and lower levels and this is in draft form. This will be finalised and circulated widely so that employees are aware of the career paths for different health cadres.

The MoH shall finalise and implement an incentive scheme for health workers including those working in hard to reach areas. This incentive scheme shall among other things help in attracting health workers to hard to reach areas and hence ensure that such areas are properly and adequately served by skilled personnel. Since November 2012 as part of the incentive package GoL started providing a hardship allowance which was increased from M275 to M600. The MoH is also providing in hard to reach areas free accommodation, transport to and from Maseru, airtime of M500 per month, two 45 kg gas cylinders, a stove and a heater among other benefits. The provision of these incentives for staff in hard to reach areas shall continue during the course of implementing the HSSP. Since a lot of health workers are also leaving the sector for greener pastures, the MoH and other stakeholders shall revisit, finalise and implement a health workers' retention strategy. Even though the retention strategy is in draft form it is partially being implemented. The MoH shall also advocate for the increase of emoluments for health workers as this will also help in retaining health workers. There will also be a need to strengthen professional associations.

The five health training institutions in Lesotho aim at providing adequate and well trained HRH that can effectively deliver ESP to the people of Lesotho. The MoH and stakeholders will work with these health training institutions to develop a transformation and capacity building program for these local institutions. This will be aimed at training an adequate number of health workers who will be responsible for delivering health services. In addition to offering basic health training programs the health training institutions will also offer post basic programs. The MoH will also work with training institutions to develop a strategy for continuous medical education and an implementation action plan. For example where necessary the MoH will arrange on the job training through innovations such as e-learning. The offering of courses by e-learning will be possible because plans are underway to install internet and related facilities at all health centres in Lesotho. Such an initiative will help to train many health workers in a very short time. A needs assessment will be carried out in order to establish different short term and long term training programs for the health sector. The establishment of training institutions is not a mandate of the MoH hence the NHTC shall become autonomous over the course of the implementation of this strategic plan. Since there is no medical school as of now the MoH will explore the establishment of a medical school in Lesotho which will be responsible for training of medical doctors.

10.4 Health promotion

The Health Promotion and Education Division has the responsibility of developing IEC materials for the different departments and programs in the MoH. It will continue producing and distributing these materials at different levels of the health system and also act as a clearing house for all the IEC materials

produced by other stakeholders. In this regard the Division will develop and implement national standards and guidelines on the development of health promotion strategies and interventions for ESP services based on geographical targeting. The development of these IEC materials will be based on research evidence.

Health educators shall be employed within the DHMT who will be responsible for health promotion and education at the DHMT as well as at community level where they will among other things be responsible for building the capacity of VHWs and other health workers to conduct health education and promotion activities at all levels. At the central level the focus shall be to resuscitate the Health Promotion and Education Studio, providing all health educators and technical officers with appropriate operational non-office equipment and developing a health media policy. In addition to this the Division will also engage health training institutions in Lesotho to regularize the training of health educators in the country. At the same time the Division will work with these health training institutions to review curricula so that health workers are knowledgeable about health promotion activities as they finish their training programs.

10.6 Quality assurance

A Quality Assurance Unit has been established in the MoH and it reports directly to the Director General. In order for the Unit to function properly all authorised structures shall be put in place as described in the Quality Assurance Policy and Strategic Plan at MoH headquarters, DHMTs, hospitals and health centres. Since there are misperceptions about quality assurance, in order to ensure that quality assurance is internalised by all front line workers in the health sector trainings shall be conducted at different levels of the health care system in Lesotho in order for them to understand this. This training shall also be aimed at ensuring that health workers are able to conduct self assessments or peer assessment . At the end of each year there will be general accreditation assessment for health facilities. The MoH shall recognise best performers and ward certificates and this shall motivate health facilities to, among other things, achieve accreditation. The MoH and stakeholders shall from time to time conduct client satisfaction surveys focusing on the client's perception of among other things waiting time and staff attitude, availability of drugs and consumables, appropriateness of user fees, and quality of care in general.

10.7 Infrastructure and equipment

The first intervention will be to build the capacity of the Estate Management Unit for it to perform its work efficiently. Over the next few years the MoH will carry out a comprehensive health infrastructure needs assessment for the sector which shall inform the investments that need to be made in order to effectively deliver the ESP services in Lesotho. While currently with support from MCA all health centres and some staff houses are being constructed, over the next 5 years there will still be a need to construct more staff houses as need is still there. Although the MoH says that there is an adequate number of health centres in Lesotho and that all these are being renovated or being replaced with support from MCA, stakeholders expressed the need to construct more health centres in order to reduce the distance that clients travel. Most of the health centres are located in rural areas where there is no electricity. The

GoL shall install solar electricity in these health facilities as a way of attracting health workers to work in these rural areas. At district level there will be a need to construct district hospitals where there are no such facilities for example Maseru in order to decongest the National Referral Hospital. For health training institutions such as NHTC in Maseru there will be a need to construct classrooms, an examination hall and offices for staff. This will enable them to increase uptake of students. The MoH and stakeholders shall also explore the possibility of establishing a medical school during the course of implementing this strategic plan.

