MINISTRY OF HEALTH AND SOCIAL WELFARE

LESOTHO PHC REVITALISATION PLAN

2011-2017

FOREWORD

The international conference on Primary Health Care and Health Systems in Africa, at Ouagadougou in 2008, reaffirmed the principle of the Declaration of Alma-Ata of September 1978, in regard to health as a fundamental right and the responsibility that governments have for the health of their people.

Following the Ouagadougou Declaration the Government of Lesotho recommitted on involvement, participation and empowerment of communities in health development in order to improve people's lives. Therefore, the Ministry of Health and Social Welfare together with Ministry of Local Government embarked on decentralisation process in which PHC has been embedded in, as a result the government has developed the PHC framework to create an enabling environment for improving the nine priority areas agreed upon in the Declaration, namely: Leadership and governance for health, health service delivery, human resources for health, health financing, health information, health technologies, community ownership, participation and partnership for health development.

The tenets of the implementation framework shall be the national health sector policy and strategic plan, primary health care that shall be applied from the centre, district and health centre level to the community. The village health worker as guided by the village health worker manual shall be the interface between the community and the health centre.

Integral to this community empowerment strategy shall be a Health Centre Committee and Village Health Committee that shall provide oversight to the operations of the health centre and village health worker respectively and ensure accountability of the health facility services and service provider including health implementing partners and nongovernmental organizations. The central MOHSW shall provide policy and strategic plans including primary health care implementation plan and village health worker manuals that shall commandeer the health care provision at the district, health centre and village level.

Successful implementation shall bear resemblance to what is found in a military operation. The battlefield shall be the community, the soldiers shall be the village health workers, the ammunition shall be the policy, strategy and village health worker manual, the field commanders shall be the village health committee and nurse clinicians and registered nurse midwives while the central and district level provide the oversight.

The framework will be implemented as a package that is integrated within the already existing structures. It further recognises the importance of partnership with development partners and civil society.

This framework is a result of technical support availed by the WHO to the MOHSW. The Community Health Programme Manager Ms. Cecilia Khachane managed the technical support and we wish to appreciate her for playing this crucial role. We also wish to sincerely acknowledge the participation of CHAL, Directors and Programme Managers and District Health Teams in the Ministry for their participation in this exercise. Chiefs, village health workers and the general public that interacted with the team are acknowledged. Our sincere appreciation also goes to Development Partners including the United Nations Agencies for being there when Lesotho made history as one of the countries that have taken the first step towards operationalizing the Ouagadougou Declaration.

Dr. Mpolai Moteetee
Director General of Health Services
Ministry of Health and Social Welfare

ACRONYMS

AIDS:	Acquired Immune Deficiency Syndrome
AJR:	Annual Joint Review
ARI:	Acute Respiratory Infections
CES:	Continuing Education Strategy
CHAL:	Christian Health Association of Lesotho
CHW:	Community Health Worker
DHMT:	District Health Management Team
DHT:	District Health Team
DHP:	District Health Package
DGHS:	Director General of Health Services
DHS:	Demographic and Health Survey
DPHC:	Director of Primary Health Care
DPTC:	District Pharmaco-Therapeutic Committee
EML:	Essential Medicines List
HIS:	Health Information System
HIV:	Human Immuno-deficiency Virus
HPSD:	Health Planning and Statistics Department
HR:	Human Resources
HSS:	Health Systems Strengthening
IBR:	Institutional Review Board
ICAP:	International Centre for AIDS Care and Treatment Programmes
ICT:	Information and Communication Technology
IDSR:	Integrated Disease Surveillance and Response
IHR:	International Health Regulations
MOHSW:	Ministry of Health and Social Welfare
MOLG:	Ministry of Local Government

MDR:	Multi-Drug Resistant
NGOs:	Non-Governmental Organisations
NHA:	National Health Accounts
NHTP:	National Health Technology Plan
PHC:	Primary Health Care
PRS:	Poverty Reduction Strategy
PRSP:	Poverty Reduction Strategy Paper
PSM:	Procurement Management System
STGs:	Standard Treatment Guidelines
TB:	Tuberculosis
TOR:	Terms of Reference
TWG:	Technical Working Group
UN:	United Nations
UNFPA:	United Nations Population Fund
UNICEF:	United Nations Children Fund
VHW:	Village Health Worker
WHO:	World Health Organisation

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1.0 INTRODUCTION

Lesotho is a unique kingdom small in size, mountainous, landlocked, surrounded by the Republic of South Africa. It has four ecological zones, viz: Lowlands, Foothills, Mountains and Senqu River Valley. The country is literally outside the tropics and has a population of 1,876,633 divided into 912,798 (48.6%) males and 963,835 (51.4%) females according to the Lesotho 2006 Population and Housing Census[1]. Lesotho has few exploitable natural resources, extremely limited natural resource base, limited agricultural potential and a people that have developed a strong culture of wage employment. The level of poverty in Lesotho is differentiated by geographical area, assumed to be highest in the mountainous areas, class, gender and age. Access to and provision of basic social services, in particular water and sanitation, health and education, is acknowledged by the government as critical for economic and industrial growth.

The government of Lesotho adopted Primary Health Care in 1979 as the focal strategy for attaining health for all by the year 2000. This measure led to early progress in health service provision. However, lack of clear policies, changing health environment, inappropriate management and planning practices, loss of human resources for health and weak co-ordination between the Government of Lesotho (GoL) and its non-state partner the Christian Health Association of Lesotho (CHAL) as well as partners operating in the health sector have undermined previous accomplishments. Accordingly, GoL embarked on comprehensive health sector reform process that has been running for a period of ten years beginning in 2000. The aim of the reform process was to attain affordable, universal coverage and equity in health services delivery. The reform programme initially involved the strengthening of institutional capacities, followed by the progressive introduction of suitable reforms on a national basis.

After almost thirty years since the adoption of Primary Health Care (PHC) as the foundation for health development in Lesotho and following the country's participation in the International Conference on Primary Health Care and Health Systems in Africa: Towards the Achievement of the Health Millennium Development Goals in April 2008 a thorough revitalisation of Primary Health Care and Health Systems Strengthening was felt essential. As part of this laudable reform process, the Ministry of Health and Social Welfare (MOHSW) in May 2010, commenced the process of developing and implementing the PHC Revitalization Action Plan 2011-2017 with technical support from WHO. The exercise sought to achieve the following key objectives as outlined in the terms of reference[2]:

i. Define the village health worker (VHW) in Lesotho: roles, and function, selection, training, supervision etc
ii. Develop an implementation plan for Ouagadougou Declaration.

While undertaking this mission, the following **assumptions** were made:

1. Primary beneficiaries are the communities
2. Secondary beneficiaries include the MOHSW, Local Government Councils, District Health Teams, line Ministries (Local Government, Public Service, Finance, Education and Training) CHAL, Development Partners and other stakeholders in health.

[1] Lesotho National Population Census 2006.

[2] Terms of reference :Technical Assistance: The CHW and Implementation Plan of the Ouagadougou Declaration on PHC Ministry of Health Lesotho , May 2010

The PHC Revitalization Plan seeks to promote institutionalization of primary health care, partnership with communities including strengthening the operational effectiveness of community health workers. In developing the plan, due understanding has been taken to recognize and factor in important prevailing macroeconomic and social issues in context to ensure sustainability and achievement of the objectives of the PHC Revitalization Plan. Under government leadership, the PHC Revitalization plan seeks to and promotes accountability, community ownership and opportunities for better inter sector collaboration at all levels and upholds targeted health priority interventions at the primary, secondary and tertiary health care levels.

2.0 HEALTH SECTOR ANANLYSIS

2.1 Policy Context

Lesotho's health sector has undergone a fundamental transition over the years, in the time before colonial era right to the present. Currently, health care organization and delivery is structured to support the Government of the Kingdom of Lesotho to achieve the Poverty Reduction Strategy (PRS) and to address issues of poverty including quality service delivery, increase in human resource capacity, management and improvement in public service delivery and improvement in access to health care and social welfare.

Overall, a positive political environment exists for health and donor policies have tended to be very supportive to the government thrust and have actually worked closely with government in designing the Vision 2020 and the PRSP.

The incidence of HIV/AIDS is a growing concern as it will erode household resource security and certainly lead to sharply increased poverty. The Government of Lesotho is thus faced with the challenge of striking a balance between creating an enabling environment for sustained economic growth and lasting employment opportunities, and sustainably delivering adequate levels of social services and mitigating the effects of HIV/AIDS.

Hence, whilst good governance, political stability, improved communications, privatization and financial sector reforms are critical for the creation of the enabling environment, sufficient public resources will need to be directed to improvements in health, education, sanitation and water supplies. These critical considerations will have to be factored in the conceptualization and design of the PHC Action Plan to ensure success and sustainability.

Within the context of the on-going decentralisation, the lack of clarity among line ministries especially on the precise roles of the MOHSW on one hand and that of the Ministry of Local Government (MOLG), a situation termed confusion about "***Referee and a Player Role***" of the MOLG prevails. There is need for this situation to be clarified by the authorities.

2.2 Organization and provision of health care services

Health care services organization and delivery arrangements have been structured to align with the on-going decentralization. Under the decentralization process, health services delivery is aimed on achieving provision of improved quality service through enhanced local control and decision making especially at the district and community levels. Government is placed in leadership position to provide strategic direction for core health functions including leadership and management, provision of quality

evidence for planning and decision making, funding and coordination considered vital for success and sustainability.

The provision of health care services in Lesotho is mainly by the government and the CHAL. Private Practitioners have been involved in the provision of health care services for several years in the past and in recent years the clientele for private practitioners has grown tremendously. The contribution of different sectors in the provision of health care services is captured in table 1.

Table 1: Contribution of sectors in provision of health services

TYPE	GOL	CHAL	PRIVATE	TOTAL
Tertiary Hospital	3	0	0	3
Hospitals	9	8	2	19
Urban filter clinics	4	0	0	4
Health centers	96	75	0	171
Health posts	1	16	0	17
Surgeries	0	0	36	36
Total	**113**	**99**	**38**	**250**

Source: Ministry of Health and Social Welfare, Health Facilities List 2007

At a glance, the key services of the different tiers within the district health system are summarized below as defined in the district health package (MOHSW):

Community Health Services	
Average population varies from community to community	Recommended services: * Community based health services * Promotive and limited preventive services covering the essential public health interventions
Health Centre (both government of Lesotho and CHAL)	
Average population coverage – within 8 km from health facility	Recommended services * First tier of contact with formal health care system * Supervise community-based health services * Public health services * Limited curative care as described under the scope of the health centre * Out-patient services * Limited in-patient services * Gate-keeping function in referral system – refer as indicated to district hospital
District Hospital Services (both government of Lesotho and CHAL)	
Average population coverage – based on beds per population	Recommended services * Second tier of contact with formal health system * Outpatient services * In-patient admissions and care * Supervise community-based and health centre services * Referral to Regional Referral and/or to Queen Elizabeth II hospital

Figure 1: Referral tiers within the district health system

2.3 Services at community level

At community level services offered are predominately health promotion and preventive in nature. They collectively constitute the essential public health interventions under the Essential Services Package (ESP) – community level. They include: *health education and promotion* – education and awareness creation; *child survival* – immunization, nutrition, management of common diseases – community mobilization, outreach immunization sessions, growth monitoring; *Environmental Health* – promotion of good sanitation, safe drinking water, good environmental and personal hygiene.

