



GOVERNMENT OF LESOTHO

LESOTHO HEALTH POLICY - 2011



MOHSW

Table of Contents

List of Acronyms	5
Foreword	8
1.0 Situation Analysis.....	9
1.1 Health Profile, Challenges and Emerging Problems.....	9
1.1.1 Health Profile	10
1.2 Current Health Policy Appraisal	14
1.3 Organization and Structure of the National Health System	17
1.4 Resources.....	20
1.5 Health Services Access and Utilization	20
1.7 Users' Demand and Participation	20
1.8 Strengths, Weaknesses, Opportunities and Threats (SWOT).....	21
1.9 Main Health Policy Issues and Major Challenges.....	22
1.10 Health Needs and Priorities.....	23
1.1.11 Socio Economic Environment.....	23
2.0 Vision, Mission, and Goal of Health Sector	25
3.0 Values and Guiding Principles.....	25
4.0 General Policy Objectives	27
5.0 Policy Orientations.....	27
5.1.1 HIV and AIDS	27
5.1.2 Sexual and Reproductive Health and Rights.....	28
5.1.3 Child Survival and Development.....	28
5.1.5 Environmental Health.....	29
5.1.6 Emergency and Humanitarian Action	30
5.1.7 Occupational Health	30
5.1.8 Health Education and Promotion.....	30
5.1.9 Pharmaceutical Services and Medical Technologies.....	31
5.1.10 Communicable and Non-communicable Diseases.....	31
5.1.11 Oral Health Services.....	32
5.1.12 Mental Health Services	32
5.1.13 Clinical, Diagnostic and Nursing Services.....	33

5.1.14	Referral Services outside the Country	33
5.1.15	Traditional Health Services.....	34
5.2.1	Human Resource Development (HRD).....	34
5.2.3	Health Financing	35
5.2.4	Health Infrastructure.....	35
5.2.5	Quality Assurance	36
5.2.6	Research	36
5.2.7	Health Management and Information System (HMIS).....	37
5.2.8	Sector Monitoring and Evaluation	37
5.2.9	Information Communication Technology (ICT).....	38
5.2.10	Health Regulation	38
5.2.11	Community Based Health Care.....	39
5.2.12	Partners' Coordination	39
5.2.13	Public Private Partnerships.....	40
6.0	Implementation Framework.....	40
6.1	Decentralization	40
6.1.1	Role of MOH	41
6.1.1.1	Central Level Activities	41
6.1.1.2	Local Level Functions	41
6.2	National Council for Health	41
6.3	Management of Health Facilities	42
6.3.1	Hospitals/Filter Clinics	42
6.3.2	Health Centres.....	42
6.4	Public-Private Partnership.....	42
6.4.1	Partnership with CHAL and LRCS.....	42
6.4.2	GOL's Partnership with Other Private Sector Bodies	43
6.4.3	Partnership with Traditional Health Practitioners	43
6.5	Implementation Arrangements.....	43
7.0	Monitoring and Evaluation of the Policy.....	43
8.0	Conclusion.....	47
9.0	Bibliography.....	49

Annexes.....	50
Annex 1: Indicators for measuring key outcomes:	50
Annex II: Fact Sheet.....	53
Annex III: Resources.....	54
Annex IV: Synopsis of Specific Programmes.....	61

List of Acronyms

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Clinic
AJR	Annual Joint Review
ART	Anti Retroviral Therapy
ARV	Antiretroviral
AZT	Zidovudine
CHAL	Christian Health Association of Lesotho
CHW	Community Health Worker
DDCC	District Development Coordinating Committee
DFID	Department for International Development (UK)
DHC	District Hospital Committee
DHMT	District Health Management Team
DHT	District Health Team
DPCF	Development Partners Consultative Forum
EHP	Essential Health Package
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EU	European Union
GNP	Gross National Product (per capita)
GoL	Government of Lesotho
GoL/BOS	Government of Lesotho/ Bureau of Statistics
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAART	Highly Active Antiretroviral Therapy
HESA	Health and Environment Strategic Alliance
HMIS	Health Management Information System
HSA	Health Service Areas
HSA 2010	Health System Assessment 2010
HSS	Health System Strengthening
HTC	HIV Testing and Counseling
ICT	Information and Communication Technology
IMCI	Integrated Management of Childhood Illness
IMR	Infant Mortality Rate

KYS	'Know Your Status'
LDHS	Lesotho Demographic and Health Survey
LFA	Logical Framework Approach
LPPA	Lesotho Planned Parenthood Association
LRCS	Lesotho Red Cross Society
MCC	Millennium Challenge Corporation
MDR-TB	Multi Drug Resistant Tuberculosis
MDR/XDR-TB	Multi Drug Resistant/ Extra Drug Resistant Tuberculosis
M&E	Monitoring and Evaluation
MEAs	Multisectoral Environmental Agreements
MMR	Maternal Mortality Ratio
MOFDP	Ministry of Finance and Development Planning
MOHSW	Ministry of Health and Social Welfare
MOPS	Ministry of Public Service
MOLG	Ministry of Local Government
MOU	Memorandum of Understanding
MTEC	Ministry of Tourism Environment and Culture
MTR	Mid Term Review
NCDs	Non-Communicable Diseases
NDSO	National Drug Service Organization
OPD	Outpatient Department
OVC	Orphans and Vulnerable Children
PEPFAR	President's Emergency Plan for AIDS Relief
PHC	Primary Health Care
PWD	People with Disability
PMTCT	Prevention of Mother to Child Transmission
PRS	Poverty Reduction Strategy
QE II	Queen Elizabeth II (Tertiary Hospital)
S.B.C.C	Social and Behavioral Change Communication
SACU	South African Customs Union
SADC	Southern Africa Development Coordination Conference
STD	Sexually Transmitted Diseases
STI	Sexually Transmitted Infection
SWAPs	Sector Wide Approaches
SWOT	Strengths Weaknesses Opportunities and Threats

TB	Tuberculosis
TB-DOTS	Tuberculosis – Directly Observed Treatment Short Course
TFR	Total Fertility Rate
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
USAID	United States Agency for International Development
WHO	World Health Organization

Foreword

The Ministry of Health and Social Welfare is charged with the responsibility of policy formulation and strategies for the delivery of health and social welfare services, with the ultimate goal of ensuring that every Mosotho has the opportunity for good health and an acceptable quality of life.

The Ministry has therefore undertaken to review its first policy developed in 2004 in order to further restructure its health system, and to meet the multiple challenges faced by the health sector today. This document attempts to capture some radical changes that must be implemented to make the health system not only responsive to the needs of Basotho, but more importantly, to guarantee sustainability of the system to carry out the sector's mandate.

The document is a product of several months of consultations with the major stakeholders and implementors. The consultations started with group discussions with the selected districts whereby Hospital Management Teams, District Health Management Teams and selected members of Community Councils were met. The Technical Working Group was established at the headquarter level to oversee the process ; review sub-sector policies ; undertake literature review of several studies conducted during the reform process and the tenure of the policy under review ; align the policy with the National, Regional and International policies and develop a preliminary policy document. The consultant was engaged to analyse and synchronise the information into a refined policy document through conducting a series of consultations with the Senior Management, Heads of Programs and conducting consensus workshops to be able to come up with the draft document. The Ministry is confident that this wide participation in the preparation of the document guarantees ownership and commitment of all stakeholders and the implementors of the policy.

I would like to express my deepest appreciation to all those who have been involved in supporting this important process and the excellent work that has been accomplished.

.....
Hon. Dr. M. Ramatlapeng
Minister of Health and Social Welfare

LESOTHO HEALTH POLICY - 2011

1.0 Situation Analysis

Lesotho's vision 2020 and Development Plan present clear Government guidance and challenge to formulating sector development policies and plans. The UN Millennium Declaration and other regional declarations called on countries to focus development policies on poverty reduction, as well as rededicate to and revitalize primary health care and health systems strengthening. As countries work towards meeting goals and targets related to global health challenges, it has become increasingly clear that strong health systems are essential to delivering high-quality, accessible, sustainable, and safe health services with an equity and human rights focus. A review of Lesotho's Health and Social Welfare Policy (2004) therefore takes into account the dynamic environment and attendant challenges towards guaranteeing optimal health for her people with careful examination of the current health profile and state of the health system as a starting point.

1.1 Health Profile, Challenges and Emerging Problems

The Population and Housing Census of 2006 recorded a population of 1,877,889 people for Lesotho. The GNP stood at US \$ 1970 with a total health per capita spending of about US\$ 50. Poverty remains widespread in Lesotho; the Household Budget Survey of 2002/03 found that 29.1% of households were 'very poor' and 50.2% 'poor' in 2002/03. Inequality of income and consumption remains very high (especially considering urban rural differentials).

The country was headed towards attaining herd immunity levels in vaccination coverage before it experienced faltering in the past half a decade; malnutrition has however recorded encouraging decline during the same period. Wasting as well as underweight categories have declined from 4.3% and 19.8% respectively (in 2004) to 3.8% and 13.2% respectively (in 2009). Chronic malnutrition has decreased from the above 40% level (LDHS 2004) to 39 (recorded in LDHS 2009). This declining trend in nutrition indicators has to undergo significance testing despite pointing in the right direction. Immunization coverage improvement during the first half of the decade showed decline between LDHS 2004 (total 67.8%) and 2009 (61.7%). Life expectancy at birth for males was 39.77 and females 42.28¹; this represents a decline due to high prevalence of HIV (232 per 1000 adults 15-49 years) and TB (490 per 100,000 population) accounting for high adult mortality even upon excluding the estimated high maternal mortality (762 as per DHS 2004 and 1,155 as per DHS 2009). The under fives mortality rate has increased to 117 (LDHS 2009) as compared to 113 in 2004. Mortality in the post-neonatal period has been reported to have increased (LDHS 2009) even though IMR remained the same figure (91 per 1000 live births) between 2004 and 2009. The country's health profile² however gives the following as the main causes of deaths under five years: Prematurity tops the list, followed by birth asphyxia pneumonia, neonatal sepsis and diarrhea.

¹ GOL MOFDP Bureau of Statistics. 2006 Lesotho Population Census Published June 2010.

² Lesotho Country Profile 2008 www.who.int/countries

1.1.1 Health Profile

Major causes of morbidity, mortality and disability

In table 1 respiratory tract infections is followed by gastrointestinal conditions and diarrhea in terms of magnitude: The absolute number of skin and subcutaneous diseases (101,961) presented as 8% is either a records error or calculation error. Interestingly Hypertension records as number three, signaling relative importance of NCDs.

Table 1: Top 10 diseases (signs and symptoms) seen at OPD in the country in 2008 and 2009

Disease	2008	2009
Cough and cold	23770 (19%)	266317 (19.8%)
Other skin and subcutaneous	101961 (8%)	86552 (6.5%)
Diarrhoea and gastrointestinal infections	78375 (6%)	73838 (5.5%)
Hypertension	75519 (6%)	79553 (5.9%)
Other respiratory diseases	66998 (5%)	73128 (5.5%)
Other muscular skeletal and connective tissue system	65103 (5%)	63594 (4.7%)
STI	-	69093 (5.2%)
Other diseases of digestive system	31866 (3%)	27991 (2.1%)
Conjunctivitis	26613 (2%)	24644 (1.8%)
Tonsilitis	26429 (2%)	25369 (1.9%)
Other diagnosis	509725 (40%)	

Source: Ministry of Social Welfare AJR 2008/09 and 2009/10

In table 2, mortality from HIV and AIDS tops the list followed by Tuberculosis and both show a rise comparing 2008 and 2009 figures with a higher level of HIV and AIDS mortality among females.

Table 2: Causes of death 2008 and 2009 males and females

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

Source: Ministry of Social Welfare AJR 2008/09 and 2009/10 (Based on routine HMIS data)

Considering the top position of HIV and AIDS, the occurrence of trauma and prevalent anaemia mortality among adults (table 2 above) and children (table 3 below), blood donors recruitment for the supply of safe blood becomes an important issue for policy and strategy. The under five nutritional status is a good pointer of food security. Improvements in nutrition indicators have been noted but prevalence of both chronic and acute malnutrition continue to show up. Vitamin A deficiency rate is 13.4%; the prevalence of goiter is 43% among school children and 7% in women of child-bearing age.

Table 3: Causes of death 2008 and 2009 children aged 12 and below

Cause	2008	2009
Pneumonia	218 (16%)	147 (20%)
Diarrhoea and gastroenteritis	236 (17%)	146 (20%)
HIV AND AIDS	185 (13%)	120 (16%)
Other types of Malnutrition	305 (22%)	110 (15%)
Other forms of anaemia	-	33 (4%)
Dehydration	-	26 (4%)
Kwashiokor	38 (3%)	25 (3%)
All forms of meningitis	35 (3%)	23 (3%)
Pulmonary TB	39 (3%)	17 (2%)
Pueperal sepsis	16 (1%)	14 (2%)
URTI	18 (1%)	

Pneumoconiosis	15 (1%)	
Other diseases	278 (20%)	84 (11%)

Source: Ministry of Social Welfare AJR 2008/09 and 2009/10 (Routine HMIS data)

According to LDHS 2009 some health indicators have either stagnated or have shown a corresponding decline as the general trend while a few have shown some improvement (tables 4 and 5).

In table 4 some improvement is noted in access to safe drinking water it would be more useful to have urban/rural disaggregation of this data to be more informative:

Table 4: State of environmental health indicators 2004 and 2009

Indicator	DHS		Census	Comments
	2004	2009	2006*	
Access to safe drinking water	50.9%	73%	73.9%	Some improvement is noted. Aspects of functionality, continuity of supply and quality may need to be given attention.
Access to adequate sanitation	55.8%	49.8%	58%	Based on the DHS, a regression is noted while the 2006 registered an improvement from the coverage noted in 2004 DHS.
Proportion of population using solid fuels	67.8%	65.7%	52.5% wood	There is a general decline in the use of coal, wood and dung for cooking and heating purposes especially looking at the 1986, 1996 and 2006 census.