With regard to transport and equipment over the next five years the MoH shall embark on the process of standardizing the equipment that should be procured in health facilities and ensuring that they are of the same brand. A standard list of equipment shall be described for health facilities at different levels and ensure that these are purchased based on need. The MoH shall also ensure that personnel are trained who shall be responsible for repairing equipment. The MoH shall purchase vehicles in order to address the transport challenges that prevail in Lesotho's health system. The purchase of these vehicles will help to ensure that supportive supervision from central to districts and lower levels is conducted as scheduled as well as markedly improve the conduct of outreach clinics. Standard operating procedures shall be developed and enforced for planned preventive maintenance of vehicles. Since there are certain geographical locations that can only be reached using helicopters the MoH with support from development partners shall every quarter helicopters are hired in order to provide integrated services to helicopter sites.

10.8 Health financing

While the MoF allocates a lot of funding to the health sector, there is still a need for more resources in the health sector; hence the MoH and other stakeholders will advocate for increased government allocation as well as continued donor support to the health sector. The MoH shall also strengthen public finance management systems and build technical capacity to operate them. In addition to this, the MoH and stakeholders will develop and implement a robust health financing strategy that will help to mobilise additional financial resources to the health sector from different sources. As part of the health financing strategy the MoH will further explore the establishment of a social health insurance in Lesotho. A resource allocation formula will be established for allocation of resources to departments and geographical location really based on disease burden as well as demographics. Once the resource allocation formula is established, it will be disseminated to all the departments in the MoH and CHAL. Lastly, National Health Accounts shall be institutionalised within the health sector in Lesotho. The ultimate aim will be to increase funding levels in the sector which can be efficiently and effectively used to implement ESP at all levels.

10.9 Monitoring, evaluation and Surveillance

In order to address the challenges that are being experienced in the management of health information, the MoH in conjunction with the Ministry of Local Government shall strengthen the capacity at all levels of managing data and ensuring that quality data is timely sent to the MoH headquarters. Data verification shall be conducted at all levels in order to ensure that there is a flow of quality data through

the HMIS. The necessary tools for data collection especially at health centre and community levels will be provided in order to ensure that data collection is not interrupted. The MoH shall enforce by authority for the Health Providers particularly the Private Sector to report on health data to DHMTs in districts of residence. These interventions will ensure that monitoring, evaluation and epidemiology including surveillance is strengthened.

While at national level there is a national IT policy, in the health sector this is not available. The MoH and stakeholders will therefore develop an ICT policy and strategic plan that will guide investments in ICT in the sector. This shall be widely disseminated at all levels of the health care system. The central MoH and all hospitals have an established wireless Local Area Network and internet access which is being facilitated by the Ministry of Communication. Equipment for providing internet access at all health centres in Lesotho has already been bought and the next phase will be to ensure that all health facilities have access to internet and that staff at health centres, in due course will be able to send data to DHMT and headquarters electronically. There will therefore be a need to build capacity at this level to use these facilities and a PPP arrangement shall be used to manage these facilities. The major responsibility over the coming years will be to ensure that these investments in ICT are maintained. As is the case with other departments, there will be a need for more qualified staff within ICT who will be able to maintain this and provide support to health facilities. The MoH shall also:

- Develop electronic medical records in hospitals and outpatient department with requisite features to assure confidentiality and data security protection measures.
- Explore establishment of infrastructure for e-health or telemedicine.

As a way of motivating health workers and facilities the MoH shall develop and implement an incentive mechanism for achievers to be recognised. Lastly, currently the HMIS operates a hybrid model with some programs collecting data vertically. The ICT Department shall work towards integrating and operationalising all systems of data collection (e.g. HRMIS, Laboratory Management Information System, Pharmaceutical Management Information Systems). As part of the strengthening of the HRMIS, the MoH shall put in place a multi-sectoral observatory platform as recommended globally.