Activities at this level are provided through Community Health Workers (village health workers, traditional birth attendants) and extension workers such as Health Assistants with support from Health Centre Nurses, Public Health Nurses and Public Health Inspectors. There are currently an estimated 7,140 trained Community Health Workers in the country (Lesotho MoHSW 2010).

2.4 Health Sector Challenges

Overall, the health sector still faces important challenges including those associated with the HIV/AIDS epidemic. A significant number of the country's health indicators show a decline including maternal and child health. The country is also heavily burdened by acute and chronic infectious diseases, and chronic non-communicable diseases (DHS 2009).

In terms of administration, management and operations, the health sector still encounters some management and operational challenges which negatively affect the quality of service delivery. These challenges include:

1. Highly decentralized decision making[3]
2. Weak and ineffective information system
3. High rate of attrition of trained health staff.
4. Concern that GoL's declared priority for primary health care is not reflected in the allocation of its capital and recurrent resources and that a disproportionate provision is directed towards secondary and tertiary health care.
5. HIV/AIDS still poses a serious challenge in Lesotho and is thus not only a health problem but also a critical challenge across all sectors with most serious social, economic and cultural implications.

The government funding for health is estimated at 14% which is in line with the Abuja Declaration Commitments and stakeholders have expressed need to justify present support by improving performance. This observation points to a need for the sector to undertake public expenditure and budget management review and to give better clarity to the effectiveness and use of available resources in the health sector.

3.0 PROBLEM STATEMENT

Lesotho has achieved a lot of success following the launch and implementation of the Alma Ata Declaration on Primary Health Care. However, the impressive gains that were made have been gradually eroded over the past years. The health sector has been struggling to systematically adjust to emerging challenges that confronted the sector including: high attrition of human resources for health, HIV/AIDS, TB and growing burden of non-communicable disease. The sector has also witnessed an influx of multiple partners and interventions many of whom have not been well coordinated. This situation has impacted negatively on the Community Health Workers Programme and PHC implementation. For example, discrepancies in the existing payment of incentives to Village Health Workers by different agencies have contributed to demotivation of government supported Village Health Workers. Concerns have been raised about the sustainability of "Volunteer Health Workers". Faced with these challenges, there is a recognized need for the health sector to explore the implementation of cost effective interventions that address and respond to current and emerging challenges.

4.0 METHODOLOGY

This exercise was conducted in two phases. Phase I was conducted from 30 May to 11 June 2010 while Phase II was run from 29 November to 3 December 2010. In undertaking this exercise an orientation and briefing session was provided by the top management of the MOHSW led by the Director General of Health Services.

[3] Lesotho: International development Collaboration at Stakeshttp://idc.stakes.fi/NR/rdonlyres/.

To gather in-depth data and information on the Health Sector and Primary Health Care and Health Systems in Lesotho, existing literature was reviewed, in-depth discussions were also held with important stakeholders including communities (beneficiaries), community health workers, health workers in health facilities (health care providers in government and CHAL institutions), development partners including the UN Agencies involved in Health, Health Managers, Senior Policy and Decision Makers in health (public and private) and top management of related line Ministries (Finance, Local Government). During the interactions, information was gathered on the system's performance in the past and present. The interactions revealed the country's successes and pitfalls in implementing primary health care and proposed measures that should be factored into the plan to revitalise Lesotho's Primary Health Care and Health Systems. In addition, relevant issues including priorities, lessons and recommendation from official documents and evaluation reports were identified. Effort was taken through feedback triangulation mechanisms to tease out key issues including priorities and strategies learning on the experience gained by the country in PHC implementation. The exercise also explored strategic orientations of the MOHSW with regards to scale up plans for village health workers: roles and functions, selection, training, supervision incentive and motivation.

5.0 KEY FINDINGS AND PROPOSED COURSE OF ACTION

Community health workers: WHO, 1990 defines community health workers as: "Men and women chosen by the community and trained to deal with the health problems of individuals and the community and to work in close relationship with the health services. They should have had a level of primary education that enables to read, write and do simple mathematical calculation". The stakeholder consultation in this mission identified the following groups that are addressed as community health workers in Lesotho: village health workers (VHW), traditional birth attendants (TBA), community based distributors (CBD) of family planning commodities, know your status lay councillors and support groups**.** A brief description of each of the groups is given below.

- **Village Health Workers**: A member of the community who, after having gone through a structured training for village health workers, is tasked with providing essential health services in the community. He/she is the first contact with communities when they have problems. He/she provides crucial information to health professionals on prevailing health conditions in the community. He/she is a representative of the Ministry of Health and Social Welfare at community level. This definition is closely related to that given in the training manual for village health workers in Lesotho: "The Village Health Worker is a Primary Health Care (PHC) worker. He is a resident member of the village community where he works. He is nominated by the community members, with the approval of the local authorities, for training in primary health care. After the training he becomes a member of the team of community health workers who promote good health within the community. He gets help and support from his fellow community members, the community leaders and the staff of the nearest Health Centre".
- **Traditional Birth Attendants**: selected on the same qualities as village health workers though some could not read or write. For those who were village health workers, they had an additional responsibility of assisting with deliveries at community level. Their training was programmed to run for three weeks. Based on WHO guidance, the Ministry of Health and Social Welfare is no longer recruiting and training new TBAs. Where they still exist, the function is to refer women to deliver at health centres or hospitals.

- **Community Based Distributor agent**: VHW given additional training on the distribution of family planning commodities in the community
- **Know Your Status Lay Counsellors**: Community members trained on counselling and testing for HIV whose role is to do HIV testing and sometimes part of the work done by VHWs. Recruitment qualities include: know how to read and write English and Sesotho with minimum qualification of Junior Certificate. They are drawn from VHW or straight from the general community members. They are not paid but sometimes given some incentives from partners. They report to HIV Senior Counsellor and Public Health Nurse (PHN).
- **Support groups:** Members of the community who volunteered to provide services to people who were sick especially those who were HIV positive. Their training is guided by: "Community based care givers manual".

Whilst appreciating the roles played by the different community health workers, various stakeholders identified VHWs as the most suited to support primary health care since their training manual is broad in terms of PHC elements, their roles and functions are broad and address a greater proportion of the key elements of PHC. They are reliable and make follow up of patients in the community including making referrals to health facilities. Critically looked at, the category does nearly all the functions that the other categories perform. In view of the varying ways in which different groups are treated especially in terms of incentives, village health workers become disadvantaged despite carrying a heavier burden of community work. For example, support groups engaged and working with some partners get a far better package of incentives than village health workers working with CHAL and MOHSW. Table 2 shows a summary of stakeholders' views on village health workers. The table shows how there are viewed in terms of their roles and functions, the selection criteria and systems, their training, supervision, monitoring, incentives and factors that could improve their motivation.

Table 2: Summary of stakeholders' and informants views on village health workers

PRESENT	PROPOSED
Roles and functions	
Support those who are sick in various ways; assist them to prepare food to eat; growth monitoring and weighing children; cleaning the environment where the ailing stay and assisting in washing their clothes; fetching water for them; providing HIV testing services (voluntary testing); caring for OVCs. Report to Councils on the work they do.	Working together with extension workers including primary health care workers, chiefs, community councillors and other community leaders, VHWs: promote good health practices in the community, identify community needs and problems and engage communities identifying possible solutions, refer people who need further attention to health care facilities. The following are some of the key roles and functions of village health workers: • Assist communities in developing and maintaining safe water supply and sanitation. • Identify village health needs and facilitate the use of village resources to meet the identified needs. • Assist health centre team in controlling outbreaks of diseases such as water borne diseases. • Assist chiefs with vital statistics (birth and death registration). • Promote good nutrition and recognize, manage, and organize follow-up of under-nourished children. • Promote Maternal and Child Health Care, including Antenatal Care, Postnatal Care, Child Care and Family Planning. • Identify, provide initial treatment, and give referrals to people with common clinical problems, such as diarrhoea/vomiting. • Promote personal hygiene and healthy living during home visits, small group discussions and community gatherings. • Recognize, refer and organize follow-up of HIV/AIDS, TB and Leprosy patients. • Provide First Aid where applicable. • Participate in monthly health center meetings. • Keep patient and other records and report monthly activities to Health Center nurses.

Selection system and criteria	
The village health workers are selected at public gatherings by their communities based on the following qualities: • Be able to read and write Sesotho. • Be trustworthy. • Should have proven to maintain confidentiality on public matters. • Be dedicated to serve on voluntary basis. • Be a full time resident in the village. • Be an adult. • Should have had a child (in some communities). • Should undergo the approved village health workers' training.	The village health workers are selected at public gatherings by their communities based on the following qualities: • Be able to read and write Sesotho or at least Junior Certificate. • Be trustworthy • Should have proven to maintain confidentiality on public matters. • Be dedicated to serve on voluntary basis • Be a full time resident in the village (this will depend on the type of incentive given the prevailing poverty) • After their selection, be subjected to an external interview process. • Should undergo the approved village health workers' training. • Entry and exit age: 25-70 years old.
Training	
Training manual for village health worker out-dated.	The training should be guided by the recently updated training manual which addresses issues such as: • The Role of a Village Health Worker in PHC. • Social Mobilization and Health Education • Identifying and Solving Health Problems • Personal and Environmental Hygiene • STIs and AIDS • Maternal and Child Health Care • Family Planning • Child Nutrition • Integrated Management of Childhood Illnesses • Infectious Disease of Childhood • Adolescent Health • Sexual Abuse • Trauma, Accidents, and First Aid • Mental Health • Tuberculosis (TB) and Leprosy • Essential Drugs and VHW Kit • Records, Record Keeping, and Reporting

Supervision, performance monitoring, incentives and motivation	
Mechanisms followed for supervising, monitoring, motivating and providing incentives to VHWs include: • Participating in monthly meetings at the health centre for reporting, sharing problems and being informed on new events. • Follow up of VHWs in the community by health centre nurse. • Receives free medical care for him/herself and his/her nuclei family in public facilities • Play an active role during outreach services conducted in their catchment areas. • Since 2008, VHWs receive a monthly allowance of M300.	The existing mechanisms are week, especially supervision and follow up at community level. The monthly allowance does not reach the beneficiaries regularly, sometimes it is received after three months. To improve the situation, the following could be considered: • Monthly meetings should continue to be run and all VHWs should submit their reports for month based on what they would have planned to do for the month. This would act as a good mechanism for monitoring their performance. • Regular refresher training should be provided at least every two years. • Staffing pattern at health centre should be improved to accord the facility nurses to allocate time to do community visits for monitoring and encouraging VHWs to work harder. The health centre staff will need reliable transport to enable them to do the visits regularly. • The non-monetary incentive of free medical care for him/herself and his/her nuclei family in public facilities should be maintained. • Clear mechanisms for working with and getting support from chiefs, village health committees and community councils should be clearly spelt out. • Should continue to play an active role during outreach services provided in their catchment areas. • VHW kits should be regularly replenished and should have some form of personal protective equipment. • Monthly allowance could be raised to M500 per month in view of the updated training and the expanded roles and functions that go along with the training. Partners currently supporting other categories could be mobilised to channel their support through the existing government system.