Source: DHS 2004 and 2009; *2006 Lesotho Population and Housing Census – Analytical Report

The high level of HIV and AIDS has worsened the health indicators (table 5 below) through its social economic impact. Knowledge of AIDS is around 95% among women and men respondents (LDHS 2009); but this needs to be complemented by knowledge of prevention (Using condoms and limiting sexual intercourse to one un-infected partner) which is trailing behind at 70.9% and 60.2% in women and men respectively. Four out of ten women and five out of ten men used a condom with any sexual partner during sexual intercourse in the past year (LDHS 2009). Considering that the practice of multiple sex partners is still occurring and that only 37.5% of respondents who had 2 or more partners reported using a condom, higher-risk sexual intercourse is fuelling HIV transmission. Apart from the impact of HIV and AIDS, the number of vulnerable people has increased as a result of retrenchments, increasing poverty, and other causes of death of breadwinners.

In table 5 improved life expectancy during the 1980s and 1990s entered a losing era in the past decade. Gains on infant mortality reduction suffered likewise. Under fives mortality has been declining along with MMR. Reduction in total fertility is challenging to interpret.

Table 5: Trends of Health Indicators

Indicator	1970s	1980s	1990s	2000s	2004	2009
Life expectancy	40	54	59	54	41.02*	*41.84
IMR/1000 live births	122	84	74	80	91	91
Child mortality rate/1000	-	34	34	38	24	28
U5 mortality rate/1000	55	-	-	113	113	117
Total fertility	-	5.3	4.9	4.3	3.5	3.3
Maternal mortality Ratio	-	282	282	419	762	1,155

/100,000 live-births						
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Source: Bureau of Statistics-
Demographic Survey 2001, LDHS 2004 and 2009

*Life expectancy average calculated from 2006 Census data and projections.

Non-Communicable Diseases:

The 2001 study on Non Communicable Diseases (NCDs) in Lesotho³ showed the following results:

Table 6: National Prevalence of NCDs.

DISEASE	PREVALENCE RATE (%)
Hypertension	37.6%
Diabetes	1.5%
Obesity	36%
Alcohol Use	38.8%

Table 7: Prevalence of NCDs in Urban and Rural Areas.

DISEASE	URBAN (%)	RURAL (%)
Hypertension	37.6	35.5
Diabetics	0.4	1.4
Obesity	46.3	33

Table 6 reveals significantly high levels of Hypertension, obesity and alcohol use and in table 7 insignificant differences in Hypertension and Obesity between urban and rural locations are notable.

Further findings from the study indicated the prevalence of hypertension, diabetes and obesity were higher among women than men, and smoking and alcohol use were higher among men. Seventy four per cent of people never exercise. More recent data would be useful for trend analysis but in the absence of specific programmatic interventions and sustained lifestyle it is unlikely that the trend of Hypertension has gone down.

The physicians to population ratio stands at 0.5 per 10,000 and Nurse and Midwives ratio was 6.2 per 10,000, which is way below WHO AFRO Region averages (2.4 and 10.9 respectively⁴).

1.1.2 Health Challenges:

- High maternal mortality due to limited accessibility of essential maternal care services.
- Faltering trend of under five and Infant Mortality
- Decline in immunization coverage
- Increased morbidity and mortality from HIV and AIDS and concurrent resurgence of Tuberculosis overburdening the weak health system
- Inequity in allocation of resources and access to health services.
- Behavior change in light of drivers of the HIV and AIDS pandemic is an evasive and pervasive element.
- Poverty remains widespread in Lesotho; the Household Budget Survey of 2002/03 found that 29.1% of households were 'very poor' and 50.2% 'poor' in 2002/03.

³ Survey on Prevalence of Hypertension and Diabetes in Lesotho, 2001

⁴ Lesotho Health System Assessment 2010 pp 48.

- Inequality of income and consumption remains very high (especially considering urban rural differentials).

Vulnerability is very high in Lesotho; 553 000 Basotho were unable to meet their annual food requirements after the drought of early 2007 (Food Security and Vulnerability Monitoring Report of June 2007).

1.1.3 Emerging Health Problems:

- HIV related conditions and Stigma.
- Obesity and concurrent NCDs
- MDR/XDR Tuberculosis
- Trauma due to Road Traffic Accidents and Assault.

1.2 Current Health Policy Appraisal

The current Health and Social Welfare Policy has existed and continued to be used in draft status since 2004. Its basis has largely been the commitment to the Alma Ata Declaration of 1978 (on Primary Health Care) which the country adopted in 1979 by creation of 18 Health Service Areas, building further on the Country's experience with making basic health care services available nearest to the population dating back to 1975. Fuller implementation of the current policy has been limited by lack of its formal launch even though it has been referred to in guiding the sector strategy and various programmatic policies. Since 2004, Lesotho has been in process of transition from Health Service Areas (HSA) to ten districts managed through the District Health Management Teams.

Impact of the draft policy has been observed through the transition from HSAs to District as administrative bodies to further improve access, equity and promoting community involvement and participation. This existing draft also guided planning in the programmes and facilitated resources mobilization for programmes implementation. There has been a marked level of adherence to the policy in its draft form through programmes strategic plans, e.g. establishment of a functional Oral Health programme.

In line with the GOL policy the main goal of reforms is to decentralize accountability and responsibility for delivery of health care services to local authorities to increase accessibility, equity, efficiency as well as strengthen ownership. The Ministry has looked into capacity building issues for the reform both at the centre and at the local government level. Furthermore the Ministry has appointed a decentralization coordinator who provides technical and managerial support to the programmes on a daily basis and ensures alignment of the health services decentralization with the broader National Decentralization Action Plan.

At district level 10 DHMTs have been established to provide technical leadership to district operations. Most DHMTs have about 60% of the core staff, 30% are in dedicated offices and all of them prepare annual operational plans to guide their activities. To date however there is no evidence that the indicators planned have changed significantly as the process is still at its infancy and accountability for performance is being pushed by Government and Development Partners.

The policy had no M&E outline to it. Structures or committees charged with reviewing, adapting, or changing Health Information System (HIS) indicators are typically convened on an ad hoc basis. In the absence of a standing committee or task force charged with organizing

periodic reviews of indicators, the emergence of large vertical disease programs has led to a proliferation of ad hoc committees on M&E/HIS. In addition, the MOH-led M&E technical working group is not functional because the central level unit is chronically understaffed.

Rationale for Updating and Reviewing the Policy:

Operating in a policy environment which is dynamic requires adjustment to changes in socio-cultural interactions, global financial turbulences, population profiles and factors influencing demographic trends. Recourse to Primary Health Care (PHC) and emerged importance of Health Systems Strengthening puts the country on course with implementing the Ouagadougou Declaration on PHC and Health Systems passed by WHO-AFRO Member States (April 2008): The main thrust to getting flagging health indicators back on track and attaining better health in Lesotho. Emerging challenges dictate stronger policy measures followed by determined drive for planned actions based on clear set of priorities. The HRH problems of supply, deployment, retention and market stabilization present an ominous threat to the health system if left unattended for much longer. A rising disease burden and workload at health facilities from HIV and AIDS, Tuberculosis resurgence along with drugs resistant strains need urgent and more determined attention. Management capacity has to be built to meet the growing needs and burden in the health system, especially when considering the current reality of low budget utilization against planned programmes, epidemiological transition mixing communicable diseases with Non-Communicable Diseases, and the complex problem of inequity (of allocation, access, utilization and outcomes).

The foregoing set of issues requires not only review of policy measures, but also coherent corresponding strategies to guide operational planning and action at all levels of the health sector. Likewise some of the measures will need legal enforcement which may require revisiting existing Acts and Regulations in terms of their sufficiency to effectively support policy implementation. In the process of review due attention has been given to harmonization and alignment to National Vision and Development Policy overall.

Review of the policy and appraisal of current strategic plan is an ongoing process aimed to inform the production of the next strategy 2012-2022.

Main Priorities of the Current Policy

The outlined district health package and targeted health problems and diseases that account for a high burden give a sense of the policy and plan priorities. Included in the district health package are:

- Essential public health interventions (Health promotion, immunization, nutrition, IMCI and Environmental health)
- Communicable disease control (HIV AND AIDS, STIs, TB etc)
- Sexual Reproductive Health and Rights/ Family Planning (Reproductive health, Safe motherhood, Maternal and infant nutrition, Adolescent health, PMTCT and ARVs etc)
- Essential Clinical services (Services for common illnesses, basic dental care, mental health services)

Health and Social Welfare Reform Agenda

The reforms agenda focused on improving technical and administrative as well as managerial aspects:

Technical areas

- District health package
- Infrastructure
- Pharmaceuticals (logistics and supplies)
- Social Welfare

Administrative/ Managerial Areas

- Human Resources reforms
- Financial reforms
- Decentralization of health services
- M&E and HMIS
- Donor coordination and Partnership (including SADC and other Regional Institutions)

The country committed to the social goal subscribed in the PHC approach by pursuing a course towards achieving universal coverage with substantial health gains post 1979. This was in the 1980s and 1990s affected negatively by lack of a comprehensive and clear policy framework, appropriate planning and management expertise, insufficient resources, poor coordination between CHAL and MOHSW in delivery of services and the advent of HIV and AIDS with concurrent resurgence of TB.⁵ The district health package that came into the picture in early 2000 has constituted the locus of health prioritization at district but weakness in supervision affected sustainability of quality particularly at the level of extending services from health facilities to the community. In addition staff attrition has persisted due to hesitancy in implementing retention policy proposals.

Specific gaps in the current draft policy include lack of consideration to traditional health practice, Non-Communicable Diseases (NCDs), investigative clinical services, rehabilitation and implementation of International Health Regulations. In addition the coordination and harmonization of the Health Information System has not been addressed.

Although joint planning with complementarity, synergies and coordination is established, problem solving has been shifting attention away from needs based planning. Besides the Essential Health Package and some efforts at TB-HIV integration there is no other tool or entity that pursues integration of health services. The policy is silent about bottom-up planning and supportive supervision.

⁵ MOHSW 2000. Lesotho Health Sector Reforms Plan.

1.3 Organization and Structure of the National Health System

Public sector

Structure and main functions of the MOHSW-Health Services

The new structure of the MOHSW has defined roles and functions of the central and district level units. The central level units will concentrate on policy, strategic planning, supervision as well as M&E, while implementation is left with districts. Health services are undergoing a process of decentralization to place decision making authority at the district level. Under this new system, districts will be responsible for budgeting, planning, implementing projects, managing health centers, and tracking resources, while the central will retain management of hospitals. The central level is also responsible for resource mobilization, advocacy and partner coordination, and provision of a regulatory framework for all health care providers.

Specifics of Health system:

The health system has both formal and informal domains. In the formal system health facilities are divided into the national (tertiary), district (secondary), and community (primary) levels. Numbers of these facilities by level and geographical distribution have been documented⁶ showing concentration of primary facilities (both public and private) in Maseru, which also hosts the Tertiary Referral Hospital, 2 specialized tertiary care hospitals and 4 secondary hospitals. The systems strength is in a nationwide web of health centres and community health posts. The district level comprises hospitals that receive patients referred from the health centres and filter clinics. Any patients with conditions that cannot be addressed at the national level hospitals are referred to South Africa for care, through the national tertiary referral hospital. Under public-private partnership a larger tertiary care hospital has been constructed to replace the current referral hospital and strengthen referral care needs. There are other specialized health care facilities like Senkatana for HIV and AIDS Management, Botšabelo for MDR TB, Baylor's Paediatric Centre of Excellence.

In Lesotho, 42 percent of the health centers and 58 percent of the hospitals are government owned, 38 percent of the hospitals and 38 percent of the health centers fall under the Christian Health Association of Lesotho (CHAL), and the remaining facilities are either privately owned or operated by the Lesotho Red Cross. In addition to the health care facilities recognized within the GOL system, there is an extensive network of private surgeries, nurse clinics and pharmacies providing care and/or medicines.

Health centers are the first point of care within the formal health system staffed by nurse clinicians with comprehensive skills in preventive and curative care and in the dispensing of medication. Health centers offer curative and preventative services, including immunizations, family planning. Health posts are community initiatives where Village Health Workers operate under supervision of Nurses from Health Centres.

Stakeholder Analysis

Besides the Government itself a second major stakeholder in provision of health services is the Christian Health Association of Lesotho (CHAL). It is the largest private-for-no profit public sector, and plays a crucial role in providing first or frontline care to at least 30 percent of the population, most of whom live in remote areas where coverage by government-owned facilities

⁶ MOHSW, USAID, Irish AID. Lesotho Health Systems Assessment 2010 pp13

is relatively poor. In addition to CHAL, a number of NGOs and private for profit health care providers are involved in health both in urban and rural areas.

The MOHSW also collaborates with other public sectors as well as health partners on health matters. A Health Partners' Forum meets to discuss health-specific donor assistance under the MOHSW, linking or relating at macro level to the Development Partners Consultative Forum (DPCF). Health development Partners members include Bilateral and Multilateral partners and NGOs.

Legal Framework

The Health Sector is regulated through the Public Health Order. Different levels of the health system and their relationships with other health and health-related statutory bodies including local government, special health projects, as well as oversight on private health services provision call for revised regulatory instruments to be in step with ongoing sector reforms.