10.10 Research

Research is important as it generates evidence which can be used in the health sector to inform policy and programming. As a way of promoting research the MoH shall allocate 2% of the national health budget on research in line with the recommendations of the Commission on Health Research for Development (COHRED) and as endorsed by Ministers of Health in Abuja in 2006 and in Algiers in 2008 and as also outlined in the National Health Research Policy of the GoL. In addition to this 5% of external aid for health research shall be allocated to research as part of strengthening the health research system. More staff will be recruited to man the Research Coordination Unit and these will be trained in order for them to understand and carry out research in conjunction with various departments in the MoH and other stakeholder in the sector.

As a way of strengthening the Lesotho's health research system, the RCU shall have the responsibility of establishing MoUs for health research with various partners, establish a vibrant documentation centre, actively monitor the conduct of research, orient senior managers on how to translate research findings into use and organise annual dissemination seminars where research results will be disseminated. The MoH will also establish a National Health Research Institute which shall be responsible for conducting health and related research in Lesotho. In order to ensure that the research being conducted in Lesotho is useful to inform policy and program, the Ministry will lead the process of developing and implementing a National Health Research Agenda which shall consist of priority research areas for the health sector.

10.11 Public private partnership

This will be aimed at strengthening the involvement of the private sector in the delivery and management of health services. While the GoL has developed a specific PPP policy, there will also be a need to develop a specific PPP policy and strategic plan for the health sector that will guide all PPP initiatives in health which will be disseminated widely. Other strategies that will be implemented over the HSSP period will include (i) renegotiating and implementing the GoL-CHAL MoU in order to incorporate emerging issues and also ensuring that the level of funding subsidies given to CHAL are linked to agreed outputs; (ii) implementation of revised reporting requirements to ensure improved accountability; (iii) identification, development and implementation of potential PPP within the health sector and establishment of a committee that will review and implement the code of conduct and strengthen partners meetings. Structures should also be established at district level to facilitate coordination among partners. In addition to this GoL shall negotiate the possibility of ensuring that the private sector submits data to the HMIS. The MoH shall use lessons from the PPP with Tsepong to assess further opportunities for collaboration to improve health infrastructure. There will also be a need to strengthen partnerships with NGOs especially at district level as there is a lot that they are doing in terms of health promotion and education. In order to ensure quality in health promotion and education the MoH shall develop, implement and regulate standards for health promotion and education through the Health Promotion and Education Division.

10.12 Partnerships with communities

During the implementation of the health sector reforms between 2000 and 2011 community participation in the delivery health services was promoted through the VHWs but as mentioned earlier the major challenge is that lack of financial resources. During the implementation of the HSSP the MoH and stakeholders will continue promoting community participation through the use of VHWs who will be supervised according to schedule. For this to be achieved the MoH and stakeholders will tirelessly mobilize resources in order build the capacity of VHWs to deliver services. VHWs and health centres shall help in strengthening the linkage between communities and health facilities so that these communities can contribute to decision making on health services delivery. The formation of health facility committees will also strengthen the participation of communities in health services delivery as these will include members from communities. Lastly capacity building initiatives shall be conducted in

the communities as a way of empowering them to participate in the management of health services. They will be encouraged to develop bye-laws would empower them to be responsible for their own health including demanding services that they believe are important.

11. Technical assistance for health

The successful implementation of this strategic plan will require engagement of technical assistance. As has been mentioned earlier, while a strategy for implementing the decentralisation process in the MoH was developed and by now services delivery would have been fully decentralised, the challenge is that the process has stagnated. Operational structures for example at district level that were supposed to manage health services delivery have not established. In order to speed up this process the MoH will engage a technical assistant with specialisation in decentralisation to push this process. As has been mentioned the shortage of HR at all levels of health care is a chronic problem and an HR TA will be engaged in order to help address this challenge. The successful implementation of decentralisation will require fast tracking the recruitment of health personnel at all levels hence this will require substantial amounts of financial resources; hence there will be a need for a TA who will lead the process of developing a robust health financing strategy. This strategy will be key in mobilisation of resources for the sector. Other TAs that will be required during the implementation of this strategic plan will include public-private partnership, procurement, health promotion, environmental health, monitoring and evaluation, epidemiology, pharmaceuticals and laboratories. It is expected that the development partners will help sourcing and financing of the TAs

12. Governance and leadership in the health sector

This Chapter discusses the governance structures for the health sector during the period of implementing the Plan. The health sector was one of the earliest to start the process of decentralisation. In 2005 the MoH developed the Decentralisation Plan for the Health Sector which provided guidelines for the implementation of the decentralisation process.