5.1 Priority areas

The key findings and recommended actions address the following priority areas and themes as recommended in the Ouagadougou Declaration on Primary Health Care and Health Systems Strengthening: Leadership and governance for health, health service delivery, human resources for health, health financing, health information, health technologies, community ownership, participation and partnership for health development. These issues are captured in table 3.

Table 3: Findings on thematic areas and proposed course of action

Themes	Highlights of key findings/comments	Proposed course of action
Leadership and Governance for Health	i. Absence of a Strategic Framework to guide implementation of Village Health Work and PHC	The framework in the form of an implementation plan forms part of this report. The plan needs to be well disseminated and resources mobilised to support its implementation.
	ii. The main piece of legislation guiding the Health Sector " Public Health Order of 1970" is very old and inadequate for addressing the current Health Reforms	The Public Health Order of 1970 is being revised to respond to, *inter alia,* the needs for the Health Sector Reforms and PHC revitalisation. The new act should also address the growing concern of illegal and substandard clinical practise which is growing at an alarming rate.
	iii. Policy oversight on VHWs activities is weak	A policy framework guiding the operations of VHWs needs to be developed. This could be incorporated in the on-going process for developing the new Health Sector Policy.
	iv. Support structures to enable VHWs to function effectively exist but are weak (resources, capacity, communication, supplies and equipment)	The necessary resources to enable VHWs function effectively should be mobilised and despatched to the lower levels of the health care delivery system. This will be factored into the implementation plan generated from this exercise.
	v. Successful implementation of the on-going decentralisation requires change in mind set shift among staff, capacity building, management tools and leadership skills in the Health Sector.	Capacity building programme and development of relevant management and leadership tools should be packaged in the decentralisation strategy or be supplementary documents to the strategy.
	vi. Community Council management structures require adequate allocation of resources to successfully undertake their new mandate and responsibilities: finances, equipment, capacity development and orientation.	A strong advocacy should be embarked on so that the councils could have the necessary resources. The health sector should also develop a programme for training and orienting the councils on the special needs for managing the sector.
	vii. Need to promote collaborative partnership with Ministry of Local Government, District Councils, Public Service, Education and Finance identified within the on-going decentralisation	A formal collaborative system should be developed. This could be in the form of a clear memorandum of understanding.
	viii. Many donors provide support to NGOs to deliver health services. However some of the NGOs do not have adequate	The PHC Directorate should be strengthened to provide the necessary leadership and coordinate PHC Implementation.

Themes	Highlights of key findings/comments	Proposed course of action
	capacity to deliver the services. On the other hand, the Ministry also lacks capacity to monitor the NGOs to ensure that they deliver quality services that are in line with the defined service package.	Strengthen the Ministry's capacity especially the Monitoring and Evaluation and the Quality Assurance Units to provide quality monitoring of services offered by public facilities (GoL and CHAL), NGOs including the private sector.
Health Service Delivery	i. The Health Service Area concept is considered strength in a manner that it recognizes the complementary role of the private sector. However, absence of updated supervisory tools and guidelines potentially affect the quality of services provided. Further, District Health Teams and support structure require managerial capacity development including provision of tools to guide them in fully undertaking assigned roles and functions effectively. ii. There is an apparent lack of appreciation of expected roles by different actors to make PHC work effectively. iii. How do we strengthen the CHWs to cope adequately with new/emerging health challenges? iv. Weak referral system v. Concerns about emerging trend of some CHWs undertaking "***complex technical activities***" beyond their capacity (administration of injections to the MDR clients and messaging on complex treatment). vi. Need to revise proportion of household allocation per VHW given concerns about growing workload. vii. There is an increase of institutional reported children deaths associated to diarrhoea and ARI according to the latest AJR.	A strong capacity building programme should be developed and implemented to enable the DHMTs to effectively provide the necessary guidance to the district health teams. Consideration could be made in adapting existing training tools such as the WHO District Health Management Team Training Manuals (Health Sector Reform and District Health Systems, Management, Leadership and Partnership for District Health, Management of Health Resources and Planning and Implementation of District Health Services). This should be complemented by the development of integrated supervision tools and strengthening supportive supervision at all levels: Central to District, District to Health Centre and Health Centre to Community. There is need to effect referral note to the VHWs and feedback to them for referred clients. The Ministry needs to look into the practice of some VHWs administering injectables contrary to prevailing guidelines. This consideration should be made taking into account challenges (HRH) facing the country.
Human Resources for Health	i. VHWs acknowledged as vital link between Health Facilities and Communities. ii. Continuing Education Strategy has been finalised and is due for implementation.	There should be introduction of performance based rewards amongst the VHWs and other Health Workers. There is a project to be piloted in three districts whereby the VHWs and Health Workers will be rewarded if the required performance indicators are achieved. This needs to be

Themes	Highlights of key findings/comments	Proposed course of action
	iii. Shortage of Nurse Clinicians and Public Health Nurses is impacting negatively on the on-going training and supervision of VHWs. iv. Due to acute shortage of Nurse Clinicians, General Nurses/Registered Nurse Midwives are increasingly being resorted to fill the existing gaps in health facilities. However, their limited orientation to undertake Public Health functions has constraint their effectiveness to supervise VHWs. v. Nursing Assistants cadre was introduced after the Alma Ata Declaration to augment the supervision of VHWs. However, because of the shortage of nursing staff in the facilities the Nursing Assistants have had to be used to undertake clinical duties. vi. To achieve effective supervision of VHWs, there is need to implement the desired staffing norms in health facilities vii. There is a dwindling production of Nurse Clinician cadre. Additionally, those that have been produced could not be retained due to "unattractive package". viii. Absence of minimum package of performance based incentives. ix. Coordination and institutionalization of training curriculum	explored further to avoid causing disharmony amongst staff. The implementation could be guided by set performance based indicators for all levels. The system could also be balanced by experience and level of education. Need to develop attractive package for retention of nurse clinician and attracting more into the system. The PHC was not gender based but there is a plea from VHWs that males be involved because they are currently available at homes as opposed to the past where many were working as migrant labours in the South African mines. Their participation can address issues relating to other males better than they are currently handled. There is a need for recognition of VHWs but no need for creation of yet another cadre which will require several regulatory preparations. Village Health Post concept to be reactivated Funding should be mobilised to speed up the timely and increased uptake of nurses for deployment to health centres so as to achieve the desired staffing standards at this level. Further, the staff retention strategy needs to be marketed and put into operation to cut on the high number of staff leaving the health system.
Health Financing	i. The country has made tremendous progress towards achieving the ***Abuja Declaration,*** for example in 2010/2011 the government budget allocation is 13.8 % of the national budget. ii. Allocation of budget to the districts is largely based on historical considerations, and tends to favour curative interventions.	There is need to increase value for the money applied to the health sector making the health outcomes commensurate and match fiscal support. Efforts to encourage programme based budgeting have been practiced in health programmes and there is need to look at how this is impacting

Themes	Highlights of key findings/comments	Proposed course of action
	iii. Efforts are in place to encourage programme based budgeting. iv. Several funding opportunities exist to support provision and delivery of PHC services however there is a need to explore and leverage existing resources. v. The programme leveraging of available resource from vertical programmes to benefit PHC is weak.	on programme delivery. There is need to prioritise fiscal support targeted at health promotion and diseases prevention interventions while sustaining efforts to address curative issues.
Health Information	i. Whereas the sector has invested considerable time and resources to undertake different useful studies, action to distil findings and apply recommendations from these studies has been low. ii. There is an existing shortfall in appropriate documentation of key institutional interventions: Documentation of PHC experience in Lesotho, documentation of evaluation of "***Three District Pilot for Decentralisation***", development of comprehensive database for VHWs. iii. Poor sharing of reports produced by different programmes and agencies. iv. The data collected by VHWs using Village Health Register is not analysed, not adequately reflected and findings are not always used to improve services based on community needs assessment.	The Monitoring and Evaluation unit in the Health Planning Department needs to be strengthened with adequate human resources who are adequately skilled to distil, facilitate and follow up the implementation of key recommendations from the numerous studies undertaken in the country. This includes the implementation of recommendations emanating from the assessment of the Health Management Information System (HMIS) under the support of the Health Metrics Network (HMN). The strengthening of the unit would also enable the Ministry to timely generate analytical reports to meet the emerging needs of the Health Sector: health reforms and the transition to PHC revitalisation, decentralised health system, implementation of a restructured Ministry of Health and Social Welfare. The Ministry is already engaged in quarterly reviews with programmes and districts. The documentation of these reviews and dissemination of the review outputs would serve as an excellent platform for addressing weak sharing of reports. As a prerequisite for undertaking the reviews, districts and programmes ought to produce their reports for the quarter prior to the review meetings. The tradition of shipping data from the lower level to the next without transforming the data into information that could be used for planning and decision making has to be addressed immediately. Skills imparted to health centre nurses and district level officials on disease surveillance should be effectively used to benefit the entire health system. The data

Themes	Highlights of key findings/comments	Proposed course of action
		collected by community health workers should be translated into meaningful information for the VHWs to share with their communities.
Health Technologies	i. Basic medicines and supplies for VHWs are not regularly replenished. ii. The essential medicines list is out-dated. iii. Protective gears and uniforms not regularly done. iv. Medical supplies are purchased but do not reach communities this could be due the feeling that there is lack of ownership.	There is an urgent need for the DHMTs to intensify collaboration with health centres to effect replenishment of VHWs kits with critical items like gloves. There is need to supply VHWs with Uniform not overalls and the model can be copied from Red Cross. TB and HIV programmes should explore that possibility within government setting. There is need to update the essential medicines list. A clear and transparent system for the procurement, supply and management system for medicines and other medical technologies should be agreed upon and implemented.
Community Ownership and Participation	i. Growing Tendency to by-pass Community Structures. ii. Limited involvement of communities in the selection of VHW. iii. Interference in the selection of VHWs. iv. Growing plethora of Community Health Workers with confusing titles and functions. v. The entry and exit age for VHWs is not defined. vi. Males are highly under-represented in the VHWs.	Guidelines for setting up Village Health Committee and their terms of reference should be put in place to enable this structure to function effectively. All village health workers to go through the same standard training sing the WHO adapted guidelines and manuals. Village workers to receive refresher courses as provided for in the manual and guides. The community to use standard set criteria for selection of village health workers through the village committees. VHWs to be on wages supported from fiscal budget. Village committees to meet regularly where records are taken and available for inspection. VHW to be the liaison between health center and the community.