Private Sector

Besides CHAL operating with the MOHSW through an MOU, other nonprofit organizations include the Lesotho Planned Parenthood Association (LPPA), the Red Cross, Clinton Health Access Initiative (CHAI) and Partners in Health (PIH). The LPPA operates 10 urban-based clinics in eight districts and has an outreach program working through community-based distributors. The Red Cross has four health centers in Leribe, Maseru, Mafeteng, and Mokhotlong districts providing comprehensive primary care services and preventive HIV initiative among the sexually active age groups. PIH runs and provides support to 9 MOH and CHAL clinics, serving rural communities in the highlands through implementation of the Rural Initiative Program including HIV and TB care and treatment in rural communities in the mountains and other related interventions. PIH relies on the support of the Lesotho flying doctors, a service supported by the GOL, Irish Aid, and the Mission Aviation Fellowship, to serve remote mountainous areas. In the four years since its inception, the Rural Initiative Program has reported a marked increase in service utilization.

The growing private-for-profit sector plays a lesser role than the public and nonprofit sectors in outpatient visits. In FY 2006/2007, 37% percent of outpatient visits in the country and 68 percent in Maseru were to a private provider (World Bank 2009). The Omnibus Study in Health Care Financing (Oxford Policy Management 2008) identified 190 private providers (including Pharmacies, nurse clinics, private surgeries, health centers and hospitals), with nearly 90 percent of these located in four districts: Maseru, Berea, Mafeteng, and Leribe. Most private practices in the country were reportedly run by one or more doctors, complemented with nursing and administrative staff.

Public-Private Mix

Through a Memorandum of Understanding, the MOH is in partnership with the private health practitioners for their involvement in TB control. The private sector also contributes to the expansion of ART services upon meeting of the MOH defined accreditation standards.

A more comprehensive MOU has been reviewed to facilitate the participation of the private practitioners in provision of a broader spectrum of primary health care services in a coordinated manner.

Contractual Arrangements:

The GOL through the MOH has entered into purchaser-provider partnerships with CHAL and Lesotho Red Cross Society (LRCS) for provision of a defined Essential Health Package (EHP). The objective of the partnerships is to improve access to care to all Basotho and expand coverage to larger numbers of people regardless of location, through a standardized user fee structure which includes elimination of user fees at the health center level.

The MOH has demonstrated its commitment to PPPs with the first PPP transaction which involves the sublease agreement with a private developer for the MOH Headquarters building. The MOH has also entered into a PPP agreement with Tšepong to design, build, partially finance, fully equip and operate the new referral hospital and to refurbish, equip and operate three filter clinics. This first of its own kind PPP in the Sub-Saharan Africa will contribute to strengthened health service delivery and is a key milestone that represents progress in the government's effort to overhaul the health system. The partnership will run for 18 years.

Traditional Health Sector

Organization and practice of traditional medicine is happening informally without a legal instrument to back up the practice. Government, however, encourages collaboration between conventional medicine and traditional medicine. Availability of traditional medicines still needs to be documented to facilitate efficacy and safety.

Community Participation

The Country is credited with conceptualizing and legally establishing Local Councils community participation mechanisms and engaging in massive training of Village Health Workers (VHW) during the 1980s and 1990s. While it is acknowledged that VHWs provide a key link for health services between Health Centres and Communities Lesotho's PHC experience and lessons have not been systematically documented to inform policy and strategy. The sector did not develop formal policies to define the VHWs' role within the system. There are no official mechanisms in place to ensure active engagement of the community in the management of the health system and the delivery of services. The link provided by VHWs has remained informal despite its huge contribution. Voluntary VHWs, estimated in 2004 to constitute 56 percent of the total formal and informal personnel in the health sector were intended to provide the first line of contact for basic health care services to the community at the village health post level. Supportive supervision for the community system is inadequate, as is financial assistance for the VHWs' operations, such as transport allowances when carrying out their duties. Community-based facilities and workers are also faced with frequent stock-outs of drug kits and other commodities.

The inadequate recruitment and replacement of VHWs in the last 10 years has resulted in another threat to the health delivery system at the grassroots as the old ones retire. VHWs are essential for delivery of social welfare and health interventions at both the community and household levels, and for creating a demand for facility-based services through social mobilization. A VHW is responsible for approximately 40 households. VHWs are supervised by facility-based health professionals who in turn are supervised at the district level by the district public health nurse. At the national level, this program is coordinated by a community-based health service coordinator in the Division of Family Health.

The VHW attends meetings of the Health Centre Committee along with other representatives from the community. Beyond the Health Centre there is need for a community/village health committee that is supervised by DHMTs overseeing the quality of care and determining the community priorities in the health sector as well doing semblance of M&E using the protocols on quality assurance from MOH HQ preferably articulated within the Local Government system.

1.4 Resources

Physical resources, human and financial resources, equipment, medical supplies and transport have been elaborated in annex III.

1.5 Health Services Access and Utilization

About 79.5 percent of the national population lives within two hours' walking distance of a fixed health facility, but much of the travel is over rough terrain. In 64 percent of the hospitals significant proportion of clients showed satisfaction with the health services during recent quality assessments. The reasons for dissatisfaction include long waiting time and un-availability of medicines. The average waiting time ranged from 1 to 7 hours, although there seems to be improvement in this parameter from many facilities over the years.⁷

The average OPD contact per capita has increased due to removal of user fees from about 0.5 in 2007 to 0.7 in 2009. This correlates to less than one visit per year, per Mosotho and is well below the WHO norm of 3.5 visits per capita per year (Strachan 2007). The average bed occupancy rate in 2009 for GOL and CHAL hospitals were 38% and 42% respectively. None of the hospitals except QE II hospital were within the expected limits of bed occupancy of 75-80%. (Annual Joint Review report 2009/10)

Although no significant change has occurred in the number or relative accessibility of facilities, efforts are underway to further improve the existing structure through an extensive, MCC-supported renovation and construction activity. (Lesotho Health Systems Assessment 2010)

1.6 Synopsis of Specific programmes is highlighted in Annex IV.

1.7 Users' Demand and Participation

Clients' satisfaction is a regularly monitored feature of the system (AJR reports show this clearly). The most common concern of clients is waiting time which is perceived to be long. Experienced stock outs of common medicines (judged from monitored tracers) indicates clients' expectations for medicines are sometimes not met as again noted in AJR reports. A patients' charter is acknowledged to have been made available to health facilities – this should be a useful tool for facilitating patients' as well as provider rights and obligations.

Under the new system of decentralization, districts will be responsible for budgeting, planning, implementing projects, managing health centers, and tracking resources. Participation of communities is attained through their representation and mobilization under District and Community Councils structure.

Health posts provide community outreach services. Generally, health posts are opened at regular intervals (not daily) and provide promotive, preventive, and rehabilitative care in

⁷ MOHSW 2010. Annual Joint Review Report 2009/10 FY

addition to organizing health education gatherings and immunization efforts. Volunteer CHWs include village health workers, traditional birth attendants and community-based condom distributors, among others.

Challenges that have affected the growth and consistent performance of the community-based program run by the volunteer CHWs include inadequate funding, increased burden of diseases, acute shortage of health professionals to supervise, and inadequate incentives—all of which have led to low morale and de-motivation of this workforce. Discrepancies in the existing payment of incentives to Village Health Workers have been a further contributor to the de-motivation in particular of government supported Village Health Workers. Concerns have been raised about the sustainability of “Volunteer Health Workers”. All these point to one fundamental problem: Absence of a Strategic Framework to guide implementation and harmonization of Community Health Work and community mobilization for better health in terms of a more determined local health promotion. Besides activities defined as responsibility of health workers at community level, how households and communities are empowered to engage in health action and attain better health has not been clarified.

1.8 Strengths, Weaknesses, Opportunities and Threats (SWOT)

Strengths	Weaknesses
<ul style="list-style-type: none"> ○ Strong track record of adequately financing the health sector and Government providing more funding for ARVs. ○ Most of the key strategies for addressing production, hiring, retention, capacity building, and continuing education of health workers have been developed. ○ Some basic training infrastructure for all cadres (except doctors) in place ○ Existing mechanisms and agents to facilitate effective community participation; Strong cadre of VHWs given incentives since 2008 ○ HIV AND AIDS and TB policy framework ○ SRH and ADH policies and PMTCT guidelines in place ○ Infant and Young Child Feeding policy and Nutrition guidelines in place ○ Restoration of health infrastructure at various levels ○ Nurses and Midwives Act and Rules and regulations reviewed, Nursing Strategic Plan developed. ○ Laboratory policy is in place ○ Pharmacy policy and guidelines in place 	<ul style="list-style-type: none"> ○ Low risk-pooling mechanism with high household expenditures for health. ○ Lower levels of budget execution ○ Tardiness in implementing existing human resource plans ○ An HR policy guide is lacking ○ Weak coordination between MOH, public service, and training institutions ○ Lack of an integrated Health Information System affecting linkage of evidence to health policy and strategy. ○ Weak regulatory frameworks for pharmaceutical commodities and professionals (Nurses an exception) ○ Low capacity to discharge procurement functions which could be related to issues of coordination with the parent Ministry ○ Inadequate replacement of VHWs in the last 10 years ○ No policy framework formalizing the roles, responsibilities, and status of voluntary/CHWs and VHW ○ No national Quality Assurance Policy guidance ○ Consideration towards establishment of a health service commission to address HRH specifically.

<p>Opportunities</p> <ul style="list-style-type: none"> ○ Substantial international goodwill ○ Health sector development is a priority at highest level of Government ○ Strengthened health governance possibility available through the decentralization process ○ Abolition of user fees in all health centers of GOL and CHAL. 	<p>Threats</p> <ul style="list-style-type: none"> ○ The burden posed by HIV and AIDS ○ Inadequate strategies for retaining health experts ○ High attrition of health personnel ○ High level of dependence on external HR capacity in service delivery creates a state of health insecurity
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1.9 Main Health Policy Issues and Major Challenges

Main health policy issues

- Human Resources for Health – Retention, attraction
- Finance – Efficiency issues in utilization; fiscal decentralization
- Equity – Access at levels higher than Health Centre depends on ability to pay; underserved community
- Decentralization – Strengthening functions at decentralized levels to manage the health agenda within decentralization plans
- Community health work –partnership with related sector ministries, absence of strategic framework, fragmented /uncoordinated support

Major Challenges

- Human resource development - attrition, sick and unskilled workforce work against deployment and retention efforts and encourage dependence on external HR capacity
- Improving efficiency as well as effectiveness in utilization of financial resources
- Pharmaceutical and essential supplies management; weakness in procurement system
- Sloth in fiscal decentralization given capacity limitation of local government, undermines decentralized planning and management
- System of health services – Transition from HSAs and District Health Management within the capacity limitations of Local Government affecting comprehensive decentralized health planning, budgeting and implementation management.
- Infrastructure - Maintenance and planned preventive maintenance culture not in place
- Enhancing and sustaining environmental health and hygiene standards (sanitation, food and water safety, waste management) at individual level, households and public premises.
- Coordination and Harmonization of Health Information System (HIS) and M&E

1.10 Health Needs and Priorities

Priority setting is toned by two major considerations: Contributors to the heaviest burden of disease and periodically updated essential health package.

- HIV and AIDS care, treatment and prevention tops the list of needs
- Tuberculosis detection and treatment
- Raising and sustaining immunization coverage
- Managing childhood illnesses (Neonatal conditions, ARI, Diarrhoea)
- Ensuring safe motherhood and health of the newborn
- Addressing non-communicable diseases (Hypertension, Diabetes, Trauma, heart disease and cancer, etc)
- Sanitation and hygiene
- Disease prevention through education and health promotion
- Addressing existing severe health systems weaknesses, particularly the shortage of and inequity in distribution of key qualified health professionals, leadership, fragmented health information, supply chain management for essential medicines and vital supplies, and poor budget execution.
- Surveillance, Research and M & E

1.1.11 Socio Economic Environment

The magnitude of poverty in Lesotho is big and is increasing. Poverty incidence is estimated to be 50%, poverty depth 21%, and poverty severity 15%. All poverty indices have taken a worsening trend (LBOS, 2002). Moreover, economic and social inequality in Lesotho is one of the highest in Africa. The Gini-Coefficient (measurement of inequality, where 0 is full equality and 1 full inequality) in Lesotho is 0.66 with district variations of 0.60 to 0.70. Inequities and poverty are more in rural areas. The mainstay of the economy had been remission of funds from Basotho migrants working in South Africa. This has changed as many migrants working in South Africa mines have been laid off. Now the South African Customs Union (SACU) is the major income earner for the country more recently threatened to decline. The gross domestic product (GDP) is currently gauged at US\$516.87 per capita (World Bank 2010). Agriculture has been the traditional form of sustenance for Lesotho. However, this is not yet developed enough to make a significant contribution to economic development. Efforts have been made to initiate small and medium-sized enterprises but these are in infancy. Other forms of economic activities being developed, also in their infancy, are tourism and mining. Other sources of livelihood are subsistence farming (22% of household), cash wages and salaries (17% of households), cash cropping and livestock sales (12% of household) GOL/TWG, 2003). A more recent analysis has observed that vulnerability is increasing, and social sharing mechanisms that have provided protection for the vulnerable are themselves under threat⁸.

⁸ Government of Lesotho 2008/9-2009/10. Realising the National Vision through tackling Vulnerability. An issues paper for the National Development Plan.

The United Nation Development Programme, (UNDP) Human Development Index (HDI) indicates that Lesotho has dropped back on the poverty/development scale. In 2000, Lesotho's HDI was 0.497 making it rank 127th out of 174 countries. In 2002, the country's HDI reduced (worsened) further, making it rank 132 out 174 countries. Poverty and development efforts have been complicated by HIV and AIDS where the general population has a sero-prevalence of 31% and women attending antenatal clinics in Maseru have an HIV prevalence of 42.2% (GOL, 2002 HIV AND AIDS Surveillance report). The country is prone to humanitarian crises such as drought, food shortage, insecurity, malnutrition, illness and unemployment.