12.1 Governance Structure at National Level

The Local Government Act was passed by Parliament in Lesotho in 1997. This Act calls for devolution of decision making processes to the district level. It also outlines a new local government system and 10 district councils and 128 community councils have since been created. The roles that were held by central Government of Lesotho's (GoL) Ministries and Departments were to be devolved to the districts and this process of decentralization started in 2004. The line Ministries such as MoH are therefore not supposed to be involved in the implementation of interventions as this is now the responsibility of local governments. In line with the Local Government Act, currently the MoH is largely responsible for the development of policies, strategic planning, resource mobilization, supervision, monitoring and evaluation (M&E) and providing a legal framework within which health services are being provided in Lesotho. The central MoH, however, retains the responsibility of managing referral hospitals namely district, regional and National Referral Hospitals. The MoH will establish the National Council for Health

whose responsibility will be to advise the Minister of Health on health and development, inter-sectoral coordination and community participation.

12.2 Governance structures at district level

At district level the District Medical Officer (DMO) is the head the District Health Management Team (DHMT) which has the responsibility of managing health services delivery at health centres including community level health interventions. During the health sector reforms the challenge was that the DHMT was never fully constituted and the DMO were not given the authority they required. The process of decentralization therefore was not completed and it actually stalled. Adequate resources were never provided to effect decentralization of health services delivery⁵¹. The specific functions of the DHMT are to provide leadership for district health services delivery; planning and resource mobilization, monitoring and evaluation, capacity building among health workers in the district, HRH management and development, financial management, emergency preparedness and conducting operational research. The DHMT is also responsible for providing technical advice to the district council. Currently there is no capacity at district level to plan and carry out the rest of the functions. In order to address this challenge MoH will work with MoLG to strengthen the capacity of all DHMT in Lesotho through training, improving staffing levels and providing optimal levels of funding. A DMO shall be recruited in order to manage health services delivery in the district and he will be given authority as needed. In addition to this a District Council Advisory Committee on Health will be established which will deal with all health matters and it will report to the District Council. This Committee will support development and monitor implementation of district health plans and receive reports and recommendations from existing health facility and community committees. While there will be a head for each health centre, he or she will report to the DHMT. The health posts will be manned by VHWs and will be visited by a health professional. The management of a health centre will do his or her budget including that of the health post and submit to the DHMT for approval.

13. Implementation arrangements

13.1 Delivering the ESP

The implementation of HSSP shall be led by the MoH but a variety of stakeholders shall play a role. The process of implementation will be guided by the National Health Policy, thematic policies, the Public Health Act (public health law that will be prevailing) and the Local Government Act. At all levels of the health care system namely national, district, health facility and community councils annual action shall be developed as a way of operationalising the HSSP. These plans shall be based on their strategic priorities as outlined in this plan. At district the DHMTs shall develop annual work plans based on the ESP which shall be submitted to the District Councils for approval. Aggregation of these plans with Central level plans shall constitute annual rolling plans yearly projected on three year MTEFs.

⁵¹ Ministry of Health. (nd). *Impact evaluation of the Lesotho health sector reforms of 2000/1 to 2010/11*. Maseru: Ministry of Health.

Development Partners resources shall be directed to support the relevant aspects of the MTEF based annual plans of action.

At Community level the Community Councils shall ensure that there is local participation and involvement in addition to providing support to advocacy for specific health and social welfare interventions. Involvement of civil society, individuals, and households shall be a key feature for interventions that appeal for behavior change, modifications in local cultural norms and traditions, as well as where local resource mobilization is required. Key partners such as CHAL, LRCS etc shall carry out implementation obligations based on agreements established under the PPP mechanism with due regard to periodic reviews and updates of these agreements. Institutions and health facilities shall be required to submit annual plans drawing from the priority strategies in this Strategic Plan guided by indicated budget ceilings.

13.2 Financial arrangements

The Finance Department of the Ministry of Health handles all financial issues on behalf of the Ministry. Once the budget of the MoH is approved the MoF transfers the amount to the MoH account which then transfers the funds to the districts. For funds from development partners the GoL signs an MoU with the donor after which the MoF opens a foreign denominated account (FCDA) at the Central Bank of Lesotho. The MoF also opens another account for the MoH at a local commercial bank. The funds are transferred from the FCDA to the local MALUTI account at the local bank when need arises. For projects the Project Accounting Unit (PAU) in the MoH manages and accounts for the funds from development partners. The financial regulations of the GoL require financial reports which are produced by the Finance Office. Donors can also get the financial reports for the projects they are sponsoring. The Auditor General audits MoH funds The Procurement Unit manages all procurement issues for the Ministry in accordance with established governments rules and regulations.

13. MONITORING THE IMPLEMENTATION OF THE HSSP

The M&E section of the MoH shall have the responsibility of monitoring and evaluation of the performance of the health sector. Data shall be routinely collected using the HMIS. During the implementation of the HSSP the HMIS will be strengthened in order for the system to be able to produce timely, reliable and of very good quality. Routine data will also be collected through IDSR.