Themes	Highlights of key findings/comments	Proposed course of action
		Health centre nurse to provide supportive supervision to the VHW and ensure that records are kept and available for inspection. There should be a clear two way/bidirectional communication across all the systems from VHW to Health centre nurse to district hospital to central level.
Partnership for Health Development	i. Coordination of community interventions including implementation arrangements for VHWs (training, curriculum, performance monitoring, incentives). ii. Existing opportunities for improved sharing and collaboration among programmes are not fully utilized. iii. Absence of profile of community health workers (who are they, services undertaken, reporting relationship) iv. Sharing of Reports and Feedback to District Health Authorities DHT, Health Facilities and Community Leadership	Need for adherence by partners to Code of Conduct of Partners as well as TORs. Village committees should be empowered with skills on health issues especially promoting disease control and setting up priority issues as guided by the VHWs and Health centre nurses. There is need for re-emphasis on the improved interactions amongst central programme managers. It is essential to reinforce good Government/CHAL working relations and advocating other partners to comply.

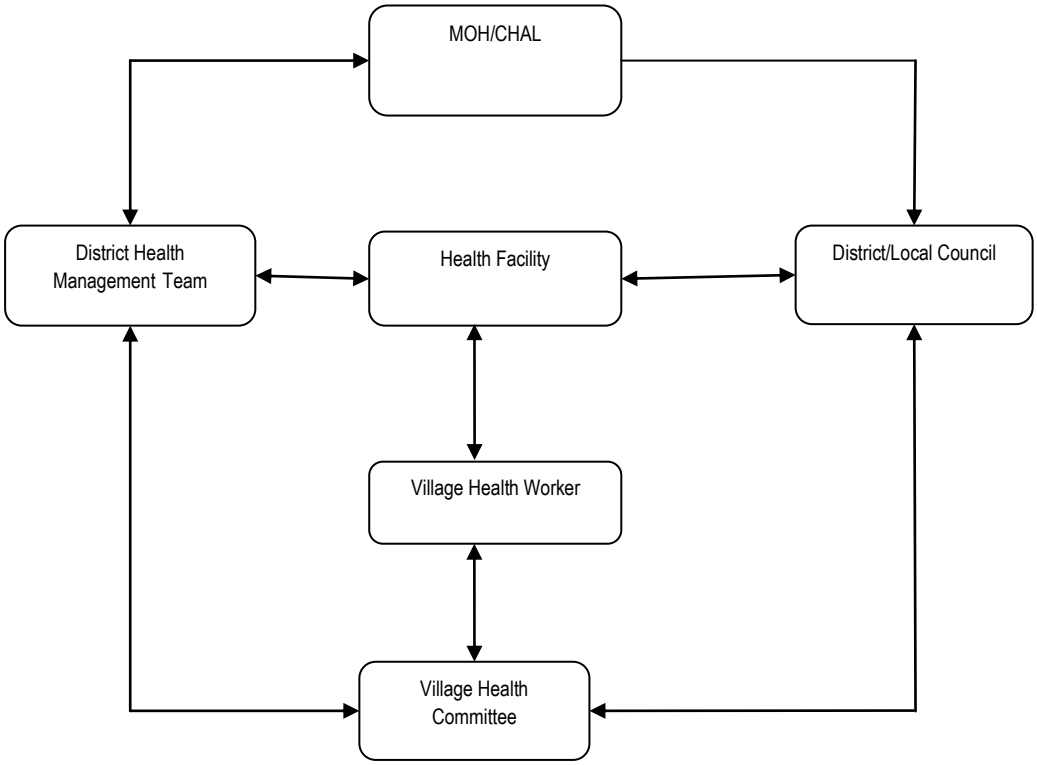

Figure 2: Communication within the sector

5.2 Major Policies

The Government of the Kingdom of Lesotho has put forward a poverty reduction strategy (PRS) for 2004/5 to 2006/7 period to address issues of poverty, key among which is employment creation and income generation. The key strategies include creation of employment, improvement in agricultural production and food security, development of infrastructure, deepening democracy, governance, safety and security; increase in human resource capacity, management and conservation of the environment, improvement in public service delivery and improvement in access to health care and social welfare[4].

The government has also put in place a Public Service Improvement and Reform Programme to help effect the PRS goals. The government has also pushed the Free Primary Education Policy with construction of schools, takeover of teacher and tuition requirements for all schools as well as supplementary feeding in schools. The government with support from partners is implementing Agriculture Improvement Programmes, Water and Sanitation, Health and Road Sector Reforms through Sector Wide Approaches and currently implementing decentralization of public services including health.

Decentralization: The decentralization thrust currently in place addresses issues of improved service delivery and natural resources management through local control. Overall, donor policies have tended to be very supportive to the government thrust and have actually worked closely with government in designing the Vision 2020 and the PRSP. Most of their policies are aligned to the two documents. Also anecdotal findings emerging from the field and discussions with key stakeholders within and beyond the health sector indicates emerging concern about the progress and performance of current

[4] Ramson Mbetu and Mavasu Tshabalala: Lesotho Concept Paper Local Development Programme, June 2006.

decentralization arrangement. Moreover, some key informants have acknowledged the existence of confusion among key ministries especially on the precise roles including the existing confusion on "***referee and a player***" role of the Ministry of Local Government. There is need for this situation to be clarified by the authorities.

Education

In addition, since the mid-1970s the principal policies for the education sector have been to provide every Mosotho with access to primary education; to offer non-formal programmes in literacy and numeracy, to facilitate the acquisition of occupational, technical and managerial skills and to ensure the quality, efficiency and relevance of the education system. Current interventions to realise the policy include the introduction of free primary education, the expansion and improvement of vocational and technical training and greater use of opportunities for cooperation with South Africa.

Health and Social Situation

Overall, two main challenges facing Lesotho and the health sector are poverty and the HIV/AIDS epidemic. Lesotho is ranked one of the poorest countries in the world; and it is estimated that half of the population live below the poverty line. A significant number of the country's health indicators show a downward trend and the country is heavily burdened by infectious and non-communicable diseases. In addition, both infant and maternal mortality have increased.

The government of Lesotho adoption in 1979 of primary health care as the focal strategy for attaining *health for all by the year 2000* led to early progress in health service provision. However, a lack of clear policies, a changing health environment, inappropriate management and planning practices, loss of medical staff and lack of co-ordination between GoL and its non-state partner (CHAL) have undermined previous accomplishments. Accordingly, GoL has embarked upon comprehensive health sector reform with the aim of attaining affordable, universal coverage and equity in health services delivery. The reform programme initially involved the strengthening of institutional capacities, to be followed by the progressive introduction of suitable reforms on a national basis. Also in response to the alarmingly high incidence of HIV/AIDS, GoL launched in September 2000 the *National AIDS Strategic Plan 2000/2001 – 2003/2004*. The ultimate vision of this programme is an HIV/AIDS free society, while the short-term objective is to control the spread of HIV/AIDS and to mitigate its impact on society. In 2001 the Lesotho Aids Programme Co-ordinating Authority (LAPCA) was established within the Office of the Prime Minister.

6.0 IMPLEMENTATION PLAN FOR PHC

6.1 Priority Interventions and projected Costs

The priority areas for the Lesotho Framework for the implementation of the Ouagadougou Declaration on Primary Health Care and Health Systems Strengthening in Africa, its objectives, interventions and key activities plus the projected associated costs are detailed in the matrix for the implementation plan. The projected associated costs amount to US$13,924,000 over a period of five years. The projected costs by priority area are summarised in table 3.

Table 4: Summary of projected costs by priority area

PRIORITY AREA	PROJECTED COSTS (US$)
Leadership and governance	598,000
Health services delivery	6,030,000
Human resources for health	3,255,000
Health financing	240,000
Health information system	1,075,000
Health technologies	589,000
Community ownership and participation	940,000
Partnership for health development	287,000
Health research	910,000
TOTAL	**13,924,000**

6.2 Implementation and management framework

The implementation of the plan is based on the outlined PHC Revitalization and associated budget cost projection. Annual operational plans are to be elaborated at all levels of the health system in order to coordinate activities and objectives of the PHC Revitalization Plan 2011-2017.

The roles of stakeholders including the MOHSW, District, and communities are clearly outlined and the packages of activities defined for each level of the health system. Overall, the central level would focus on legislation, policy issues and strategies to promote resource generation and flow, coordinate partnership and provide technical, logistical support and essential supplies.

The districts are expected to provide a network of hospitals and health facilities with the necessary organization of health services covering the minimum health service package (district health package), administrative support including support to various committees which serve as vehicles for community participation, logistic support, management of resources and supervision of the community health workers. Within this context, hospitals are expected to play a complementary role to support activities outlined by the DHMT working within assigned decentralized roles and responsibilities.

Communities would overall be expected to contribute to the delivery of the minimum health package while promoting partnerships, working within traditional and decentralized structures and complementing the roles of the secondary and tertiary levels of care.

The following important considerations were factored in the proposed implementation and management framework for the PHC Revitalization Action Plan:

1. Assumptions

To ensure effective delivery of the 5 year PHC Revitalization Plan, the following assumptions were made:

a. There will be continued favourable political support in the country.
b. A favourable policy and institutional arrangements that are aligned to identified priorities of the PHC Plan will be put in place.
c. There will be good leadership and management practices.
d. There will be an effective and integrated implementation of the outlined activities in the 9 strategic priorities.
e. Adequate funding will be solicited and well managed.
f. Collaborative Partnership will be developed at relevant levels.
g. There will be clear delineation of roles and responsibilities including defined activities:
    i. At community level
    ii. Within community and district health authorities
    iii. At the hospitals
    iv. At the central level
    v. Amongst Partners including the private sector and civil society groups.

2. Management and Implementation Arrangements: *Community and District Focus*

The communities are expected to lead the process of PHC development, by generating analysis of needs and demands for services. Likewise under this scenario, the district is considered the cornerstone of the organizational framework for implementation of required PHC services. Community participation involving key stakeholder groups from village to district headquarters, inter-sectoral collaboration including involvement of the decentralized local administration and the presence of qualified health workers especially at the front line health facilities is considered crucial for success. Hence focus is given within the PHC Revitalization Plan to empower, train and capacitate the district health authorities.

3. Health Systems Strengthening Approach

The overall objective is to deliver sustainable PHC services at all levels using the Ouagadougou PHC and HSS framework to strengthen the health system in the county. Hence, the need to incorporate all relevant health providers in the public, private and faith based groups. In addition, to accelerate implementation of identified priority programmes and services, service delivery is to be implemented using decentralized health infrastructures within the stated roles and responsibilities outlined in the on-going decentralisation policy process.

In the process of implementation, efforts would be taken to ensure fostering of joint planning under community and government leadership using approved government technical norms and standards. Moreover, special efforts would be taken to progressively incorporate special vertical programmes to ensure functional integration especially at the health facility and community levels. These considerations have been factored within the PHC Revitalization plan and interventions to strengthen

collaborative planning and mobilization of "local resources" to complement external funding is to be promoted.