The country got independence from Britain in 1966. It had its first democratic elections in 1965 under a West Minister model based on a multi-party democracy. Lesotho subsequently went through a period of political instability from 1970 to 1992. The second democratic elections were held in 1993. The third elections held in 1998 unfortunately led to widespread civil unrest and destruction of economic investments. Subsequent elections held in 2002 and 2006 were calm and the political situation has remained stable until now.

The macroeconomic prospects are to be improved through the Poverty Reduction Strategy. The average economic growth of 8.2% experienced between 1997 and 2001 declined to 4.6% due to riots resulting from the elections held in 1998. Public debt stood at M6.8 billion in 2001. Lesotho has a high external debt/GDP ratio of 96.4%. Ninety per cent of Government revenue is used for debt servicing (GOL/BOS, 2001). Since 2003/04, the Government has run fiscal surpluses, largely due to unanticipated additional revenue from the SACU revenue sharing arrangement⁹.

⁹ Government of Lesotho 2008/9-2009/10. Realising the National Vision through tackling Vulnerability. An issues paper for the National Development Plan.

2.0 Vision, Mission, and Goal of Health Sector

The Health Vision is to have a healthy population, living a quality and productive life by 2020.

The vision for development is articulated in the Constitution of the Kingdom of Lesotho and in Vision 2020. Both documents were developed through democratic and participatory processes.

The Constitution of Lesotho 1993 in Chapter III: Principles of State Policy articulates the vision and broad policies on socio-economic development including principles of Equality and Justice, Protection of Health, Universal Education, Good Conditions of Work, and Protection of Children and Young people.

Vision 2020 of Lesotho states that the country shall be a stable democracy, united, prosperous nation at peace with itself and its neighbours. It shall have a healthy and well-developed human resource base. Its economy will be strong, its environment well managed and its technology well established."

Vision

The Nation will have access to affordable and equitable quality health care irrespective of geographical location.

Mission

To establish a system that will deliver quality health care efficiently and equitably.

Goal

To have significantly reduced morbidity and mortality, and thus contribute to attainment of improved health status among the people of Lesotho.

3.0 Values and Guiding Principles

Core Values

The following are key core values articulated in the Constitution of Lesotho, Vision 2020 and other International and Regional Conventions that guide the health sector policies:

- a) The spirit of sharing benefits and responsibilities;
- b) Respect of self and for others;
- c) Humanity in development of health strategies;
- d) Family bond and primacy of family unit;
- e) Gender sensitivity and responsiveness and special consideration of women due to their special reproduction role;

- f) Transparency in activities, actions and resource use;
- g) Accountability for resources and actions;
- h) Participation and involvement of communities and stakeholders;
- i) Partnership with NGOs, churches, labour organizations and the private sector and civil society and international organizations.

Guiding Principles

Political Commitment: The Government is committed to poverty reduction with emphasis on economic growth and social protection. This commitment will provide the critical guidance in priority-setting and resource allocation. Commitment to this policy will be required at all levels of political, civil and cultural leadership.

PHC Approach: In accordance with Alma Ata declaration of 1979 and the Ouagadougou Declaration 2008, the government of Lesotho shall provide essential health care services that are universally accessible and affordable to all Basotho. Emphasis will continue to be put on effective application of its principles and elements as well as Health Systems Strengthening.

Equity: In accordance with the Constitution of Lesotho, all Basotho shall have equal access to basic health care. Particular attention shall be paid to resource distribution patterns in Lesotho to identify and accelerate the correction of any disparities.

Accessibility and Availability: Services shall be progressively extended to reach all communities in Lesotho. Special attention shall be given to the disadvantaged regions and underserved communities in the country. Services shall be community based taking into consideration special socio-cultural circumstances.

Affordability: The Essential Health Package shall be free of charge or highly subsidized. Other services shall be obtained for a fee. The fee structures for such services shall take into consideration the wide range (variation) abilities of Basotho to pay. Alternative options for health financing shall be explored.

Community Involvement: Communities shall be actively encouraged and supported to participate in decision- making and planning for health. Through ownership of community projects, communities will be masters of sustainable primary health care programmes in their own areas.

Integrated Approach: This lays the ground for a common approach and for a common front to improve the quality of life. The health service provision will continue to approach health issues holistically such that treatment of diseases will be coupled with aspects of nutrition, hygiene and promotion of healthy lifestyles.

Sustainability: The ability for a service to continue into the future is referred to as sustainability. New and ongoing programmes will be subjected to sustainability assessment.

Efficiency of Resources: As much as possible, resources shall be used where the greatest benefit to an individual or community is envisaged. Periodic cost- effectiveness analysis shall be carried out to identify cost-effective interventions.

Inter-sectoral Collaboration and Partnership: Government and non-Government sectors will be consulted and involved in implementation, monitoring and evaluation of health using effective collaborative mechanisms.

Quality: Efforts will be made to ensure that all Basotho receive quality health care services. National norms and guidelines and standards of services shall be reviewed, formulated and applied to ensure that good quality services are provided.

Gender Balance: Gender sensitivity and responsiveness shall be applied in health service, planning and implementation. Special consideration shall be accorded to women due to their culturally constructed lower status in the society and their special role in reproduction. Where men have been disadvantaged, special effort will be made to support them.

Ethics and Human Rights: Health workers shall exhibit the highest level of integrity and trust in performing their work. They will observe ethical conduct guided by ethical guidelines, which will be enforced by professional councils. Health service consumers and health workers shall be protected by legislation specifying their rights and channels of appeal. Both service consumers and providers shall be oriented to and shall apply the human rights based approach in health.

4.0 General Policy Objectives

1. To reduce morbidity, mortality and human suffering among the Basotho.
2. To reduce inequalities in access to health services.
3. To strengthen the pillars of health system.

5.0 Policy Orientations

5.1 HEALTH SERVICES

The overall objective of health services is to contribute to improved health status through equity and access to quality health care in both public and private domains guided by the principles and strategy of primary health care and health systems strengthening.

5.1.1 HIV and AIDS

Lesotho has one of the highest HIV and AIDS infection and prevalence rates in the world. HIV and AIDS poses one of the greatest challenges for national development, and threatens the very survival of the nation and its attainment of the Millennium Development Goals (MDGs)

Policy Objective

To fight the HIV and AIDS pandemic by preventing the further spread of the epidemic, providing treatment, care and support services.

Policy Measures

The Ministry shall: a) Ensure free universal access to HIV and AIDS information, prevention, treatment, care and support to all population. b) Ensure an effective decentralization system that makes the Local Authorities the Gate-Way in the fight against HIV and AIDS. c) Ensure harmonisation between the law and medical ethics. d) Coordinate and ensure integration

among HIV, STI, TB and other related services to provide a continuum of care. e) Establish clear guidelines and legislation on implementation of HIV and AIDS programmes that include issues of patient rights and child protection as well as in special conditions/situations

5.1.2 Sexual and Reproductive Health and Rights

Reproductive health rights refer to people's freedom and ability to reproduce and to decide when and how often to do so.

Reproductive Health is a state of complete physical mental and emotional wellbeing and not merely the absence of conditions that affect reproduction.

Sexual health refers to the enhancement of life and personal relations whereby among others, counseling and care related to reproduction and *sexuality*, are provided.

Policy Objective

To make pregnancy and childbirth safe for mothers and newborns, and reproductive health services acceptable to individuals, families and communities.

Policy Measures

The Ministry shall: a) Ensure access to safe, effective, affordable and acceptable reproductive health services including family planning services to youth, women and men. b) Promote and enhance family planning, safe motherhood and new born care. c) Promote and enhance adolescent sexual and reproductive health including prevention of transmission of HIV and other STI's. d) Strengthen prevention of mother to child transmission of HIV and STI. e) Develop and implement legislation related to sensitization and education in respect of sexual and reproductive rights for individuals, families and communities. f) Provide comprehensive services for victims/survivors and promote reduction of all forms of Gender Based Violence.

5.1.3 Child Survival and Development

Many children still die before their fifth birthday due to preventable diseases. Inappropriate early childhood management and challenges in parenting lead to poor physical and mental development of the child.

Policy Objective

1. To preserve the life of children and ensure quality growth and development.

Policy Measures

The Ministry shall: a) Provide quality child health services in order to reduce childhood morbidity and mortality. b) Ensure elimination and eradication of vaccine preventable diseases as well as reach herd immunity for routine immunizable diseases of children. c) Develop early childhood development strategy used to give children the best chance for development and growth including guardian education and counseling; d) Promote care of children who have undergone

all forms of abuse; e) Coordinate and ensure the links between childhood diseases control, environment, hygiene and nutrition.

5.1.4 Nutrition

Malnutrition and micronutrient deficiencies among the general population have increased over the past decade. Stunting and Wasting are major nutritional problems in children under five years; they lead to early death, frequent illnesses; and affect physical and cognitive capacity. The LDHS 2009 indicates that the stunting level (chronic malnutrition 39%) has not improved and is far beyond the WHO cut off point of 20%.

Policy Objective

To contribute to the nutritional status of the population and contribute to socio-economic development. The specific objectives are to: 1) to contribute to reduction of childhood and maternal malnutrition; 2) Reduce micronutrient deficiencies.

Policy Measures

The Ministry shall: a) Promote diet diversification and balanced food distribution in the household, especially to children and mothers. b) Provide technical guidance to attain community and institutional ante-natal and post natal nutrition screening, counseling and support, including promotion of breastfeeding. c) Provide facility based nutritional care and support to vulnerable children and women. d) Advocate for the private sector to fortified foods with micronutrients.

5.1.5 Environmental Health

The emerging and actual threats to human health and welfare, as well as the environment need to be addressed through the implementation of environmental health interventions, that include promotion of appropriate water supply and sanitation; food hygiene and safety; occupational health and safety; pollution control; emergency preparedness and response; housing; and port health services.

Policy Objective

To promote environmental conditions and interventions that will improve health and social welfare.

Policy Measures

The Ministry shall: a) Promote appropriate water supply and sanitation, food hygiene and safety, pollution control, emergency preparedness and response, occupational health and safety, housing and port health services. b) Encourage a multidisciplinary approach to secure collaboration between different sectors; c) Review and update legislation that impact on environmental health. d) Institute environmental surveillance mechanisms in collaboration/consultation with relevant stakeholders. e) In partnership with stakeholders

establish a Health and Environment Strategic Alliance (HESA) for the implementation of the Lesotho's obligations under Multisectoral Environmental Agreements (MEAs) on health issues.

5.1.6 Emergency and Humanitarian Action

The most common hazards in Lesotho are: drought, snowfall, strong winds, harvester termites, local floods and disease outbreaks. The country is also affected by sudden manmade disasters such as widespread fires, road traffic accidents and social conflict. Although Lesotho has not experienced significant disasters, but expansion of industries increases potential for technological or industrial disasters, including effects of industrial waste. In addition, rapidly growing urban areas increase potential disasters related to urbanization/ slums. A multi-sectoral and multidisciplinary approach is an effective way to respond to the situation.

Policy Objective: 1) To minimize disaster risks, prepare and respond to emergencies/disasters and mitigate health and social consequences.

Policy Measures

The Ministry shall: a) Strengthen community, district and national level preparedness and response to health emergencies and disasters. b) Establish and implement pre- hospital emergency medical services. c) To strengthen coordination in response to emergencies in collaboration with other stakeholders.

5.1.7 Occupational Health

The protection of workers' health and welfare is an essential aspect of health considering the risks at the workplace.

Policy Objective

To prevent the occurrence of occupational hazards and accidents and rehabilitate those who are affected by occupational hazards in order to ensure healthy workforce.

Policy Measures

The Ministry shall: a) Establish a comprehensive multisectoral, multidisciplinary and participatory approach to occupational health prevention and hazard management. b) Monitor and enforce relevant legislation on occupational health and safety. c) Strengthen capacity to deliver a comprehensive occupational health and safety services across the country. d) Monitor adherence to Infection Prevention and Control measures in all health care facilities.

5.1.8 Health Education and Promotion

Diseases can be prevented and good health promoted if people adopt healthy lifestyles. This requires people to be informed and persuaded to change their lifestyles. A high level of NCDs is a clear signal to have a more determined health promotion drive within the sector reaching out effectively to the general public. Optimizing existing opportunities for promoting health requires enhancing the profile and functionality of Health Promotion and giving it latitude for innovative engagement of key stakeholders.

Policy Objective

- 1) To advance health education and strategic communication on risky lifestyles in order to promote behavior change.
- 2) To enhance application of health promotion methods through raised profile and functionality of health promotion in the sector.

Policy Measures

The Ministry shall: a) Strengthen and enforce the communication strategy and mechanisms at individual, community and national levels. b) Encourage a change in people's social behaviour and lifestyle c) Optimize social marketing for health.

5.1.9 Pharmaceutical Services and Medical Technologies

Procurement of medicines is relatively expensive as Lesotho relies on importation from other countries. This challenge is compounded by the limited capacity to timely quantify the requirements/needs leading to speculations and increase in medicine prices. Medicine use is not always rational and medicines supply management at health facilities is extremely variable. Safety, standards and procedures for monitoring use and efficacy of medical devices, blood and blood products as well as transfusion services call for establishment of ethical and accountable practices.

Policy Objective

To ensure that essential, safe, efficacious, acceptable quality and affordable medicines and other therapeutic products, medical devices and technologies are available at all times in health facilities and are accessible to all.

Policy Measures: The Ministry shall a) Promote rational use of and prevent antimicrobial resistance to medicines. b) Establish Medicines control and Regulatory Body through an Act of Parliament. c) Strengthen the management of Pharmaceutical Services country wide by level. d) Strengthen Supply Chain Management and promote regional collaboration on Pooled Procurement. e) Promote local production that complies with Good Manufacturing Practices and in line with regional initiatives. f) Monitor and document Indigenous traditional medicines. g) Establish regulation and control to ensure safety and efficacy of medical devices, therapeutic technological equipment including blood and blood products and monitor their utilization.