Annually the MoH in consultation with partners shall organize an AJR which shall review the progress being made in the implementation of the strategic plan and the policy and how challenges being experienced can be dealt with. All major stakeholders in the health sector including development partners, other line ministries, civil society, parliament, CHAL, LRCS and the private for profit sector will attend the AJR. The AJR will be replicated at district level.

In addition to the routine collection of data, there will also be studies commissioned by the MoH and partners to monitor progress in implementation of interventions and the impact that such interventions

are having. The DHS and MICS are examples of studies that are done every few years and among others these two surveys collect information on impact level indicators. There might be some indicators that will not have any baseline data; there will be a need to conduct baseline surveys in order to have such data. It is anticipated that after 2 years of implementation of the HSSP the MoH and development partners will commission a mid-term review to determine progress made in the implementation of interventions. The plan will again be evaluated in 2017 to determine what has been achieved and this will inform the development of the successor plan.

ANNEX 1: AN EHP FOR LESOTHO DEFINED BY LEVEL OF HEALTH CARE DELIVERY

ANNEX 2: LOGICAL FRAMEWORK MATRIX FOR THE HEALTH SECTOR STRATEGIC PLAN 2012-2017

Goal	Key Performance Indicators	Key assumptions		
To reduce poverty and achieve sustainable development	<ol style="list-style-type: none"> 1. Proportion of people of Lesotho living below the poverty line 2. Unemployment rate. 3. Annual GDP Growth 	<ol style="list-style-type: none"> 1. Political stability and increased community participation in poverty reduction programmes. 2. Sustained economic growth 		
Purpose	Impact indicators			
To consolidate health systems that will guarantee quality health care to the poor, vulnerable and disadvantaged.	<ol style="list-style-type: none"> 1. Reduce MMR from 1155/100000 live birth to 300/100000 by 2017. 2. Reduce IMR from 94 to X by 2017. 3. Reduce U5MR from 117 to X by 2017. 4. Reduce adult HIV prevalence from 23% to X by 2017. 5. Reduce prevalence of stunting from X to X by 2017. 6. Reduce TFR from 3.3 to 3 by 2017. 7. Reduce HIV prevalence from 23% to 16% by 2017. 	<ol style="list-style-type: none"> 1. Multi-sector effort is sustained and leads to increased socioeconomic growth and development 2. Universal access to health reduces household costs and improves productivity 3. Evidence of declining HIV/AIDS epidemic and existence of a strong multi-sectoral interventions 		
HEALTH SERVICES DELIVERY:	KEY STRATEGIC ACTIONS	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	KEY ASSUMPTIONS
<p>Objective: To contribute to improved health status through equity and access to quality health care in both public and private domains guided by the principles and strategies of primary health care and health systems strengthening.</p>	<ol style="list-style-type: none"> 1. Review and implement the ESP based on changing disease burden as well as on emerging evidence from studies. 2. Strengthen the delivery of health services through an integrated approach. 3. Adopt decentralization as an approach to implementing health services delivery in line 	<ol style="list-style-type: none"> 1. Proportion of clients satisfied with health service. 2. Decentralisation implemented according to the MoH Decentralisation Plan. 3. An integrated approach being used in service delivery including supportive supervision. 4. Tuberculosis treatment success rate. 	<ol style="list-style-type: none"> 1. Client satisfaction surveys 2. DHS 3. AJR 4. HMIS data 5. Health facility surveys 	<p>Enabling environment Availability of technical and financial support from Government Growth in application of QA methods Demand for quality health services continues to grow Willingness of MoH to decentralize.</p>