While efforts would be made to ensure provision of comprehensive services, cognizance is taken of the prevailing global economic situation, and the prevailing poverty and narrow resource base of the country. Hence, priority would be given to promotion of preventive interventions, promotion of healthy life styles, priority clinical and public health services and interventions with proven cost benefit to the population. Also, at the community and primary care level, improved maternal and childhood survival is to be emphasized including improved physical, mental and social fitness; and empowerment to prevent communicable infections and non-communicable conditions. Likewise at the secondary health level, further reduction in morbidity, and mortality from life threatening diseases and injuries would be promoted.

Tertiary care is to be tailored to promote PHC services given considered comparative advantage in a complementary manner. Moreover, hospitals are regarded as "community resource" to complement district and community service delivery structures including provision of mentorship, supportive supervision, referral, information sharing and resource mobilization. Health centre teams are to be facilitated to conduct outreaches and supportive supervision to communities. Additionally, it is expected that the necessary central authorities would facilitate deployment of qualified health workers to districts and facilities to ensure optimum performance. Overall, special efforts would be made to ensure development of a culture of functional referral and feedback from and to each relevant level of the health system. Within the framework of the plan, capacity building interventions have been outlined to overcome the rigid segmentation of each level of the health sector including both public and private sector.

Within the framework of this plan, due advantage is taken of the presence of a range of faith based, private and civil society health providers to collaborate with the MOHSW. The relationship of these agencies including CHAL would be strengthened, including development of well negotiated memorandum of understanding and performance contracts.

4. Promotion of Community Ownership and Accountability

Given that the Lesotho community has always played a role in the provision of health care, the PHC plan is designed taking advantage of existing community political, social and administrative structures and resources including the decentralization process. The MOHSW aims at empowering communities to look after their health needs by implementing community based health interventions in a genuine participatory manner including village health workers. Community participation and decision making is given priority within the PHC Plan. Villages, communities and district authorities are expected to be orientated to permit better performance and accountability using existing local skills and resources complemented by central government and external support. With this context, the recognition and credibility of front line health workers (both formal and informal) would be promoted. Efforts would be made to strengthen local leadership skills and ability to facilitate sound decision making, resource management, referral service, community mobilization and supervisory support. In addition, operational support including supportive supervision, to get work done effectively at the district and local level will be supported.

Technical support from the district hospitals, DHMT and the central level is anticipated to ensure quality service provision at the community and district level. Within this context, the central level is expected to avail strategic support including translation of policies, use of technological options, and translation of national strategic planning priorities in practice. It is also envisaged that at each level the relevant health management structure is to be empowered with prerequisite skills and tools to effectively undertake their roles and responsibilities. Community health workers and communities in particular would be supported to identify local health priorities and develop plans to address them.

5. Mutual Accountability for Results: **Self-evaluation of the effectiveness of interventions**

Under the implementation arrangements, the PHC Plan seeks to encourage development of predictable complementary funding from government, local sources and external funding support to intervene and address targeted priorities and programmes. Efforts have been taken to promote development and strengthening of transparent frameworks for assessing and monitoring progress and agreed commitments within the PHC Plan 2011-2017. In addition, planned interventions would have measurable goals and evaluated regularly to track progress.

6. Operational Infrastructure and Communication

Due recognition is made of the scattered nature of Lesotho villages, coupled with the difficult mountainous terrain and weather conditions in the mountains, efforts would be made to strengthen communication and transportation infrastructure to enhance operational efficiency . Given that relatively all villages in Lesotho have community health workers, particular efforts would be made to ensure their operational effectiveness in addition to other interventions targeted at this cadre who are widely acknowledged as a key strength of the Lesotho health workforce.

7. Health Policy

Decentralization: The decentralization of health care management and provision has resulted in broad split between the districts and headquarters of the Ministry of Health and Social Welfare. While the district health teams have demonstrated improvements, they are facing challenges including weak maintenance, shortage of transport, high staff turnover and limited autonomy with concerns of over-centralization of decision making at the Ministry headquarters. Moreover, coordination of activities between the central authorities and Ministry of Local Government is not clear resulting in some confusion. There is need for clarity and overall direction as to who exactly takes what decision. To avoid general paralysis of general management function, this plan would concentrate on efforts including sensitization of key stakeholders on their roles and responsibilities as per on-going decentralization of health. Interventions to strengthen collaborative partnership mechanisms at the central, district and community levels will be embarked on. Particular efforts would be made by the ministry to empower communities and district authorities to see the larger picture in health. Furthermore, partnership with other ministries would be pursued to support district authorities to be proactive and innovative.

8. Health Financing

Finance for health services in Lesotho come from a variety of sources. While the government is the largest provider of finance, the country still depends heavily on external funding support. Actual figures on the contribution of government, international development partners and the population are not well detailed. A major challenge for the Lesotho government is the means by which health care can be adequately and sustainably financed, a situation complicated by the absence of Health Financing Policy and Strategy. The question of the long term financial sustainability of the health system, given the financial burden placed on the population, remains among the main challenges of the system. There is need for adequate preparation and analysis of various options to ensure equity concerns (fee structure, cost at point of delivery, etc.) are adequately addressed. Within the PHC plan, interventions to promote financial accessibility to health services especially among the poor and vulnerable have been outlined. Also there is plan to undertake analysis of budgeting, expenditure patterns and health financing options considering conceptual and operational issues with a view to ensure limited resources are used in a controlled fashion to achieve maximum use of available funds. Also subsidized pricing of services for the poor and vulnerable groups would be promoted.

9. Health Information

While substantial progress has been made towards generation of quality and reliable health data, there is still concern as available information is often incomplete and inaccurate. Among the formal health workers, analytic capacity is weak. The situation is worse at the sub district level and the communities where the bulk of health workers are sometimes unqualified and poorly supervised. There is agreement within the framework of the PHC revitalization plan to address this issue, and interventions have been designed to stimulate improvement in the generation, analysis and use of available health information in planning and decision making.

10. Human Resources for Health

Lesotho is still faced with serious challenges in the production, deployment and retention of qualified health workers. The underlying contributory factors are multiple and varied. The capacity of existing training infrastructure requires expansion and upgrading including provision of training faculty. The sector is also faced with unattractive remuneration and poor coordination of various training initiatives and interventions, and meanwhile, the implementation of the Health Sector HRH Strategic Plan 2005-2025 has been slow overall.

The PHC Revitalization aims to implement a three prong set of interventions aimed to strengthen and scale-up existing training capacity, promotion of better deployment practices and implementation of retention package. In addition, supportive supervision and outreach services would be promoted.

11. Medicines, vaccines and consumables

The PHC action plan aims to improve on the availability of quality medicines, vaccines and consumables, particularly essential drugs, vaccines and family planning products and consumables. To achieve these objectives it is expected the MOHSW would within the framework of the PHC plan, purchase required medicines, vaccines and consumables. Also, interventions to strengthen the capacity to forecast, procure and distribute these items would be strengthened to ensure optimal and

rational consumption by the population. Likewise quality assurance measures to generate and disseminate pharmaceutical information to the public would be pursued.

12. The Role of the Ministry of Health: Strategic support at the central level

In designing this plan, the MOHSW has analysed several factors outlined in the previous sections, and has initiated several positive actions including plans to update the national health strategic plan, develop a new Health Sector Policy, and recently approved a new MOHSW organogram as part of reforms to enable achievement of the revitalization of PHC. In addition, interventions to strengthen decentralized institutional functions are in place including institutionalization of coordination of health stakeholders under the leadership of government. Institutional capacity building including management, planning, monitoring and evaluation, ICT, health information management, and negotiation skills would be strengthened.

The government is committed and has identified PHC as a clear priority over the next five years and expects to channel its resources to facilitate its functions and implementation of the objectives of PHC Revitalization and bring back strategic direction to the national health development process, and hopefully with it positive health gains by the population, improved health workers morale and performance, a key factor for success of the government's plan.

LESOTHO IMPLEMENTATION PLAN FOR THE OUAGADOUGOU DECLARATION ON PHC AND HSS IN AFRICA – 2011-2017											
Priority Area 1: Leadership and Governance for Health											
Goal: To create an enabling policy and management environment for primary health care development											
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To systematically implement of strategic priorities to achieve sustainable primary health care development in the country										
Implement key recommendations of the PHC and HSS of the Ouagadougou Declaration	Rationally allocate, use and account for available health resources	Increased allocation and expenditure for PHC and HSS	10,000						Increased proportion of resources allocated for PHC	Senior Management Ministry of Health and Social Welfare
	Train DHMTs to conduct public expenditure analysis	10 DHMTs trained	60,000						Number of DHMTs trained	Director PHC
	Undertake annual district public expenditure analysis	10 districts conducted annual public expenditure analysis	60,000						Number of districts with annual public expenditure reports	DMHTs
	Sensitise community and district leadership on their roles and responsibilities as per strategic PHC and HSS priorities and plan	128 Community Councils, 10 District Councils, 10 Urban Councils, 1 Municipal Council and 23 Principal Chiefs given orientation	85,000						Number of community and district leaders sensitised	DHMTs, Local Government, MMC
Institutionalize inter-sectoral action for improving primary health care and health systems strengthening	Disseminate the country framework for implementing PHC and HSS	Framework for implementation disseminated and used	35,000						Availability of the framework countywide	DGHS
	Revitalise and strengthen inter-sectoral steering committee (district and national) to coordinate and follow up progress on funding and implementation of PHC	11 functional inter-sectoral committees (1 national and 10 district committees)	15,000						Number of functional inter-sectoral committees	Director PHC, DHMTs

Objective 2: To foster good leadership and enabling policy environment for primary health care development										
Updating national health policy in line with PHC and HSS approach	Update the national policy to reflect identified PHC and HSS priorities	Updated policy with PHC and HSS priorities in place	5,000						Presence of updated policy	HPSD and DGHS
	Document and monitor the implementation of PHC and HSS related elements of the health policy	Implementation progress monitored and documented	70,000						Number of annual progress reports generated and disseminated	DGHS, HPSD, PHC Department, DHMTs
Objective 3: To foster improved performance, transparency and accountability of the health system										
Updating the National Health Strategic Plan in line with priorities identified in the revitalisation of PHC and HSS approach	Share PHC and HSS priorities and update PHC and HSS elements of the national strategic plan	Updated national strategic plan with PHC and HSS priorities	2,000						Presence of updated strategic plan	HPSD, DGHS, PHC
	Track progress achieved in the implementation of identified PHC and HSS priorities in the plan	Implementation of the PHC and HSS priorities monitored	20,000						Number of progress reports produced	DGHS, HPSD, PHC Department, DHMTs
	Sensitise district & community authorities on their roles in support of the implementation of the PHC plan	District, urban and community authorities supporting the implementation of the plan	30,000						Number of authorities sensitised	Director PHC and DHMTs
Strengthen mechanisms showing evidence on transparency and accountability in the health sector	Train PHC Programme Managers and DHMTs in tracking and accounting for resources	Programme Officers and DHMTs trained to track and account for resources	35,000						Number of Programme Officers and DHMTs trained	HPSD, DGHS
	Provide relevant tools and working equipment for PHC and CHWs	Required tools and equipment in place	65,000						Proportion of required tools and equipment available	HPSD, PHC Programmes, DHMTs