5.1.10 Communicable and Non-communicable Diseases

Lesotho is experiencing a double disease burden as a result of an incomplete epidemiological transition. While the burden of communicable diseases (STI, HIV infection, TB) is still high, there has been an accelerated increase in Non-Communicable Diseases. These include hypertension, cardio-vascular diseases, diabetes, and cancers and trauma. The underlying causes include smoking, alcoholism, obesity and inappropriate diet, lack of physical activity and road traffic accidents.

Policy Objective

To reduce the mortality, morbidity and disability due to communicable and non-communicable diseases.

Policy Measures

The Ministry shall: a) Promote healthy lifestyles and change of behaviour that leads to good health. b) Promote and contribute to healthy environment, which includes safe food and water, personal hygiene, adequate sanitation, shelter and ventilation. c) Undertake regular surveillance and interventions against all diseases including vector borne and zoonotic diseases locally and those affecting neighbouring countries. d) Strengthen immunization against communicable diseases for vulnerable groups such as infants, mothers, adolescents, elderly people, people in congregate settings, PLHIV and migrant populations. e) Conduct epidemiological investigation of disease outbreaks. f) Protect susceptible community members by immunization, education and other appropriate interventions including quality assured medicines for management of diseases like HIV infection, TB, MDR/XDR-TB. g) Integrate physical, mental and social rehabilitation activities in the epidemic control measures.

5.1.11 Oral Health Services

The Oral Health Programme in Lesotho has a great challenge of human resources which greatly affects the quality of services provided on the health facilities as it is depended on non-nationals and the majority of dental assistants receive training on the job. Dental caries is the most common dental problem seen in all facilities followed by periodontal disease, oral cancer, dental fluorosis and oro-facial trauma.

Policy Objective

To improve oral health of Basotho through preventive, curative and rehabilitative services provided by appropriately trained health personnel.

Policy Measures

The Ministry shall: a) Integrate oral health into PHC programs. b) Develop appropriate curriculum for Dental Therapists and Dental Assistants at the National Health Training College. c) Increase output of Dental Therapists and dental Assistants for deployment to health facilities. d) Integrate oral health data into HMIS.

5.1.12 Mental Health Services

The mental illnesses are on the increase in Lesotho and these include drug/substance abuse, HIV and AIDS related psychoses, suicide in addition to depression, schizophrenia and organic psychoses. At the same time mental health services are not easily accessible to patients due to stigma and prejudice.

Policy Objective

1) To enhance /improve the mental health of the population of Lesotho. 2) To build capacity to provide sustainable mental health services to all those in need.

Policy Measures

The Ministry shall: a) Strengthen public mental health services. b) Ensure that communities are capacitated to manage mental illness at family and community levels. c) Promote provision of incentives and professional pathways in mental health care. d) Provide access to quality mental health services. e) Contribute to protection of mentally ill people.

5.1.13 Clinical, Diagnostic and Nursing Services

For majority of the people, the most urgent service is the clinical, diagnostic and nursing service. It is often the only service an individual voluntarily seeks. It is a service that becomes increasingly necessary when preventive and other public health interventions are not available, and have not been successfully implemented, or have not worked. In most cases, clinical, diagnostic and nursing services make the immediate difference between life and death.

Policy Objective

To provide quality, effective and efficient clinical, diagnostic and nursing services for prevention, treatment of diseases, and rehabilitation for all those in need of the services.

Policy measures

The Ministry shall: a) Implement service package and level of technological sophistication according to classified typology. b) Capacitate health professionals to provide evidence based clinical and nursing care. c) Establish a system for sourcing, vetting and maintenance of health and medical technological equipment and procedures for handling health care technical service needs. d) Develop national health care referral system. e) Licence all health facilities. f) Regulate user fees for accessing health care in the country. g) Safeguard access to clinical services in support of the continuum of care. h) Strengthen a National Blood Transfusion Service to manage recruitment of donors and standard operating procedures for collecting, storing and distributing safe blood and blood products. i) Encourage the donation of body organs and forbid their sale. j) Only keep bodies of patients who die in government health facilities for fourteen days in the government hospital mortuaries.

5.1.14 Referral Services outside the Country

Health care capacity within the country is not adequate to handle highly complex disease conditions. Referral services within the country need to be reorganized or well managed to enhance efficiency of our tertiary institutions. However, only specific complex diseases can be referred abroad

Policy Objective

1) To develop a system that will cater for referrals of highly specialised cases

Policy Measures

The Ministry shall: a) Develop protocol for referrals abroad. b) Establish partnership with specialised health care institutions abroad

5.1.15 Traditional Health Services

It is a well known fact that most Basotho consult with the traditional health practitioners before presenting to health facilities

Policy Objective

To enhance the collaboration with traditional medicine healers.

Policy Measures

The Ministry shall a) Develop guidelines for the partnership with traditional and allopathic in the context of Basotho culture. b) Develop legal regulatory framework to guide the partnership. c) Promote documentation of available traditional medicines to inform future studies on efficacy and safety. d) Promote and preserve indigenous knowledge of traditional medicine.

5.2. SUPPORT SERVICES

5.2.1 Human Resource Development (HRD)

Human resource is the determining factor for satisfactory delivery of health services. Human resource is trained internationally, regionally and nationally. Quality assessment to ensure standards of professional performance is institutionalized. The health sector needs to retain human resources for health for quality service provision.

Policy Objective

To attain and maintain deployment of the right numbers and skills mix of appropriately trained and motivated human resources for health.

Policy Measures

The Ministry shall: a) Advocate for establishment of health workers commission. b) Ensure recruitment of quality health profession and deploy competent HRH that provide quality health services. c) Provide opportunity for effective career development and continuing education. d) Develop appropriate manpower plan to maintain adequate human resource supply for health. e) Retention of adequate health professionals. f) Strengthen collaboration with health professional bodies to maintain ethical conduct and professionalism among human resources for health. g) Rationalize health personnel in accordance with recommended FTE.

5.2.2 Education and Training

The Health related Higher Education Institutions (HEIs) are mandated to produce health professionals of different cadres to ensure that the Ministry has the appropriate health workforce for health services delivery.

Policy Objective

To contribute towards provision of increased human resources of the required competencies using research, scientific and technological developments in response to changing health trends.

Policy Measures

The Ministry shall: a) Strengthen the capacity of the existing programs/institutions b) Strengthen teaching and learning resources and or environment. c) Establish new programs according to HRH needs d) Harmonize National professional legal frameworks that regulate education and training for health professionals

5.2.3 Health Financing

The bulk of the health services are financed by the Government with the donor agencies also contributing significantly to health service delivery. It is however evident that the development assistance has been affected by unfavorable economic trends hence the need to explore alternative financing mechanisms. The problem of equitable and effective resource allocation to all programmes and districts remains a challenge due to inappropriate resource allocation criteria.

Policy Objectives

1) To ensure availability and management of funding for improved access to health services and utilization of health facilities. 2) To mobilize funds for health and ensure that funds are allocated according to agreed priorities. 3) To develop appropriate resource allocation criteria for the district health budgets. 4) To ensure that health resources/services are provided in an equitable, efficient and sustainable manner.

Policy Measures

The Ministry shall: a) Adopt a Sector-Wide Approach of allocation and expenditure i.e. HIV and AIDS activities cut across in different sectors. b) Advocate for a higher allocation of the government budget to health service delivery. c) Continue to mobilize resources from within and outside the country d) Encourage private funding through cost recovery user fees , health insurance and community pre-payment scheme e) Introduce, monitor and regulate Social Health Insurance schemes to keep costs at an affordable level and promote wider participation. f) Review user-fee policy regularly to assess affordability, criteria for exemption and access to treatment of diseases. h) Continue the subvention to selected institutions that are in partnership with the government in delivery of the essential health service package. i) Put in place resource allocation mechanisms for efficiency and equitable distribution of resources. k) Compile the National Health Accounts periodically.

5.2.4 Health Infrastructure

Health infrastructure in Lesotho has been based on proprietors' convenience. Facility requirements are changing due to the demand and supply and needs for services factors. These include: 1) Demographic changes including internal migration, emigration, changes in fertility, and changes in mortality; 2) Major epidemiological shifts such as AIDS and TB; 3) The pricing of health care; 4) Improvements in clinical case management and referrals services; 5)

Improvement in preventive and promotive health services, and 6) Mental health service capacity development.

Policy Objective

To ensure that health physical infrastructure is appropriately designed/constructed and equipment are properly procured, installed and maintained in accordance with set standards.

Policy Measures

The Ministry shall: a) standardize Health facilities. b) Rationalize health facilities. c) Maintain and ensure proper upkeep

5.2.5 Quality Assurance

Inadequate Quality assurance system to guide attainment and maintenance of quality service standards poses a challenge for health service delivery. The quality assurance system/function in the health sector is highly compromised by limited capacity. Although the policy and the strategic plan have been developed there is no manpower to push the agenda of this important function. The quality in which the services are being delivered needs monitoring to ensure adherence to the set standards.

Policy Objective

To attain and maintain required standards in all health facilities in order to meet acceptable level of service quality.

Policy Measures

The Ministry shall a) Establish an independent functional Quality Assurance Unit b) Coordinate work on quality management including Quality Assurance planning in health plans at all levels. c) Build capacity and Communication on Quality Assurance. d) Document best quality assurance practice. e) Conduct regular accreditation of health facilities. f) Set and update standards regularly. g) Institute supervision guidelines.

5.2.6 Research

The Ministry conducts specific surveys to inform and direct policy for the health sector however, very minimal research is conducted to establish the root causes of the disease patterns. The current rationale for conducting research is not often generated locally and does not grow out of an agreed National research agenda. To date the research system does not clearly articulate the process and the levels of disseminating the research findings. The current research structure is still in its infancy and is not capacitated to coordinate all health research in the country.

Policy Objective

To ensure coordinated, regulated and appropriately prioritized health research that contributes to and supports policy objectives, poverty reduction and policy/strategy reviews.

Policy Measures

The Ministry shall: a) Establish a Health Research Coordination Unit (RCU) b) Develop a system for prioritization of research activities that will be applied in the course of calling for and processing research proposals. c) Develop partnerships with international, regional and local institutions/ partners/ stakeholders to promote National Health Research System, advocate for policy relevant research and develop corresponding proposals. d) Establish an independent Research Ethics Committee that will be supported by RCU and will be responsible for research and ethical clearance of proposals. e) Undertake capacity building for research at all levels of the health system.

5.2.7 Health Management and Information System (HMIS)

Some programs within the Ministry still have centralized and parallel data collection system which does not ease consolidation of information at one point. There is therefore a need to establish a decentralized and integrated health management information system. It is also critical to develop an effective feedback mechanism throughout the whole health care system to facilitate utilization of information at all levels.

Policy Objective

To provide timely, relevant, accurate and valid health and management information on a sustainable and integrated basis.

Policy Measures

The Ministry shall: a) Establish a system that will ensure that all registers/data collection tools are in compliance with the set standards. b) Establish safe storage and observe confidentiality of patients' records. c) Maintain efficient database for all health activities. d) Analyze data at all levels and disseminate to relevant stakeholders. e) Ensure easy retrieval of records according to GOL record keeping regulations. f) Keep the records of the deceased patients in health facilities for five years while other patients' records and registers shall be disposed off every ten years. g) Institute a system to ensure that the publication of unpublished data outside Lesotho shall only be after consultation with relevant authorities. h) Restrict access to health databases to authorized units. i) Undertake Demographic Health Survey in collaboration with BOS after every five years. j) Enforce the use of "the bukana" or any other approved system in all public health institutions and encourage other health service providers to conform. k) Build a data warehouse or business intelligence solution for collation, analysis and publication.

5.2.8 Sector Monitoring and Evaluation

Monitoring and Evaluation is an important function at all sectoral levels for measuring sectoral performance to ensure informed policy decisions. The centralized nature of the Monitoring and Evaluation system creates challenges in coordinating and monitoring sector performance countrywide. The absence of defined demarcation of catchment areas is a constraint in determining health service coverage at community council level.

Policy objectives

1) To guide implementation of the Health Policy through monitoring and evaluation of the Ministry Strategic Plan. 2) To assist the sector to make evidence based decisions and measure its performance and the impact of its interventions.

Policy measures

The Ministry shall: a) Develop, appropriate indicators for evaluating performance of health systems. b) Monitor progress and performance of the Health Sector periodically against the set benchmarks. c) Strengthen the M&E system at all levels. d) Promote data use for Health Systems strengthening and Evidence-Based planning. e) Include M&E aspects in the design of new projects to ensure that M&E needs are safeguarded. f) Conduct a Mid-Term Review (MTR) as well as End of Project Evaluation for all projects.

5.2.9 Information Communication Technology (ICT)

Efficient utilization of ICT is a challenge for enhancing performance accountability within the health sector. There is a wide technical gap and weak strategy to transform the information into a major resource for health care delivery. In this context, MOH has developed a Policy with the vision that Lesotho will have the health system supported by sustainable ICT applications in all dimensions.

Objectives

1) To enhance applications of ICT in health services delivery, health management and health systems strengthening for better health. 2) To improve sector performance through ensured efficient electronic communication network for Health and its key functional units

Policy Measures

The Ministry shall: a) Establish and capacitate a sustainable central coordination ICT Unit . b) Establish a system for standardization of ICT hardware and software. c) Establish an ICT based data management system. d) Maintain health website to maximize communication, publication and information sharing. g) Through Local Area Networks and Wider Area Networking, link to key functionaries in the health system and relevant Government focal points. i) Document and copyright protect all the ICT programmes and products.