	with the Local Government Act. 4. Institutionalise QA and conduct annual accreditation exercises.	5. % of children aged 12-23 months who are fully vaccinated by age of 1 year. 6. Number of people on ART. 7. % of health centres providing a minimum package of services		
HUMAN RESOURCE	KEY STRATEGIC ACTIONS	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	KEY ASSUMPTIONS
Objective: To attain and maintain deployment of right numbers and skills mix of appropriately trained and motivated HRH.	<ol style="list-style-type: none"> 1. Conduct a functional review of the MoH and establish staffing norms. 2. Establish HSC. 3. Develop and implement a career path for health workers. 4. Develop and implement a retention strategy for all health workers. 5. Build capacity of professional associations. 6. Strengthen collaboration with professional associations. 	<ol style="list-style-type: none"> 1. Functional review conducted and positions established and filled. 2. HSC established. 3. Career paths established and implemented. 4. Retention strategies designed and implemented. 5. % of health facilities with full time equivalent staff. 6. Attrition rates. 7. Average turnover of scarce skills staff 8. Fully functional health sector with Human resources. 9. Capacity of professional associations built. 10. Collaboration between MoH and professional bodies strengthened. 	<ol style="list-style-type: none"> 1. HR records 2. AJR. 3. Work plans and reports. 4. HR reports 5. Health facility reports. 	<p>Availability of funding Approval of structures Availability of funds Political will</p>
Objective: To contribute towards provision of increased human resources of the required competencies in Lesotho's health sector.	<ol style="list-style-type: none"> 1. Strengthen the capacity of health training institutions to scale up training of health workers for effective delivery of the ESP. 2. Produce health workers of different cadres in health training institutions. 3. Introduce. 4. Establish a medical school for Lesotho. 	<ol style="list-style-type: none"> 1. Number of graduating students. 2. Increased enrolment 3. Percent of outputs produced versus expected outputs 4. Enhanced capacity of local health training institutions 5. Enhanced recruitment, deployment and retention of health workforce 6. E-learning programs introduced and running. 7. Medical school established. 	<ol style="list-style-type: none"> 1. Reports from training institutions. 2. HRD plan 3. Training modules; curriculum for e-learning. 4. E-learning programs introduced. 	<p>Availability of funds. Availability of qualified tutors. Availability of curricula. Availability of infrastructure for e-learning</p>

HEALTH FINANCING	KEY STRATEGIC ACTIONS	OBJECTIVELY VERIFIABLE INDICATORS	MEANS OF VERIFICATION	KEY ASSUMPTIONS
<p>Objective: To ensure availability and management of financial resources for improved access to health services and utilization of health facilities.</p>	<ol style="list-style-type: none"> 1. Develop and implement a health financing policy and strategy for Lesotho. 2. Develop and implement an MTEF for health. 3. Strengthen health financing initiatives by establishing a social health insurance. 4. Institutionalise national health accounts at national and district level to track expenditures. 5. Develop and implement a comprehensive resource allocation formula. 8. Advocate for increased financial allocation to the health sector by development partners and GoL. 6. Strengthen financial management skills at all levels. 7. Improve public finance management systems and build technical capacity to operate them 	<ol style="list-style-type: none"> 1. Resource Allocation formula that reflect equity are in place. 2. % of government total health budget allocated to health. 3. Absorptive capacity of MoH. 4. Availability and utilization of financial management guidelines and health financing strategy 5. NHA institutionalized. 6. Social health insurance established and implemented. 7. MTEF for health developed. 8. Availability of robust health financing strategy and plan. 9. Adherence to set financial management systems and guidelines 	<ol style="list-style-type: none"> 1. MoH Health Expenditure Reports. 2. Government Budget Allocation Paper. 3. MOF records; public and private sector contribution analyses; 4. Expenditure surveys; GOL final accounts; 5. Records of project and donor records; 6. National Health Accounts. 7. Financial reports 8. Health financing strategy in place. 	<p>Political will Availability of funds. Availability of expertise</p>

<p>MEDICINES AND SUPPLIES</p> <p>Objective: To ensure that essential, safe, efficacious, acceptable quality and affordable medicines and other therapeutic products, medical devices and technologies are available all the times in health facilities and are accessible to all.</p>	<ol style="list-style-type: none"> 1. Review the essential medicines list so that it is in line with the prevailing disease burden for Lesotho. 2. Build the capacity of pharmaceutical personnel in forecasting and quantification of drugs. 3. Strengthen management of pharmaceuticals countrywide. 4. Review and implement guidelines for drugs donations and national standard treatment guidelines. 5. Establish a Medicine Regulatory Authority for Lesotho. 6. Orient other non-pharmacy staff on drug management. 	<ol style="list-style-type: none"> 1. EML reviewed. 2. Personnel knowledgeable about forecasting and quantification of medicines. 3. Guidelines for rational use of medicines and NSTG are followed. 4. Medicines Regulatory Authority established. 5. Number of people oriented on drug management. 6. Pharmaceutical management strengthened. 	<ol style="list-style-type: none"> 1. AJR. 2. Pharmaceutical records. 3. Health facility surveys. 	<p>Availability of funds Positions created at all levels. MoH willingness Procurement procedures strengthened.</p>
<p>MONITORING AND EVALUATION</p> <p>Objective: To provide timely, relevant, accurate and complete health and social welfare information on a sustainable and integrated basis</p>	<ol style="list-style-type: none"> 1. Build capacity of health workers to collect, report, analyse and use data for decision making at source. 2. Integrate of health information systems in the MoH. 3. Strengthen community data collection systems. 4. Reinforce by authority for the Health Providers particularly the Private Sector to report on health data to DHMTs in districts of residence 	<ol style="list-style-type: none"> 1. Level of timeliness of health information 2. Level of accuracy of health and management information 3. Completeness of data from primary source 4. Data being used at source to inform programming and policy. 5. Fully operational community based information system 6. Integrated surveillance system for the sector in place. 7. % of private sector health providers reporting health data to the DHMT 8. % of public health facilities reporting health data to the DHMT timely. 	<ol style="list-style-type: none"> 1. HMIS reports. 2. Data base; disease profiles 3. AJR. 	<p>Availability of personnel Availability of funds</p>