	Train PHC Programme Managers and DHMTs on annual PHC performance audits	PHC Programme Managers and DHMTs trained to conduct performance audits	30,000						Proportion of Programme Managers and DHMTs trained	HPSD, DGHS
	Conduct, disseminate and publish annual PHC performance audit reports	35 performance audits contacted and reports published	55,000						Proportion of performance audits conducted	PHC Programme Managers, DHMTs
Updating and enforcement of Public Health Acts and Laws in line with PHC approach	Update Public Health Order to meet requirements for revitalised PHC and HSS approach	Updated Public Health Law	1,000						Availability of updated Public Health Law	DGHS, Legal Department
	Track progress achieved in the implementation of the updated law	Enforcement of the law monitored	20,000						Number of reports generated	PHC Programme Managers, DHMTs

Priority Area 2: Health Services Delivery											
Goal: To ensure well chosen, well organised and implemented health services which put people at the centre.											
Interventions	**Key Activities**	**Outputs**	**Cost**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To promote the adoption of the district essential health package in public and private facilities										
All district authorities plan and implement costed district health package	Review and update the district/essential service package in line with PHC approach	Updated district/essential service package in place	45,000						Availability of updated package	DGHS and DPHC
	Cost the updated essential service package	Essential service package costed	40,000						Costed updated package in place	Department of Health Planning and DPHC
	All districts develop annual operational plans to implement the district essential health package	10 approved district annual operational plans	40,000						Number of districts with and using annual operational plans	DPHC, Department of Health Planning
	Undertake forecasting medicines, commodities, essential technologies and infrastructure	Operational infrastructure and equipment regularly available	615,000						Proportion of facilities experiencing shortages in equipment	Director Pharmaceuticals, District Pharmacists
		Medicines, commodities, essential and supplies regularly available	980,000						Proportion of facilities experiencing shortages in essential supplies and medicines	Director Pharmaceuticals, District Pharmacists
	Develop an integrated procurement and supply management plan for the country	Integrated PSM plan in place	52,000						Proportion of facilities having the PSM plan	Director Pharmaceuticals, District Pharmacists
	Mobilise funding for implementing the integrated PSM plan	Integrated PSM plan implemented	45,000						Proportion of facilities using the PSM plan	Director Pharmaceuticals, District Pharmacists

Objective 2: To promote integration of health service delivery										
Promote joint planning, implementation and evaluation of service delivery	Undertake bi-annual programme managers consultative meeting to monitor progress on implementation of integrated services	Bi-annual consultative meetings conducted and documented	55,000						Proportion of bi-annual meetings held and documented	DPHC and Programmes
	Develop management and mentoring tools and guidelines	Management and mentoring guidelines (planning, supportive supervision, team building, information management, etc) in place	50,000						Number of districts having guidelines	DPHC and Programmes
	Mentor districts on joint planning, operational management, supportive supervision and team building	Districts' mentoring system functional	95,000						Proportion of districts receiving mentoring services	DPHC and Programmes
Monitor and maintain functionality of existing health infrastructure	Disseminate approved norms and standards for health facility infrastructure and follow up for compliance	Compliance to infrastructure standards monitored and corrective measures implemented	55,000						Proportion of facilities with non-functional infrastructure for more than 1 month	Estates Management Director, DPHC, DHMTs
	Strengthen DHMT capacities for maintenance of health infrastructure including their rehabilitation	Approved maintenance plans implemented in 10 districts	400,000						Proportion of facilities implementing maintenance plans	Estates Management Director, DPHC, DHMTs
Objective 3: To increase coverage of essential health services in line with the PHC approach										
Empower local government authorities to effectively plan, implement and monitor health activities	Sensitise local political and other authorities on their roles in district health development and implementation of the DHP and other developmental health issues	Political and local authorities involved in implementing the DHP	85,000						Proportion of authorities supporting the implementation of DHP	DPHC, DHMTs

	Strengthen district health management structures (hospital, health centres and village health committees) to enhance coverage	Adequate allocation of resources to implement identified health priorities by local authorities	980,000						Proportion of district plans with at least 80% of required costs available	Department of Planning, Finance, DPHC
	Train and support health centres and village health teams to undertake micro planning	Approved health centre and village health plans by local district authorities	705,000						Proportion of health centres with functional micro-plans	DHMTs
	Update facility catchment areas to meet community needs	Approved facility maps operationalized	48,000						Proportion of facilities using the facility maps	Department of Health Planning, DHMTs
Implementation of outreach services on priority PHC interventions	District and health facility teams undertake quarterly campaigns on maternal, immunisation, nutrition, HIV/AIDS and TB	3,000 campaigns conducted in all the districts	400,000						Proportion of campaigns undertaken	PHC Programmes and DHMTs, Health Facilities
	Train DHMTs and facility nurses on maternal and child health, nutrition, HIV (PMTCT)	DHMTs and nurses from 10 districts trained	90,000						Proportion of district teams trained	PHC Programmes and DHMTs, District Trainers
	Procure equipment for conducting campaigns	Equipment procured for 10 district health teams	345,000						Proportion of required equipment procured	DGHS, Procurement Unit
	Subcontract private providers to provide essential health service package in hard to reach areas	Service contracts for engagement of private providers approved	600,000						Proportion of private health providers engaged in provision of ESP	Department of Health Planning, DGHS, DHMTs
Promotion of the "supermarket" approach in health service delivery	Encourage health facilities to plan and forecast community health service needs	Integrated health care services provided at all levels of care	225,000						Proportion of facilities providing integrated services	DPHC, DHMTs
	Provide integrated guidelines and planning tools	Integrated guidelines and tools used at all levels	80,000						Proportion of facilities using the tools	DPHC, DHMTs

Priority Area 3: Human Resources for Health											
Goal: To have in place adequate, well managed, skilled and motivated health workforce to deliver effective health services											
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To promote retention and motivation of community health workers										
Set up an attractive and sustainable retention package	Fast-track the updating of the VHW data base	Updated VHW data base in place	20,000						Updated national data base	DPHC, Family Health Division
	Implement deployment of health workers to health centres	Staff pattern for health centre implemented	300,000						Proportion of HC with prescribed staffing pattern	HR Department, DHMTs
	Implement performance awards and prices to health facilities and community health workers	Performance award system developed and used	550,000						Number of districts implementing the performance award system	HR Department
	Provide essential working equipment, tools and supplies (transport, communication)	Functional working tools in facilities	125,000						Number of facilities with functioning tools	Procurement Unit and Administration
	Provide regular supportive supervision to community health workers	Supervision of community health workers strengthened	135,000						Proportion of health centres providing regular supervision to VHWs	Health Centre Managers
Objective 2: To scale up training of health workers including community health workers										
Coordinating training and deployment of health workers including community health workers	Evaluate/review health workforce training programmes	Status assessed and needs identified	65,000						Availability of assessment report	Continuing Education Programme
	Develop tools for assessing training capacity for scaling up of identified health workers	Tools in place and ready for use	10,000						Availability of assessment tools	Continuing Education Programme

	Mobilise resources and implement scaling up options for different aspects of the training institutions' requirements	Institutions' capacity strengthened	950,000						Number of training institutions enrolled the programme	Continuing Education Programme
	Implement the continuing education strategy	Consolidated training plan in place and implemented	350,000						Progress reports on implementation of CES	Continuing Education Programme
Objective 3: To improve the coordination and management of health workforce at all levels										
Strengthen HRH management and leadership capacity at the central, district and community level	Sensitise districts and DHMTs on good HR management practices	Good management practices standards defined and relevant tools in place and in use	70,000						Proportion of districts involved in good HR management practices	HR Department
	Designate focal persons for HR management at district level	District HR focal points in place	15,000						Proportion of districts with HR focal points	HR Department
	Undertake team building of DHMT and community management structures	Team building programme developed and implemented	65,000						Proportion of districts participating in the system	HR Department
	Train district teams in management	Management training programme for districts developed and implemented	100,000						Availability of training programme	DGHS and DPHC
	Conduct health service provider-community planning and evaluation consultative meetings	Consultative meetings conducted	65,000						Proportion of planned meetings held	DHMTs
Objective 4: To generate evidence for HRH planning and implementation										
Generate and use HRH evidence for informed decisions at all levels	Update the HRH profile	Updated profile in place	30,000						Availability of an updated profile report	HR Department

	Establish and maintain national health workforce observatory	Regularly updated workforce observatory	15,000						Availability of an updated observatory	HR Department
	Conduct studies and document good HRH practices	Good practices on HRH documented	150,000						Availability of reports	HR Department
Objective 5: To foster better coordination of human resource development between government and partners										
Strengthen existing coordination mechanism prioritise interventions	Appraise the implementation of the HR 2005- 2025 strategic plan	HR 2005-2025 plan implementation appraised	20,000						Availability of appraisal report	Monitoring and Evaluation Unit
	Conduct operational research on progress in implementing key milestones of the HRH strategic plan	Operational research conducted	150,000						Availability of research reports	Research Coordinating Unit
	Conduct stakeholders' consultative sessions to appraise the performance of village health workers and nursing assistants	Performance appraisal for VHWs conducted	70,000						Number of performance appraisals conducted	Department of Human Resources, Family Health, DHMTs

Priority Area 4: Health Financing and Social Protection										
Goal: To foster the development of equitable, efficient and sustainable national health financing to achieve national health goals										
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To promote a sustainable health financing strategy										
Elaborate a comprehensive health financing policy and a strategic plan	Establish a Health Financing Technical Working Group	TWG in place and functional	15,000						Proportion of planned TWG meetings held	Department of Health Planning
	Review the national health system financing	Review findings disseminated	55,000						Availability of review report	Department of Health Planning
	Ear-mark funding targeted for PHC	Costed PHC acceleration plan approved	110,000						Availability of costed PHC plan	Department of Health Planning
Objective 2: To ensure efficiency in the allocation and use of health sector resources										
Institutionalize national and district health accounts	Sensitize health financing actors on the importance of NHA	Actors appreciating importance of NHA	10,000						Availability of reports for the sensitization sessions	Department of Health Planning
	Conduct National Health Accounts	National Health Accounts conducted	25,000						NHA reports available	Department of Health Planning
	Sensitize policy-makers, health managers and district authorities on PHC expenditure reports	Sensitisation sessions on PHC expenditure reports undertaken	25,000						Proportion of planned meetings held	Department of Health Planning