5.2.10 Health Regulation

There is a need to regulate and provide guidance on health service delivery on various health practices. The emerging health issues and rapid technological development necessitate regular update and enactment of new laws and regulations.

Policy Objective

To develop legislation and regulations governing health services and ensures their enforcement.

Policy Measures

The Ministry shall: a) Review, update/ammend current health laws and develop new laws where necessary. b) Establish and regulate professional and allied bodies. c) Regulate the scope of practices. d) Establish a Medical Board

5.2.11 Community Based Health Care

The link between Health Centres and VHWs has been observed to be weak in the absence of regular supportive supervision that tracks interventions proven to make a difference to morbidity, mortality and disability.

Policy Objective

To attain harmonized and coordinated practice of community based health program so as to enhance take of health interventions.

Policy Measures

The Ministry shall: In collaboration with MOLGC and other stakeholders. a) Define and promote a package of health interventions to be implemented at community and households levels. b) Advocate for uniform benefits and rewards to CHWs. c) Undertake systematic assessment and documentation of the effectiveness and efficiency as well as quality of health care.

5.2.12 Partners' Coordination

The era of HIV and AIDs pandemic and the increasing burden of emerging diseases have brought with it the multiplicity of implementing donor agencies and NGOs which requires a robust coordination mechanism. One of the challenges associated with these interventions is the exclusion of their budgets from the overall fiscus of the government. In alignment to the Paris Declaration, countries are expected to establish a coordination mechanism that will ensure harmonized delivery of Donor aid. In the pursuit of harmonized donor interventions there is a need for establishment of functional coordinating structure.

Policy Objective

To establish better alignment and harmonization of partners' resources to government systems within a coordinated framework that respects integrated planning and management that enhance sustainability.

Policy Measures

The Ministry shall: a) Fully operationalize Health SWAP to ensure transparency and accountability for all health resources and improved donor coordination in planning, financing, implementation, monitoring and evaluation within the health sector. b) Institute functional structures that will facilitate regular dialogue with all development partners and other stakeholders working in health sector c) Enforce adherence to jointly agreed code of conduct in line with legal provisions governing development assistance as from time to time reviewed or enacted by Government. d) Provide all partners with the policy, strategic plan and the three year MTEF programme which should provide a framework that the partners' interventions should be aligned to.

5.2.13 Public Private Partnerships

The GOL acknowledges the contribution by the private sector towards health service delivery and the comparative advantage which the private sector has in delivering improved service. It therefore recognizes the benefits that can be reaped from partnerships with the private sector. The Government is also faced with the need to undertake more projects than it can afford and PPP as a financing strategy may be a solution. However, poorly grafted and rushed PPPs result in problems instead of attaining the anticipated value for money. The Ministry is therefore cognizant of the need for building institutional capacity for management of its PPP projects.

Policy objective

1) To improve delivery of health services by tapping into expertise and skills from the private sector, focusing on use of output-based partnerships, and ensuring an optimal allocation of risk between the private and public sectors. 2) To complement Government resources for addressing the health priorities through private sector participation.

Policy measures

The Ministry shall: a) Develop a functional structure for monitoring PPP initiatives b) Develop Health Sector PPP guidelines based on the government PPP policy. c) Adopt relevant recommendations from the GOL and CHAL partnership review. d) Improve accountability for subvention for CHAL, Blue Cross, LRCS and other partners. e) Monitor all the Health PPPs using contract management system f) Develop appropriate financing mechanism for local health NGOs benefiting from GOL subvention. g) Establish a joint committee to review and implement the Code of Conduct between the Ministry, donor partners and agencies.

6.0 Implementation Framework

6.1 Decentralization

The 2000-2010 Health Sector Reform program prioritized decentralization as one of the areas of focus. Three districts were selected as pilot areas and the District Health Management Teams were established to oversee the Primary Health Care services. In 2005 following the government decision to implement the 1996 Local Government Act, the Ministry rolled out decentralization strategy throughout the country. The councils operate fully since the end of 2005 when the first Local Government elections were held. Decentralization strengthens technical and organizational capacities of Local Councils and community structures in development planning, budgeting and management of funds. It enables community empowerment through popular and democratic participation in all matters of development and presents an opportunity for enabling application of the continuum of care.

The health services and related functions for which the Local Governments are responsible for are agreed between the MOLGC and MOHSW. The roles and responsibilities for functions earmarked for devolution and all programs that will be affected by the envisaged decentralization reform have been defined with clear roles and responsibilities expected from Councilors in support of the delivery of Primary Health Care by District and Community Councils Health Management teams. Quality standards, implementation protocols and manuals will guide professionals and Councilors that deliver core health responsibilities under the Local Government Commission Service. The Ministry will collaborate with Local Government Service to

develop service delivery targets and planning methodology to support decentralized service delivery.

6.1.1 Role of MOH

The MOH has the following roles: a) Provide overall guidance and advice on health care services; formulate policies and strategic plans. b) Provide and enforce health care standards. c) Develop and manage National Health programmes. d) Monitor and evaluate health status and services in the country. e) Ensure quality of services through supervision and quality assurance activities including development and enforcement of technical guidelines. f) Develop and enforce health care and welfare standards. g) Mobilize resources for health care services. h) Plan and implement human resource development plan. i) Develop health infrastructure.

The MOHSW is in process of restructuring to respond to decentralization and the functions above. In particular, projects and programmes will be harmonized with the Ministry's macro-organogram, and will follow the Ministry's established reporting and management channels.

6.1.1.1 Central Level Activities

Because of the multi-sectoral nature of health and the need for multi-sectoral and sector wide consultations, the following institutions have been established:

Annual Joint Review constituted as a formal institution headed by the MOH and attended by representatives from all Health Sector partners, relevant sectors of the Government, all the DHMTs, all Hospitals, District Councils urban councils and DDCCs. District Administration will be invited to attend the Annual Joint Review.

The Annual Joint Review plays the following functions: a) Review progress on annual and strategic plans. b) Review of progress with regard to the National Health Policy. c) Make recommendations to the Government on financing and management of health services. d) Recommend annual budgets to the Government including declaration of annual financial contribution by development partners.

The Quarterly Joint Review meetings have become a formal institution. The membership of the meetings is smaller, selected by the Annual Joint Review. They review progress of quarterly health plan implementation, and discuss resolve any issues arising there from.

6.1.1.2 Local Level Functions

Under the DDCC a District Health Team (DHT) has been constituted. The functions of the DHMT are to: Supervise health programs and health centers; Plan for health care delivery in districts; Mobilize resources for district health service delivery; and Integrate health services into district development plan.

6.2 National Council for Health

The Ministry shall establish the National Council for Health which will advise the Minister on broad issues of health development, intersectoral coordination and community participation. Its composition will emanate from the multi disciplines sections of the society. This Council shall consist of members appointed by the Minister.

6.3 Management of Health Facilities

6.3.1 Hospitals/Filter Clinics

Hospitals and filter clinics will be the responsibility of the Central Government. The DHT will plan and budget for districts and be responsible for sound functioning of health centres and health posts. Local councils will plan and budget for health services with technical advice from the DHT.

The District Hospital Committee/Board (DHC/B) will provide policy for the hospital, approve plans and budgets, and solve problems arising in the hospital including taking disciplinary actions.

6.3.2 Health Centres

Each Health Centre shall be managed by a team that will work closely with the DHMT. It will consist of head of the facility and three other senior staff. The Village Health Post is manned by the Village Health Worker and is visited periodically by a Health Professional.

The management will plan and budget for the health center and the Village Health Post, which will be approved by the DHMT on behalf of the DDCC. The DHMT will also discipline health center and the Village Health Post staff. It will approve local purchase of drugs and supplies.

6.4 Public-Private Partnership

PPP is a partnership between a public sector facility or institution and a private party, in which the private party assumes substantial financial, technical and operational responsibilities and risk in the design, financing, building and/or operation of a project which are normally provided through traditional procurement mechanisms by the Government. PPP is not just about the private sector financing capital projects in return for an income stream, nor outsourcing of functions where substantial financial, technical and operational risk is retained by the Government but it makes use of private sector skills and management expertise to deliver and operate public projects. It is not a donation by a private party for a public good but a form of output (performance) based financing. PPP shall exist at national and district levels.

6.4.1 Partnership with CHAL and LRCS

GOL recognizes the longstanding contribution of church facilities and other Non-government institutions such as LRCS to the health care of Basotho. However, the financial situation of these institutions has continued to deteriorate over a period of time following the decline in numbers of donors. This has therefore called for the need for Government's intervention through the partnerships.

The GOL and CHAL have entered into a partnership based on mutual trust and respect for equitable and efficient health service delivery.

The current GOL -CHAL partnership shall be reviewed to identify the shortcomings and improve its implementation. Based on the review findings, GOL and CHAL shall agree on the necessary conditions for a viable and sustainable partnership. Accreditation shall apply to all health facilities (public and private) to enhance quality of service. Meeting an agreed minimum set of accreditation criteria shall be tied to funding for a specified package of services. When found

feasible, the revised financing mechanism for CHAL will be replicated to partnerships with other health services providers.

The health sector specific public-private partnership policy and strategic plan shall be developed upon completion of the overall Government PPP policy which is currently being developed.; The financial arrangement, the organizational and coordination framework, annual plans and budgets to implement the partnership shall be developed.

6.4.2 GOL's Partnership with Other Private Sector Bodies

Management of PPPs

a) The PPPs of the MOH will be aligned to the overall policy framework of the Government. b) Within the confines of the GOL regulations, PPPs will follow a tender process which is competitive, transparent and fair to all bidders. c) The MOH will establish a dedicated PPP Unit for formulation, implementation and monitoring of health PPP projects. d) The MOH will embark on other forms of Performance Based Financing mechanisms with clear output specifications that will form basis for public expenditure. e) Other partnerships shall be forged between GOL and other private sector organizations such as Blue Cross Societies, Lesotho Planned Parenthood Association and the private practitioners.

6.4.3 Partnership with Traditional Health Practitioners

The Government recognizes that Traditional Health Practitioners play an important role in the health of the people. However the exact number and membership of the Traditional Health Practitioners and the services they provide are not known. The Government will therefore work with associations of Traditional Health Practitioners to register all their members on a mandatory and mutual respect basis; agree on a) the principles, and b) the areas or aspects for the partnership.

6.5 Implementation Arrangements

This policy will be implemented through the development of a strategic medium term plan. This strategic plan will be operationalized by annual plans at different levels. The MOH will provide technical guidance and support supervision, and carry out monitoring and evaluation.

Districts, health facility authorities and communities will develop operational plans and implement them. The DHTs will provide technical support and supervision to health centres and outreach services.

Management Information Systems will be developed with clear monitoring and evaluation benchmarks and indicators agreeable to all stakeholders for the assessment of progress towards policy goals.

7.0 Monitoring and Evaluation of the Policy

The M&E Unit of the MOH shall bear the responsibility for monitoring policy coherence and policy implementation in the health sector using a minimum set of agreed indicators as outlined below.

Core indicators for M&E of the policy:

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

	immunized				
9	Proportion of stunted children 0-59 months	10.3%	10.3%	9.8%	9.3%
	Proportion of wasted children 0-59 months				
TUBERCULOSIS CONTROL					
10	TB Treatment Success Rate	72%	73%	74%	75%
HUMAN RESOURCE					
11	Percentage of Hospitals with Full Time Equivalent (FTE) staff for the level.	0%	10%	20%	25%
	Percentage of H/C with Full Time Equivalent (FTE) staff for the level	1%	20%	30%	40%
FINANCE					
12	Proportion of GOL Budget allocated to the Health Sector	11.4% (2007/08 FY)	11.3%	11.5%	12%
13	Percentage of Health Sector Budget allocated to PHC (district health services)	24% (2007/08 FY)	30%	40%	50%
14	Percentage of Sector Recurrent Budget Expended (2007/08 FY)			
	Percentage of Sector Capital Budget Expended (2007/08 FY)			
INFRASTRUCTURE					
15	Percentage of budget allocated to maintenance	0.8% (2007/08 FY)	1%	5%	10%
	Percentage of budget allocated to medical equipment	TBD			
PHARMACY					
16	Percentage of Hospitals reporting one month 'stock out' for any of the medicines in the EML for the level.	6% (Medicines Access Survey 2007)	6%	5%	0%
	Percentage of H/Cs reporting one	14%	10%	5%	5%

	month 'stock out' for any of the medicines in the EML for the level.	(Medicines Access Survey 2007)			
HMIS					
17	Proportion of DHMTs conducting quarterly monitoring of their Operational Plan and organizing reflection meetings	0% (AJR - 2008)	30%	100%	100%
QUALITY ASSURANCE					
18	Percentage of Clients satisfied with services offered at hospitals and health centres	66% (exit survey AJR)	70%	73%	75%
SERVICE COVERAGE					
19	Percentage of Health Centres providing a defined minimum package of services	TBD	10%	10%	30%
ENVIRONMENTAL HEALTH					
20	Percentage of hospitals with functional means of Medical Waste Disposal System in line with national guidelines.(functional incinerator as proxy)	8%	30%	50%	80%
	Percentage of H/Cs with functional means of Medical Waste Disposal System in line with national guidelines. (functional incinerator as proxy)	0%	5%	5%	20%

Periodicity of data and mechanisms for collection, analysis, dissemination shall follow the procedure elaborated in the MOH Monitoring and Evaluation Plan or its periodically updated version. The M&E matrix in annex 1 clarifies how key outcomes of the policy, data sources, collection methods and periodicity, and responsible focal points are organized.