<p>ICT</p> <p>Objective: To improve the health of all Basotho by the use of Information Communication Technology for health.</p>	<ol style="list-style-type: none"> 1. Develop an ICT policy and strategic plan for the health sector. 2. Install internet software in all health centres. 3. Invest and implement in e-health technologies and telemedicine. 4. Build the capacity of health workers in ICT 5. Strengthen the ICT Department. 6. Build the capacity of training institutions in ICT. 	<ol style="list-style-type: none"> 1. ICT policy and plan developed and being implemented. 2. Infrastructure for e-learning installed and functioning. 3. E-learning, e-health and telemedicine functional. 4. Capacity of health workers built. 5. All employees of MoH including at health centre level have access to internet. 6. Number of ICT staff trained. 7. Number of tutors attending ICT workshops. 8. Computer laboratories established in all institutions. 	<ol style="list-style-type: none"> 1. ICT reports. 2. AJR 3. Health facility surveys 4. Reports from training institutions. 	<ol style="list-style-type: none"> 1. Availability of funds. 2. Availability of IT personnel 3. Willing private sector to run ICT including internet connectivity at health centre level.
<p>INFRASTRUCTURE AND EQUIPMENT</p> <p>Objective: To ensure health physical infrastructure are properly designed and constructed and that equipment are properly procured, installed and maintained in accordance with health standards.</p>	<ol style="list-style-type: none"> 1. Strengthen the capacity of the Estate Management Unit at all levels of health care. 2. Develop a comprehensive Health Infrastructure Development Plan 3. Build the capacity of health training institutions to increase intake of students. 4. Established health infrastructure standards 5. Carry out a comprehensive assessment of available equipment and infrastructure to inform planning. 6. Construct health centres and health posts where these are required. 7. Standardise equipment for health facilities. 8. Purchase equipment. 9. Strengthen the capacity of 	<ol style="list-style-type: none"> 1. Infrastructure development and estate management plan in place. 2. Inventory of equipment and health facilities done. 3. Improved health infrastructure management at all levels 4. Number of facilities constructed. 5. Number of equipment purchased. 6. Fully functional, well classified and standardised health facilities 7. Fully operational laboratories and other diagnostic equipment as prescribed in standards 8. Proportion of health facilities meeting laboratory standards 9. Established positions in the Estate Management Unit filled. 10. Number of staff trained. 	<ol style="list-style-type: none"> 1. HI Inventory 2. MoH Records 3. HI Standards document 4. Estates Management reports <p>1.1 Equipment Inventory developed.</p>	<p>The HID policy and plan approved and supported by the MoH management.</p> <p>The district support and adhere to HI standards and development guidelines</p> <p>Availability of funding</p>

	the health sector to repair and maintain infrastructure and equipment.			
Research for health Objective: To establish a research system and culture such that research is based on the country's priorities and the findings are fed into policy making	<ol style="list-style-type: none"> 1. Allocate 2% of the MoH budget to health research and related activities as recommended by the Commission on Health Research for Development and in line with Lesotho's National Health Policy. 2. Strengthen the capacity of the Research Coordination Unit. 3. Establish the National Health Research Institute. 4. Develop a National Health Research Agenda. 5. Build the capacity of managers at different levels of health care about research and translation of research findings into policy and programming. 6. Organise annual health research dissemination conferences. 	<ol style="list-style-type: none"> 1. % of MoH budget allocated to research. 2. Capacity of RCU strengthened. 3. National Health Research Institute established. 4. National Health Research Agenda developed and being implemented. 5. Capacity of managers on research built, 6. Number of publications and reports utilised by MoH 7. Number and quality of health and social welfare research studies funded, conducted and completed 	<ol style="list-style-type: none"> 1. RCU reports. 2. MoH reports including the AJR. 3. National Health Research Institute developed and functional. 4. Research reports. 5. Number of grant applications 	Government expeditiously sets up a National Research Coordination Unit Links with more established research institutions within the region on cross border health problems
Public private partnerships Objective: To improve delivery of health services by tapping into expertise and skills from the private sector, focusing on the output based partnerships and ensuring an optimal allocation of risk between the private and public sectors	<ol style="list-style-type: none"> 1. Develop and implement PPP in health policy and strategic plan. 2. Develop structures at national and district level to coordinate PPP initiatives. 3. Review and implement the CHAL-GOL to get maximum benefits. 4. Build capacity of private for profit providers and explore establishing MoU for service delivery with 	<ol style="list-style-type: none"> 1. PPP in health policy and plan developed. 2. PPP structures at all levels developed. 3. Number of MoUs between MoH and private sector. 4. Number of coordination meetings held. Improved links between MoH and private health sector on service delivery 	<ol style="list-style-type: none"> 1. MoH records. 2. AJR 	