Priority Area 5: Health Information Systems										
Goal: To increase the availability of timely, reliable information at all levels of the health system.										
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To provide strategic direction for the strengthening of national health information systems										
Update and implement the national health information system policy and strategic plan	Conduct a comprehensive assessment of the NHIS in collaboration with stakeholders	National Health Information System assessment conducted	97,000						Availability of assessment report	Department of Health Planning
	Update the national health information policy	Updated policy in place	58,000						Availability of an updated policy	Department of Health Planning
	Develop and share strategic plan for HIS with stakeholders and donors for funding	Strategic plan for HIS completed	45,000						Strategic plan available and disseminated	Department of Health Planning
	Mobilise funds for implementing the HIS strategic plan	Funding mobilised for donors and partners	5,000						Availability of funds ear-marked for HIS	Department of Health Planning
Strengthen the national HMIS to function in line with PHC and HSS approach	Recruit health information staff for the national, district and health centre levels	HIS staff recruited and posted to all levels	205,000						Inventory of HIS by level of health service delivery	Department of Human Resources
	Train health information staff for collection, collation and analysis of facility and district statistics	HIS staff at all levels trained	200,000						Proportion of staff HIS trained	Departments of Health Planning and Human Resources
	Provide health information unit with the necessary tools and operational equipment	Essential tools for managing and processing data procured	113,000						Proportion of facilities with essential equipment	Department of Health Planning and Procurement Office
									Proportion of districts with essential equipment	Department of Health Planning and Procurement Office
	Produce and disseminate annual health statistical reports to key stakeholders	5 annual health statistical reports produced and disseminated	87,000						Number of reports produced and shared	Department of Health Planning

	Generate timely data for IDSR and IHR (2005) requirements	Immediate, weekly and monthly disease surveillance data produced	115,000						Proportion of facilities submitting timely reports	HMIS Unit, District Health Information Officers, Disease Surveillance Focal Points
	Revise the essential national and district health indicators to accommodate PHC and HSS needs	Revised essential health indicators in place	75,000						Availability of revised indicators at all levels	Monitoring and Evaluation Unit
	Monitor the use of available statistical information by national, district and community levels	Available information used for influencing action at all levels	75,000						Proportion of district plans informed by available information	Monitoring and Evaluation Unit

Priority Area 6: Health Technologies										
Goal: To increase access to quality and safe health technologies including medical devices, laboratories, medicines, vaccines, procedures and systems										
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To elaborate national comprehensive policy and plan on health technologies within the context of national health policies and plans										
Elaborate an integrated national health technologies policy and plan covering medical devices, medicines, vaccines, procedures and systems	Undertake a national situation analysis of health technologies including health infrastructure, medical equipment and devices	Situation analysis conducted	35,000						Situation analysis report available	Department of Pharmacy and Research Coordinating Unit
	Define a national health technology package	National health technology package in place	8,000						Availability of the package in the districts	Department of Pharmacy
	Undertake a consultative process to develop NHTP and plan	Policy and plan for health technology in place	20,000						Policy and strategic plan available in the districts	Departments of Pharmacy and Laboratory
	Monitor and evaluate access and availability of health technologies at all levels of the health system	Access and availability surveys conducted	45,000						Survey reports available	Departments of Pharmacy and Laboratory
Objective 2: To improve access to quality, safe and affordable health technologies										
Implement quality assurance approaches in health technologies	Adapt existing global and regional norms & standards for health technologies to the national context	Norms and standards adapted	10,000						Availability of national standards	Departments of Pharmacy and Laboratory
	Establish national and international external quality assessment schemes in laboratory services	Quality assessment schemes established and functional	10,000						Availability of national and international assessment reports	Departments of Pharmacy and Laboratory
	Update the EML and STGs	Updated EML and STGs	30,000						Updated EML & STGs in place	Departments of Pharmacy
	Print and distribute updated EML and STGs to all public facilities	Updated EML and STGs printed and distributed	50,000						Updated EML and STGs in health facilities	Departments of Pharmacy

	Set up and train district pharmaco-therapeutic committees	10 district pharmaco therapeutic committees in place	10,000						Proportion of districts with DPTC	Departments of Pharmacy and Quality Assurance
		10 district pharmaco therapeutic committees trained	35,000						Proportion of districts with trained DPTC	Departments of Pharmacy and Quality Assurance
	Monitor adherence to EML and STGs in public facilities	Adherence supervision and monitoring conducted in 18 hospitals	18,000						Proportion of facilities monitored	Departments of Pharmacy and Quality Assurance
Strengthen capacities for selection, use and management of appropriate health technologies	Develop formula for determining the requirements and forecasting for medicines, commodities, medical equipment and health infrastructure	Forecasting formula developed	10,000						Forecasting system in place and used	Departments of Pharmacy
	Create a transparent and reliable health technologies procurement system including laboratory reagents and supplies for effectiveness and efficiency	Procurement system improved	18,000						Procurement system in use	Departments of Pharmacy
Strengthen sustainable management capacity in health technologies	Conduct a situation analysis of the existing management capacities for health technologies	Situation analysis for management of health technologies conducted	40,000						Situation analysis report available	Departments of Pharmacy and Laboratory
	Train health workers on management of vaccines and medicines at district and health centre levels	Health workers for 212 facilities trained	100,000						Proportion of health facilities with trained staff	Department of Pharmacy and EPI Programme
	Monitor the management of vaccines and medicines at district and health centre levels	Management of vaccines and medicines monitored in 212 health facilities	50,000						Proportion of facilities involved in the monitoring exercise	Department of Pharmacy, EPI Programme and Quality Assurance Unit
Engagement of the public on proper use of medicines	Educate the public on proper use of medicines	Public awareness on proper use of medicines conducted	30,000						Number of awareness sessions conducted	Department of Pharmacy, District Health Teams, DPTCs

	Set up regional medicines information centres	3 regional medicines information centres in place	30,000						Number of regions with MIC	Department of Pharmacy
	Conduct community surveillance on proper use of medicines	Community surveillance conducted	40,000						Availability of surveillance reports	District Health Teams

Priority Area 7: Community Ownership and Participation										
Goal: To attain effective community accountability for their health										
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To foster community ownership and responsibility for their health										
Establishment of enabling implementation framework and guidelines for community participation	Sensitise district authorities and opinion leaders on their rights, roles and responsibilities for health	40 sensitisation sessions conducted	85,000						Proportion of sensitisation sessions conducted	DPHC and DHMTs
	Mobilise key stakeholders groups to participate in community health issues	40 mobilisation sessions conducted in 10 districts	48,000						Proportion of mobilisation sessions conducted	DPHC and Programme Managers
	Orient targeted community leaders and groups	40 orientation sessions conducted in 10 districts	95,000						Proportion of orientation sessions conducted	DHMTs
Develop institutional framework for inter-sectoral support at the national, district and community levels	Organise bi-annual national inter-ministerial review meetings on PHC acceleration	8 bi-annual review meetings held	200,000						Proportion of review meetings held	DPHC
	Conduct district quarterly stakeholders meeting	160 quarterly meetings conducted	88,000						Proportion of quarterly meetings held	DHMTs
	Produce bi-annual PHC bulletin for circulation to stakeholders	8 bi-annual bulletins disseminated	44,000						Proportion of bulletins circulated	DPHC

Objective 2: To promote community adoption of healthy lifestyles										
Implement community based programme for adoption of healthy lifestyles in communities	Undertake participatory community healthy lifestyles risk factor surveys	Community progress on health lifestyle practices assessed and program developed to address identified obstacles	70,000						Survey report available	Non-Communicable Disease Programme
	Forge inter-sectoral partnership to address identified risk factors	Awareness on lifestyles and health outcomes raised through community efforts	45,000						Availability of inter-sectoral work plans and reports	NCD Programme and DHMTs
	Develop communication strategies for addressing healthy life style challenges	Communication strategy for healthy life style developed	30,000						Availability of a comprehensive communication strategy	Health Education Division
	Implement the communication strategies for addressing healthy life style challenges	IEC materials disseminated countrywide	45,000						Number of IEC materials disseminated	Health Education Division
		Participatory approach in provision of healthy life style implemented by all districts	80,000						Number of participatory approach sessions held	DHMTs and Health Centres
		Campaigns on healthy life style conducted by all districts	110,000						Number of campaigns conducted	DHMTs and Health Centres

Priority Area 8: Partnership for Health Development										
Goal: To improve harmonisation and alignment towards governmental led policy and strategic recommendations for health development										
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To harmonise implementation of essential PHC services										
Institutionalize a coordination framework for harmonisation and alignment of partner support to PHC & HSS	Implement joint government and partner planning and coordination forum	Functional Joint government and partner planning and coordination forum	32,000						Proportion of planned working sessions held	DGHS and DPHC
	Mobilise budgetary support for implementing the PHC and HSS plan	Funding for PHC and HSS mobilised	15,000						Proportion of required funds mobilised	PHC Programmes, Budget Controller – Health
	Develop guidelines for establishment and implementation of partner coordination at district level	Guiding tools produced and distributed to all districts	10,000						Guidelines for coordinating partners in use in all districts	DGHS and Health Planning Department
	Establish coordination mechanism for implementation of PHC and HSS at district level	Partner coordination at district level formalised	10,000						Working session reports	DPHC and DHMTs
	Conduct health partners' meetings at national and district levels	Partners meetings held quarterly at national level	20,000						Proportion of planned meetings held at national level	DGHS, DHMTs
		Partners meetings held quarterly at district level	50,000						Proportion of planned meetings held by districts	DHMTs
	Undertake annual stakeholder review of the PHC implementation at the district level	50 stakeholders' review meetings conducted and documented	100,000						Proportion of stakeholders' meetings held at district level	DHMTs and DPHC
	Document best practices and undertake good study tours by district and community health teams	Best practices shared amongst the districts	50,000						Number of districts involved in documenting best practices	DHMTs and Research Coordinating Unit

Priority Area 9: Research for Health											
Goal: To utilise operational research to improve primary health care development											
Interventions	**Key Activities**	**Outputs**	**Cost (US$)**	**Timeframe**					**Indicators**	**Responsible**
				Y1	**Y2**	**Y3**	**Y4**	**Y5**		
Objective 1: To develop local capacity to undertake and utilise research findings to strengthen primary health care										
Strengthen research leadership and governance	Strengthen the ethics committee	National ethics committee fully operational and providing leadership for health research	55,000						Number of planned meetings for REC held	Research Coordinating Unit
	Promote the establishment of institutional review boards	Institutional review boards in place and functional in major institutions	80,000						Proportion of training institutions and districts with IRBs	Research Coordinating Unit
	Support training of Local Institutional Review Boards	Local IBRs trained in scientific review of research projects	150,000						Proportion of IRBs trained	Research Coordinating Unit
	Mobilise resources for research committees at district, institutional and national levels	Funding available for research committees	35,000						Availability of resources for committees	Research Coordinating Unit
	Develop and disseminate guiding tools for the operation of research committees	Guidelines for research governance in place and followed	20,000						Number of committees using the tools	Research Coordinating Unit
Ministry and stakeholders identify research priorities	Define operational research agenda with stakeholders	National health research agenda followed	10,000						Availability of Research Agenda	Research Coordinating Unit
	Train programmes and districts on research design, implementation and analysis	Quality research generated in the country	200,000						Number of programme managers trained	Research Coordinating Unit
									Number of district teams trained	Research Coordinating Unit

	Sensitise district and community health authorities on the use of research findings for decision making	Evidence based planning implemented at district level	50,000						Proportion of district councils using research findings for planning	Research Coordinating Unit, DHMTs
	Provide operational equipment for documentation and analysis of research	Documentation of research implemented at all levels	30,000						Number of districts with functional equipment	Research Coordinating Unit
Objective 2: To promote documentation and dissemination of good practice										
Engage districts and programmes in conducting operational research	Provide funding for operational research	Funding for research availed to programmes and districts	230,000						Proportion of available funding used to support research	Research Coordinating Unit
	Monitor implementation of operational research	Progress on research projects tracked and guidance provided	25,000						Number of ongoing research projects monitored	Research Coordinating Unit
	Support dissemination and publication of research findings	Research findings shared locally and globally	15,000						Number of research findings published	Research Coordinating Unit
	Undertake public expenditure studies to track use of research evidence in decision making	Documentation on use of research evidence conducted	10,000						Reports on public expenditure studies available	Health Planning Department

Annex 1: Terms of reference

TERMS OF REFERENCE FOR THE TECHNICAL ASSISTANCE: THE CHW AND IMPLEMENTATION PLAN OF THE OUAGADOUGU DECLARATION AND REVITALIZATION OF PHC

Background

Lesotho embraced the PHC strategy as contained in the Alma Ata Declaration. The country attained several successes inclusive of high knowledge of priority morbidities for control, high EPI coverage, and communities' participation in programmes. A lot of the successes were owed to the Village Health Workers (VHW), later referred to as the Community Health Workers (CHW).