8.0 Conclusion

The healthy trend of the Kingdom's gains in health indicators has come under serious threat of reversal during the past decade primarily owing to HIV and AIDS, resurgence of TB and concurrent impoverishing effects. Maximal benefits of Lesotho's comfortable level of per capita health spend can be attained through determined policy implementation aimed at realizing equity in allocation of resources, and distribution and access to quality health services. Systems weaknesses particularly from severe shortage of health professionals within the background of employment freeze while attrition is on, is one major challenge calling for urgent stabilizing action. Low budget utilization at a time when key health indicators are showing signs of decline within an environment of an HIV and AIDS crisis, poverty and increasing vulnerability of critical population groups, are challenges calling for smarter and aggressive policy management; all these combined present a profound threat to the nation's health and welfare and hence reveal a national health security issue. Strong political will is needed to attain efficiency as well as effectiveness of interventions to achieve this policy's intent.

MOH Quick Gains:

- Unlocking Human resource performance and retention
- Enhancing Health Centres productivity in terms of quality and quantity of essential health package interventions delivered and effective linkage and support to community based health care
- Strengthening management practices of Health Facilities to focus on efficient problem-solving through rationalized integrated plans (joint planning, team efficiency, time personnel and finance management), and innovative performance-linked rewards (results driven).
- Advancing evidence driven health promotion for better focused BCC which among others advocates to develop an understanding that HIV AND AIDS crisis is an opportunity to promote sound public health practices by everyone at individual, community and societal level irrespective of HIV status
- Establishing a Health Service Commission with full powers to direct supply, recruitment, deployment, retention and development for stabilization of the health workforce.
- Closely interface with (NAC and) all agencies implementing the HIV AND AIDS policy to articulate areas for mutual potentiation and synergizing to attain maximum impact on HIV and AIDS prevention and impact mitigation goals.
- Revisit legal provisions so as to cater for regulating task-shifting, oversight of private practice, protection of rights of clients and service providers, as well as enhance application of gender concerns in health and social welfare service provision and health systems strengthening.
- Introduction and promotion of a duly monitored and regulated health insurance system aimed at attaining universal coverage.

To achieve a higher level of sectoral cohesion and coordination, systematic policy analysis, policy dialogue and strategy monitoring the MOH shall put into effective operation the SWAPs mechanism and its sub-structures as well as enforce compliance to an agreed code of conduct and division of labour amongst the collaborating partners. The SWAP shall focus on policy and strategy advice relevant to measures aimed at revamping the health system to achieve

- More rational and efficient use of resources
- Improvement in coordination of services (integration) and investments in health
- Improvement in planning (move from reactive to pro-active) in favour of more comprehensive and longer term approaches

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Annexes

Annex 1: Indicators for measuring key outcomes:

Key Objective 1: *To contribute to the reduction of morbidity and mortality, and mitigate physical and mental illnesses*

Key Outcomes	Definition of Outcome Indicator	Source of Data	Methods of collection	Frequency of collection	Responsibility
Herd Immunity against target diseases (> 80% coverage)	The cohort 12-23 months that had had 1 dose of BCG, 3 doses of DPT and Polio as well as 1 dose of measles.	2009 DHS	Survey	Every 5 years	<i>HMIS and Research</i>
5% reduction in under five case fatality from pneumonia.	Relative death rate from institutional pneumonia in under five with the 2007 rates as baseline.	HMIS	Routine IP data	Daily	<i>District HMIS</i>
5% reduction in under five case fatality from diarrhoea	Relative death rate from institutional diarrhoea in under five with the 2007 rates as baseline	HMIS	Routine IP data	Daily	<i>District HMIS</i>
Supervised Delivery rate of 65%	Proportion of expected deliveries that were supervised by a medical officer or midwife	HMIS + Census	Routine IP and Census data	Daily/every 10 years	<i>District HMIS + BOS</i>
ANC coverage rate of 90%	Proportion of expectant mothers that received ANC by a health professional at least once.	HMIS + Census	Routine MCH/FP and Census data	Daily/every 10 years	<i>District HMIS + BOS</i>
TB Treatment Success Rate of 75%	Proportion of registered SS+ TB patients that was either cured or completed treatment	HMIS	Routine NTP data	Quarterly/ Annually	<i>District HMIS</i>
<i>ART coverage of 80%</i>	<i>Proportion of expected eligible PLWA on ART</i>	<i>HMIS</i>	<i>Routine data HIV data + Survey + Projection</i>	<i>Daily/ Every 2 years</i>	<i>HMIS</i>

Key Objective 2: To increase access to quality promotive, curative, preventive, and rehabilitative health on the basis of equity and social justice

Key Outcomes	Definition of Outcome Indicator	Source of Data	Methods of collection	Frequency of collection	Responsibility
At least 75% Client Satisfaction with services delivered.	Proportion of representative sample of consumers satisfied with service	M&E report	Survey	Annual	M&E and Research
10% percentage reduction of the proportion of HIV positive children born to HIV positive mothers.	Proportion of HIV positive children born to HIV positive mother on ARV prophylaxis or HAART.	HMIS	Routine data	Annual	HMIS /MCH
No 'stock outs' for a basket of Essential Medicines in at least 80% of facilities	Proportion of facilities with no 'stock out' of more than 28 days a selected list of essential medicines.	Pham depart. report	Medicines access survey	Annual	Pharm. Dept, Research
100% of hospitals and 50% of health centres have appropriate means of medical waste disposal	Proportion of hospitals and health centres with functional incinerator	EH dept. reports	Routine data	Annual	Environmental Health
DMF in 12 year olds maintained at 0.4% or lower	Number of teeth either Decayed, Missing or Filled (DMF) in 12 year olds	Dental dept Report	Survey	periodic	Dental Dept.
Tobacco use regulated	Legislation governing tobacco use enacted	Govt Gazette	Legislation	periodic	HE and Legal Units
5% reduction in relapse rates on account of mental disorders	Proportion of discharged patients with mental disorder that are readmitted 7-30 days after discharge	HMIS	Routine	annual	Mental Health Dept, HMIS
5% increase in Cataracts Surgical Rate	Number of surgical cataract performed per capita	HMIS	Routine	annual	Eye Dept HMIS

Key Objective 3: To provide and administer an effective and efficient system of disease and catastrophes surveillance for both local and global concerns

Key Outcomes	Definition of the Indicator	Source of Data	Methods of collection	Frequency of collection	Responsibility
100% of district have Emergency Preparedness and Response Plan	Proportion of districts with EPR plan	DHMT reports	Periodic reviews	Annual	<i>DHMTs and M&E</i>
100% of districts collect data on common diseases and events and use it for management by 2010	Proportion of reviewing their health data for purposes of outbreaks and services management	Routine	Review of notification reports	Daily, Quarterly and Annual	<i>DHMT</i>
100% notification rate of diseases and events	Proportion of notification sites notifying in line with IDRS guidelines	IDRS reports	Routine reports	Daily, quarterly and annually	<i>DHMTs</i>
100% of outbreaks investigated	Proportion of recorded outbreaks in a district that are investigated	DHMT reports	Investigation reports	Periodic	<i>DHMTs</i>

Annex II: Fact Sheet

Main Health and Demographic Indicators

Lesotho's projected population for 2011 stands at 1,896,833¹⁰ with 25.3% urban based. Annual population growth rates have been declining gradually from 2.29% in 1966 to 2.1% (LBOS, 2000) and 0.13% (2006 Census). The current growth rate (0.289% projection for 2011) is expected to rise to 0.766 by 2025 when the population shall reach 2,038,629. The population is young with about 35% projected under 15 years of age for 2011¹¹. Life expectancy at birth projected at around 41 years and 44 years (male and female respectively) for 2011 has been seriously undermined by the combined effect of HIV AND AIDS and TB. Web based information titled 'UN Population for countries' gave a population growth rate for 2000-2005 of 0.14% and a 2002 population density of 73 persons per square kilometer. (www.infoplease.com). Women in reproductive age (15 – 49 years projection for 2011) constitute 26.6%% of the population. 52.1% of women attending antenatal clinics are below 19 years of age. Adult literacy rates favour women but are still low: for males the rate is 38% and for females 55% (GOL 2003, National Population Policy). Dependency rate is 47%; that is all those who are under 15 years and over 65 years. Those over 65 years constituted 3.43% of the population (GOL/MCDI, 2000). The proportion of the elderly fell from 5% in 1970s to 3.7% in 1996. (GOL/TWG, 2003) and currently stands at 5.3%¹². Total Fertility Rate (TFR) has been gradually declining in the past three decades considering that it was 5.4 in 1976 (Census) and 3.3 in 2009 (LDHS), recording the lowest in selected Sub-Saharan Africa Countries.

The draft Health and Social Welfare Policy of 2004 depicted the average household size is approximately five persons. The population is unevenly distributed with more than 70% residing in lowland region. In addition it stated that the spatial distribution has resulted into high population densities with the population density in the arable lands more than trebled from 306 per square kilometer in 1976 to 988 per square kilometer in 1996 putting a strain on the capacity of arable land, which is only 9% of total land mass. From recent surveys (LDHS 2004 and 2009) the mean household size was 3.9 and 3.6 respectively.

An examination of child mortality rates during three time periods (1995-1999, 2000-2004 and 2005-2009) shows a rising trend particularly marked during the post-neonatal period.¹³

¹⁰ MOFDP Bureau of Statistics 2010; Lesotho National and Sub-National Population Projections based on 2009 Lesotho Population Census.

¹¹ MOFDP Bureau of Statistics 2010; Lesotho National and Sub-National Population Projections based on 2009 Lesotho Population Census

¹² MOFDP Bureau of Statistics 2010; Lesotho National and Sub-National Population Projections based on 2009 Lesotho Population Census.

¹³ MOHSW Lesotho and Measure DHS USA, Lesotho Demographic and Health Survey 2009. Preliminary Report. May 2010

Annex III: Resources

Physical Resources

Infrastructure

Public primary health care infrastructure is wider distributed compared to private primary care. Maseru has the largest share of facilities with all types at its disposal, as is typical of national capitals.

The most significant gains in efficiency and effectiveness of the system could be attained through optimizing the functioning of health centres and filter clinics together with revitalizing community based health care support.

Table 9: Distribution of Health Facilities by district and type in Lesotho

District	Size in Sq. Km	Pop	Tertiary Care		Sec Care Hosp	Primary Care				Pharm (All priv)	Total
			Ref Hosp	Spec Hosp		Filter Clinic (All GoL)	Health Centre	Priv Surg	Nurse Clinic (All Priv)		
Maseru	4,279	431,998	1	2	4	1	47	27	34	27	143
Berea	2,222	250,006			2	1	19	3	8	3	36
Leribe	2,828	293,369			2	1	27	6	5	4	45
Botha-Bothe	1,767	110,320			2		12	2	3	1	20
Mokhotlong	4,075	97,713			1		12		2	2	17
Thaba Tseka	4,270	129,881			2		17				19
Qacha's Nek	2,349	69,749			2		11	1	1	1	16
Quthing	2,916	124,048			1		8	2	3		14
Mohale's Hoek	3,530	176,928			1		15	1	3	3	23
Mafeteng	2,119	192,621			1		20	4	9	5	39
Total		1,876,633	1	2	18	3	188	46	68	46	372

Source: Omnibus Study– Oxford Policy Management, December 2008; Lesotho Bureau of Statistics.

Equipment and transport

Medical and non-medical equipment including transport

Standard Equipment list exists for all hospital types and other facilities. The functional status of the equipment has not been assessed but Hospitals and District reports have captured lack of communication, lack of power, poor state of equipment or equipment insufficiency as causes for provider dissatisfaction (AJR 2009/10). Absence of Technical Services cadre implies absence within the health system of capacity to service and maintain equipment as and when the need is realized. Availability and maintenance state of equipment, technological appliances and communication facilities did not receive attention at the recent HSA 2010 study.

State of transport and logistics system is being compiled.

Medicines and Medical Supplies

A national Medicines Policy is in place since 2005 whose main components have been implemented except for pharmaco-vigilance which is lagging behind. Under the MOHSW Pharmaceutical Department a regulatory unit has been established which oversees import and export of pharmaceuticals, inspection, and licensing. The country is still challenged to establish a Pharmaceutical Regulatory Body to have a more comprehensive oversight of the pharmaceutical sub-sector including following up adherence to standards. The Essential Medicines List (EML) exists for different levels but adherence to the list is still problematic due to variations in prescription practices. Government strategy on use of medicines is limited to advice given by practitioners and dispensers at point of service delivery. Medicine supply and distribution system is accomplished through a Government Parastatal, National Drug Service Organization (NDSO) based in Mafeteng. NDSO distributes medicines and other supplies to Hospitals but not yet reaching Health Centres. Supply of medicines to Health Centres is neither systematic nor regular, leading to frequent stock outs of medicines and supplies at the first line health facilities. Rational use of medicines is known to happen but this has not been subjected to objective study. Availability of medicines and consumables in health facilities is affected by management capacity. For instance medicines procurement in the public health sector is affected by poor supplier and Health Facility forecasting. Stock management does not consider how to optimize procurement procedures. Effects of resource flows on procurement management need further analysis to establish influencing factors and generate viable solutions. Quality assurance measures for medicines shall be addressed when the pharmaco-vigilance component of the Medicines Policy is put into effect.

Financing arrangements for pharmaceuticals and medical supplies comprise of a public and a private domain; information on the private domain is lacking. The government is currently fully responsible for meeting the public facility requirements. Drugs and vaccines for public health measures are also fully the responsibility of government in collaboration with some Development Partners and Global Fund. Public financed drugs and supplies are also extended to selected Private facilities on the basis of competence for targeted services (e.g TB-DOTS, ARVs, Vaccinations) Revolving funds for medicines is at stage of design.