	them. 5. Establish a joint committee to review and implement the code of conduct between MoH and private sector.			
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Annex 3: Core indicators for Monitoring and Evaluation

Code	Indicator	Baseline 2011	Targets 2013	Targets 2017	Targets 2020
MANAGEMENT					
1	Percentage of facilities that received at least quarterly support/supervisory visit from higher levels	TBD	25%	50%	75%
HIV					
2	Percentage of women 15 – 24 who are HIV infected.	15% (DHS 2004)	14% (DHS 2009)	14%	14%
	Percentage of women 15 – 49 yrs) who are HIV infected	26% (DHS 2004)	27% (DHS 2009)	27%	27%
	Percentage of men 15 – 24 who are HIV infected.	6% (DHS 2004)	4% (DHS 2009)	4%	4%
	Percentage of men 15 – 59 yrs who are HIV infected	19% (DHS 2004)	18% (DHS 2009)	18%	18%
3	Percentage of HIV positive pregnant women who received complete course of ART.	31%	35%	40%	50%
4	Proportion of eligible women, men and children that are receiving ARV in line with national guidelines	26%	35%	40%	50%
5	Percentage of people still alive 12 month after initiation of ARV.	74%	75%	80%	80%
REPRODUCTIVE HEALTH					
6	Percentage of deliveries that are supervised by a skilled attendant	55%	55%	60%	65%
7	Percentage of pregnant women provided ANC by health professional	90%	90%	95%	95%
CHILD SURVIVAL					
8	Percentage of children aged 13-24 months who are fully immunized	80%	80%	80%	80%
9	Proportion of stunted children 0-59 months	10.3%	10.3%	9.8%	9.3%
	Proportion of wasted children 0-59 months	4% (DHS 2004)	7% (DHS 2009)		

TUBERCULOSIS CONTROL					
10	TB Treatment Success Rate	72%	73%	74%	75%
HUMAN RESOURCE					
11	Percentage of Hospitals with Full Time Equivalent (FTE) staff for the level.	0%	10%	20%	25%
	Percentage of H/C with Full Time Equivalent (FTE) staff for the level	1%	20%	30%	40%
FINANCE					
12	Proportion of GOL Budget allocated to the Health Sector	11.4% (2007/08 FY)	11.3%	11.5%	12%
13	Percentage of Health Sector Budget allocated to PHC (district health services)	24% (2007/08 FY)	30%	40%	50%
14	Percentage of Sector Recurrent Budget Expended	87% (2007/08 FY)	92%	94%	95%
	Percentage of Sector Capital Budget Expended	48% (2007/08 FY)	94%	96%	97%
INFRASTRUCTURE					
15	Percentage of budget allocated to maintenance	0.8% (2007/08 FY)	1%	5%	10%
PHARMACY					
16	Percentage of Hospitals reporting one month 'stock out' for any of the medicines in the EML for the level.	6% (Medicines Access Survey 2007)	6%	5%	0%
	Percentage of H/Cs reporting one month 'stock out' for any of the medicines in the EML for the level.	14% (Medicines Access Survey 2007)	10%	5%	5%
HMIS					
17	Proportion of DHMTs conducting quarterly monitoring of their Operational Plan and organizing reflection meetings	0% (AJR -2008)	30%	100%	100%
QUALITY ASSURANCE					
18	Percentage of Clients satisfied with services offered at hospitals and health centres	66% (exit survey AJR)	70%	73%	75%
SERVICE COVERAGE					
19	Percentage of Health Centres providing a defined	TBD	10%	10%	30%

	minimum package of services				
ENVIRONMENTAL HEALTH					
20	Percentage of hospitals with functional means of Medical Waste Disposal System in line with national guidelines.(functional incinerator as proxy)	8%	30%	50%	80%
	Percentage of H/Cs with functional means of Medical Waste Disposal System in line with national guidelines. (functional incinerator as proxy)	0%	5%	5%	20%