The adoption of the PHC strategy mandated a modification of the systems of service delivery that had hitherto been in place. The development of several cadres of appropriately trained health workers inclusive of the Nursing Assistant, the Health Assistant, and the Nurse Clinician, was initiated at the time. As the leader of the health center team, the Nurse Clinician also trained, supervised and had oversight over the functioning of the VHW.

The VHW programme in Lesotho dates back to 1974 (some reports even earlier) as a local initiative to address issues pertaining to addressing deliveries at health facilities. **It** was formalized with the adoption of the Alma Ata declaration. Their overall role was defined as that of the link between the health facilities and communities. The training targets and guidelines that were set indicated that each VHW should cater for a maximum of 40 households and each village should have at least 2 VHWs. They were selected or elected by their own communities based on the criteria set by the MOHSW and communicated to the village Chief by the Health Center Nurse Clinician/Nurse. The criteria were that the individual should be a volunteer who can keep confidentiality, be trusted by the community, not intending to change residence from the village, and literate in Sesotho.

The functions of the VHW were defined according to the elements of PHC as defined by the Alma Ata Declaration and included creation of awareness on health issues as well as demand for services, provision of basic health care services, and follow up and care of chronically ill patients within the community. At the same time the training of TBAs as per WHO guidelines was instituted. The observation was that in the majority of cases the selected VHWs were TBAs. The programme therefore adopted the CHW terminology.

The CHWs were trained, decentralized to the health center, according to documented standard curricula accompanied with a trainer's manual and workbook. This was built around the elements of PHC and simplified to be easily understood and written in Sesotho. The initial training was scheduled for 2 weeks for the VHW and 3 weeks for the TBA. Refresher courses were also held and the selection of topics depended on local priorities and added on elements in time.

The CHWs were to be supervised on site and through regular visits to the health center. Once a month they had to bring in reports and updates, refill their kits as well as hold joint discussions facilitated by the Nurse Clinician. The major data collection tool that they used was the formal documented Village Health Register.

Their incentives were non-monetary and as per the community decision e.g. farming on their behalf. The only incentive provided by the health care system was free care for the VHW and her/his nuclear family. In April 2008, the GOL/MOHSW instituted the payment of a monthly incentive to the CHWs.

The programme has across time faced several challenges including rising poverty and unemployment with individuals no longer able to volunteer services, subsequent high attrition, and the topography of the country that makes travel difficult. Coupled with limited supervision due to HR shortages and attrition, more and more CHWs became inactive and sought sustenance elsewhere. *The HIV and AIDS crisis brought in multiplicity of partners and strategies into the country that did not necessarily follow the guidelines for the CHWs.* This was exacerbated by that due to HR challenges such guidelines had not been updated in line with the developments, particularly HIV and AIDS. The partners either brought in innovations or copied models from other countries and implemented them in Lesotho. Notably, monetary and other incentives were paid out to the new groups; CHWs then joined these new groups and stayed in position of leadership. Concurrently there arose confusion, sometimes conflict, at community level, with regard to the functions and roles of the multiplicity of workers.

Anecdotal reports are that with the institution of the monthly monetary incentive, CHWs have been re-motivated. At the same time, as they prepare for their exit or change of focus, partners increasingly seek government intervention to sustain the multiplicity of workers based at community level. The MOHSW has also been advised to change from the Lesotho to models from elsewhere. While the MOHSW is aware of other models of CHW implemented within and
outside the continent, expert opinion shared with the MOHSW is that the Lesotho model of CHW is one of the best.

Rationale

Lesotho is signatory and is fully committed to the implementation of the Ouagadougou Declaration for the Revitalization of PHC. The MOHSW has made a policy decision that government incentives will be directed at the CHW as defined in the government guidelines; the CHW being the key health care resource at the community level.

The MOHSW has sought and received support of a partner to review and assess the impact of the existent different models of CHW on the service delivery, with emphasis on HIV and AIDS. It is envisaged that the study report will be available within the next 6 months to 1 year. It is also important that all relevant stakeholders reach and share the vision and full consensus on the CHW including on selection criteria, functions, management etc. This will be further informed by the indicated study. Technical Assistance is required to facilitate the process.

Technical Assistance is required to develop the implementation Plan for the Ouagadougou Declaration, especially on community involvement. Assistance is further required to, based on the available information (documents, Key Informant Interviews, discussions, workshop), facilitate an informed decision on the CHW desirable for Lesotho.

Objectives

Through a consultative process, in support of the MOHSW, the following are the objectives for the TA:

1. Define the CHW in Lesotho: roles and function, selection, training, supervision, etc.
2. Develop an implementation plan for Ouagadougou Declaration

Duties

1. Prepare an inventory (and compile) and synthesis of all documentation, including evaluations, that relates to both the CHW and PHC in Lesotho
2. Facilitate a stakeholders meeting towards recommending to the MOHSW:
    a. The CHW in Lesotho
    b. Draft Implementation Plan for the Ouagadougou Declaration

Deliverables

1. Draft on the CHW: selection, training, supervision, data collection, etc.
2. Draft Implementation Plan for the Ouagadougou Declaration for Lesotho

Job Specification

1. Masters or higher degree in Public Health
2. Minimum of 5 years' experience in PHC implementation, some of which should have been in a managerial position at district/provincial/national level
3. Computer literacy and proficiency
4. Analytic approach with good negotiation skills
5. Fluent in spoken and written English
6. Knowledge of Sesotho (interaction with community change agents and CHWs) will be an added advantage

Duration

4 to 6 weeks

Annex 2: List of people interviewed

NAME	INSTITUTION	DESIGNATION
Dr. Mpolai Moteetee	Ministry of Health and Social Welfare	Director General of Health Services
Dr. Lugemba Budiaki	Ministry of Health and Social Welfare	Director of Primary Health Care
Mrs Maneo Mohai	Ministry of Health and Social Welfare	Head of Family Health Division
Ms. Matŝebo Moji	Ministry of Health and Social Welfare	Chief Nursing Officer
Mrs. Lisebo Chisepo	Ministry of Health and Social Welfare	Director of Social Welfare
Ms. Gladys Moeketsi	Ministry of Health and Social Welfare	Director Human Resources
Mr. Molaoa Maqhama	Ministry of Health and Social Welfare	Financial Controller
Mr. Phakiso Sealiete	Ministry of Health and Social Welfare	Chief Legal Officer
Mrs. Mokose	Ministry of Health and Social Welfare	Legal Officer
Ms Emely Mokoena	Ministry of Health and Social Welfare	Nurse Clinician (ART) Berea Hospital
Mr. Tabalingata Qhobela	Ministry of Health and Social Welfare	Focal Point DHMT Berea
Mr. John Nkonyana	Ministry of Health and Social Welfare	Epidemiologist
Ms. Maud Boikanyo	Ministry of Health and Social Welfare	Director HIV/AIDS
Ms. Popo Ntjona	Ministry of Health and Social Welfare	EPI Programme Manager
Ms. Mannuku Mathe	Ministry of Health and Social Welfare	IMCI Programme Manager
Ms. Makapa Kampong	Ministry of Health and Social Welfare	HBC Officer – AIDS Directorate
Mr. Nkoebe Theko	Ministry of Health and Social Welfare	Chief Health Inspector
Dr. 'Nyane Letsie	Ministry of Health and Social Welfare	Consultant – Maseru DHMT
Mr. M. Masasa	Ministry of Health and Social Welfare	Director – Health Planning
Dr. Piet Mcpherson	Ministry of Health and Social Welfare	Director Clinical Services
Dr. Llang Maama	Ministry of Health and Social Welfare	Head Disease Control and TB Programme
Mrs Malentsoe Ntholi	Christian Health Association of Lesotho	Executive Secretary

Mrs Agnes Lephoto	Christian Health Association of Lesotho	AIDS Coordinator
Mrs Faith Pulumo	Christian Health Association of Lesotho	Midwifery Tutor Maluti Hospital
Ms Ella Ramatla	Christian Health Association of Lesotho	Nurse Clinician PHC Scot Hospital
Ms Lipuo Lenka	Christian Health Association of Lesotho	Nurse Clinician Roma Hospital
Ms. M. Mohlaba	Christian Health Association of Lesotho	PHC Coordinator Seboche
Ms. M. Polane	Christian Health Association of Lesotho	Nurse Clinician Maputsoe SDA
Mr. Mofokeng Makhetha	Lesotho Planned Parenthood Association	Executive Secretary
Mr. Bulara Mojakhomo	Ministry of Health and Social Welfare	DHMI Focal Point Mohale's Hoek
Mrs. Julia Makhabane	Ministry of Health and Social Welfare	District Public Health Nurse Mohale's Hoek
UNICEF	United Nations Lesotho	
UNFPA	United Nations Lesotho	
WHO	United Nations Lesotho	
Ms. Malineo Motŝepe	Independent	Vocal Community Member
Mrs. Manthuoa Seipobi	Retired	Former Public Health Nurse
Ms. Mantoetsi Makhasane	Tŝepong Mohale's Hoek	ART Nurse and Former Nurse Clinician
Mrs. Mamonyane Mohale	Retired	Former PHC Director CHAL
PARTNERS		
Mrs. M. Kalaka	Sankatana Clinic	
Dr. Koen Frederix	ICAP	Clinical Team Leader and Director a.i.
Ms Stella Mugisha	ICAP	Adherence Advisor
Ms. Danielle Morris	ICAP	Program Coordinator
Mrs. Likhapha Ntlamelle	Partners in Health	
Dr. Semakaleng Phafoli	Irish Aid	Health Adviser
REGULATORY BODIES		
Dr. M. Mokete	Lesotho Medical Council	President
Ms. Maleshoane Monethi-Seeiso	Lesotho Nursing Council	Registrar
Morena Boatile Majara	Makhunoane	Chief
Morena Mafupara Tumane	Ha Lebesa	Chief
Mr. Khethisa	Ministry of Finance and Development Planning	Principal Secretary