Human Resources

Existing HR policy, plan and HR requirements

Lesotho was among the first countries in the region to create a nurse clinician cadre. The country also introduced and expanded the VHW initiative to help reach PHC goals. On the service delivery front, the country created filter clinics, which were used to triage and lower patient loads at main hospitals. These measures notwithstanding, the health sector faces a scarcity of skills in the medical and allied professions¹⁴. Since the last census on HRH in 2003, there are no recent census data on HRH.

¹⁴ MOHSW, USAID, Irish Aid. Lesotho Health Systems Assessment 2010 pp 46.

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

Although more than 60 percent of health care is supplied at the PHC level, less than 20 percent of the formal sector labor supply is employed at the PHC level, suggesting a poor distribution of the health workforce. The largest share of the formal sector labor force is employed at the secondary level (46percent), and 24 percent are employed at the tertiary level. As a result, as of 2004, only 31 percent of filter clinics had the full-time equivalent personnel that they required, and only 41 percent of health centers met minimum staffing standards with respect to nursing personnel. Conversely, the national referral hospital had 108 percent of their full-time equivalent nursing requirements met, and district hospitals had 50 percent of their nursing requirement filled. Inequitable distribution of health professionals in favour of urban and tertiary as well as secondary levels of care and more accessible areas underscores the need for human resources for health policy that shall be consistently applied.

The number of health personnel by type (i.e. professionals) is well elaborated in the MOHSW HR Development and Strategic Plan (2005-2025) but an aggregation of total availability and requirements needs to be summarized. Concentration of population and health facilities in the Central Region in Lesotho has resulted in the central region having more health personnel than the northern or southern regions. In 2004, the central region had 2.04 personnel per 1000 population, whereas the northern region had 1.3, and the southern region had 1.13 personnel per 1000 population.

Table 10 provides information on the total stock of health workers in Lesotho.

Table 10: List of health work force in Lesotho

Category	Total number Lesotho	Density per 1000 Lesotho
Physicians	89	.049
Nurses and midwives	1123	.623
Dentists	17	.009
Other oral health cadres (government)	13	
Pharmacists	62	.034
Environmental public health workers	55	.031
Laboratory technicians	146	.081
HTC Counselors	?	?
Other health workers	23	.013
Community health workers	7,140	.449
Administrative and support staff	18	.411
Social Welfare workers	52	
Total	1532	

Source: WHO2003.

A head count of health personnel within the Government health facilities conducted in January 2010 revealed a total staff of 3,067; the report is still being compiled¹⁵.

¹⁵ HR Department Interview of Key Informants. November 2010.

As table above indicates, the largest cadre of health workers in Lesotho is nurses, who account for 73.3 percent of the total population of health workers in the country. On the other hand, dentists only make up 1 percent of the total population of health workers. Physicians account for nearly 6 percent of the total health workforce. Information on staffing norms, standards and actual realization by type of facility, as well as attrition rates is being compiled.

Regulatory bodies that exist include Lesotho Medical Council and Nursing Council. The Medical Council also regulates Dental and Pharmacy categories. These bodies are responsible for registration of respective cadres.

National capacity for carrying out the HRH development function including management arrangements: The HR Department has a staff complement of 13 out of an establishment of 15 professionals but specialized training in HRH development/administration does not exist. All districts have HR Officers responsible for district HR management issues. Recruitment, transfers, promotions and staff development remain central level responsibilities.

Financial resources available for HR development (e.g. financing of health personnel education, deployment and utilization, incentives):

Government bears a heavy responsibility of attaining a steady supply of well trained health professionals abroad and locally¹⁶ particularly to address gaps amongst Medical Doctors and Nurses.

The ministry remunerates its employees in accordance with the 1999/2000 salary adjustments. Government also pays qualified CHAL employees but structural inequity in level of compensation between CHAL and Government created distortions and consequent attrition in the CHAL sub-sector. Inter-occupational inequities in allowances also exist as well as between health cadres.

Main Stakeholders Involved in HR

Ministry of Public service is responsible for providing positions and approving schemes of service. Ministry of Finance provides financing in accordance to approved positions. CHAL manages 4 training institutions for Nurses and receive government subvention for HR staff in their health facilities. Besides the total head count conducted recently by the MOHSW, HR research is not yet undertaken.

Training Institutions, their Programmes and Outputs

There are 6 Health Training Institutions offering Nursing and Midwifery, in addition NHTC offers Pharmacy, Environmental Health and Laboratory at Diploma level. The National University of Lesotho (NUL) undertakes degree courses in Nursing, Environmental Health and Pharmacy: There are plans to establish a Medical School after completion of the new Tertiary Hospital. If optimized, existing training institutions can meet most of the major sector requirements.

Accreditation of training programmes and institutions: The NHTC courses are accredited by the National University of Lesotho (NUL) whilst nursing courses at CHAL health facilities are accredited by the Lesotho Nursing Council.

¹⁶ Kingdom of Lesotho MOHSW. 2004. Human Resources Development & Strategic Plan 2005-2025

Health Financing

Economic trends

The forecasts below were based on the most realistic assumptions at 2007 of macroeconomic and sectoral variables given available information. However, actual outcomes depended on many future unknowns, many of them outside of the control of the Government of Lesotho. For example, the level of foreign and domestic investment, and hence employment and income generation, will depend on the global financial environment, the exchange rate and any changes to Lesotho's current trade concessions. The textile industry in particular is extremely sensitive to competition. In between there has been a global financial crisis. The most substantial area of vulnerability is the customs revenue from the South African Customs Union (SACU), which was estimated to contribute 61% of domestic receipts in 2007/08. There are several emerging threats to the size of the SACU revenue pool and to the respective shares of member states.

Table 11 shows a promising economic trend but this depends very much on performance of the SACU earnings.

Table 11: Economic Forecasts 2007-2011

	2005	2006	2007	2008	2009	2010	2011
Nominal GDP (M million)	9065.3	10120.3	11358.4	13024.7	14928.9	17036.9	19243.1
Real GDP (% annual growth)	2.9	7.2	5.1	7.0	7.3	7.1	6.6
Nominal GNI (M million)	10997.6	12690.0	14204.7	16440.5	18654.5	21006.9	23581.1
Real GNI (% annual growth)	-0.2	9.1	4.9	7.6	6.6	6.3	5.9

Source: Adapted from Central Bank of Lesotho data in Issues paper for National Development Plan: Realizing the National Development Vision through tackling Vulnerability. (GOL 2008/09-2009/10)

Sources of Health Financing

The health sector is mainly funded by Government for recurrent expenditure. Capital expenditure is mainly financed through donor funds; however government also finances construction of Clinics, renovation of health facilities and maintenance in addition to providing counterpart contributions to some projects. The major source of health expenditure in Lesotho between 2004/05 and 2008/09 was government, which contributed an average of 60.7 percent of total health spending, reaching a peak of 63.1 percent of total health spending in FY 2007/08. The second major source of health spending was private sources (households and companies), contributing an average of 24.1 percent, and donors ranked third, contributing 14.2 percent of total health spending between 2004/05 to 2008/09¹⁷.

¹⁷MOHSW, USAID, Irish Aid. Lesotho Health Systems Assessment 2010

Donor Analysis

The health sector is endowed with a fair complement of donors whose support is in areas of HIV AND AIDS, TB, Family Health, HR, Infrastructure, Laboratory services, Social Welfare and Health Systems in the context of Health Sector Reforms Program. Donor coordination was relatively more problematic before introduction of the Medium Term Expenditure Framework (MTEF). Current efforts are focused strengthening MOHSW monitoring and accounting for donor inflows and assessing AID effectiveness and sector reforms.

In an effort to coordinate donor efforts MOHSW developed a code of conduct consultatively and established a MOU, to be signed with respective donors, as a basis for implementing the code of conduct. As a result most donors in health have signed an MOU with the Ministry. Establishing a SWAPs process has been under discussion in the Ministry: Government has decided that the new National Development Plan will be based upon sector wide approaches (SWAPs), where suitable, in order to prepare an integrated plan for all stakeholders within a sector. Donors have regular own meetings and are invited to participate in MOHSW quarterly and Annual Joint review meetings: together with an agreed code of conduct this constitutes the beginnings of a SWAP in the health sector.

Financing Agents

The MOHSW is the principal purchaser of health service as it also allocates a subsidy to CHAL, Red Cross, Blue Cross as well as providing programmatic inputs to private providers (ARVs, Anti TB drugs, Family Planning Commodities, Vaccines) through signed MOUs. Social Health Insurance has not been introduced even though it has been under discussion. Private Health Insurance exists but its precise contribution in financing has not been determined. Other funds for health services come from direct out-of-pocket payments to health providers and household contributions to private health insurance offered by various companies, in particular, Mammoth and Bophelo Medical Aid schemes.

Lesotho has neither a social nor community health insurance scheme in operation at public facilities for health care. The benefit to universal access that such a scheme can bring about if carefully designed and regulated shall be the strongest argument for its introduction.

Table twelve below illustrates the trends of total health expenditure as percentage of GDP or GNP

Table 12 shows per capita government spending on health has surpassed the level recommended by the Commission on Macroeconomics and Health. The proportion of government budget allocated to health is therefore substantial despite being far from reaching the Abuja target of 15%.

Table 12: Actual health expenditures in Lesotho: 2004/05 to 2008/09 financial year

Indicator	Financial Year					
	2004/05	2005/06	2006/07	2007/08	2008/09	Average 2004/05-2008/09
Total expenditure of health as % of GDP	7.4%	7.8%	6.9%	7.9%	8.5%	7.7%
Per capita total health expenditure (USD*)	45.5	51.5	48.5	61.2	66.3	54.6
Per capita total health expenditure (Maloti)	293.6	327.4	328.2	431.6	547.7	385.7

Per capita government expenditure on health (USD*)	27.7	30.3	29.2	37.0	41.8	33.2
Per capita government expenditure on health (Maloti)	178.7	192.5	197.4	261.2	345.4	235.0
expenditure on health as % of total government expenditure	9.4%	9.1%	8.1%	9.8%	11.5%	9.6%
Public (government expenditure) spending on health as% of total health expenditure	60.9%	58.8%	60.1%	60.5%	63.1%	60.7%
Donor spending on health as % of total health spending	10.1%	13.7%	11.9%	17.2%	18.0%	14.2%
Out-of-pocket spending as% of private health spending	98.4%	95.9%	95.5%	94.8%	93.9%	95.7%

Source: Lesotho Health Systems Assessment 2010

Public Funding

Information on public expenditures, budgeted and actual (capital and recurrent) for the past five years, with breakdown according to major line items (salary, drugs, maintenance...) and level of intervention (central, provincial, district) and by type of service (curative, preventive, promotive and rehabilitative) and types of facility (hospitals, health centres), by urban and rural and by geographical is being compiled. Lesotho has not undertaken a National Health Accounts (NHA) exercise. Public health expenditures by income quintiles and how resource allocation is prioritized will become clearer when an NHA has been undertaken.

Government policy on user fees in public facilities is quite clear. The Filter Clinic and below are considered an integral part of primary care. Exemptions from paying user fees apply to Filter Clinics (Dental Care excluded) and Health Centres level. Universal access applies in relation to formal services offered at Health Centres and informal services at community level.

In the country's public health sector, user fees are paid at district and tertiary hospitals. All user fees at health centers, including CHAL health centers, were abolished in 2008 with reported positive impact on attendance. At the district and tertiary hospitals, patients pay for outpatient care and inpatient care, in addition to medicines, supplies, and laboratory or other diagnostic tests. For public health benefit waiver on user fees for some Groups that use primary care services are in place [e.g., children under 5, elderly, the poor, immunizations, preventive health services, TB directly observed therapy short course (DOTS), ART, Mental Health conditions]. All exempted patients are expected to obtain an exemption letter from MOHSW headquarters/Social Welfare Department or local Social Welfare Officer depending on the level of care they are supposed to access. Fees at district and tertiary hospitals are set at the national level, and formal criteria are in place for identifying exemption eligible patients or patient groups.

Since a SWAPs arrangement has not been established disbursement of funds from donors is traditional. Donors sign agreements with Ministry of Finance and disburse the funds directly to the Ministry of Health and Social Welfare. The Central Bank captures the information as submitted from Ministry of Finance. Resource allocation uses a historical incremental method and budgeting mechanism through the MTEF.

Private Funding

Private Health Expenditure (household, firms, NGOs, private health insurance)

Population covered by private health insurance is about 8,000 people (Social Health Insurance Feasibility Study 2007) Mechanisms used in reimbursing providers of health care are not clearly known to MOHSW. Recovery rate of direct user fee mechanisms at private facilities is also not known precisely. A review of user fee revenues in MOHSW facilities (including the period before the fees were abolished at health centers) shows that user fee revenues as a percentage of MOHSW non-salary recurrent actual expenditures contributed, on average, 4 percent between 2004/05 and 2008/9. User fees fell from a high of 6 percent in 2004/05 to a low of 2 percent in 2008/09¹⁸. The dramatic fall in user fee revenues between 2006/07 and 2007/08 could be attributed to the removal of user fees at all MOHSW health centers. Although user fee revenues decreased after the removal of user fees at health centers, it is clear that, in general, user fees were not an efficient source of revenue.

External Funding

The sector is supported by UN Agencies and several Bilateral Development Partners in HIV AND AIDS, TB, Family Health, HR, Infrastructure, Laboratory services, Social Welfare, Health Systems and other programmes. Some funds operate outside the government budget through special arrangements. The Annual Joint Review (AJR) is the main mechanism for donor coordination and is attended by development partners. The overall contribution of donors being the third largest source of funding for health: International assistance has rapidly increased from a low of 10.1 percent in 2004/05 to a high of 18 percent in 2008/09¹⁹. The major changes witnessed between 2007/08 and 2008/09 were due to the increase in the capital budget of the MOHSW.

Annex IV: Synopsis of Specific Programmes

HIV and AIDS

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

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

In fiscal year (FY) 2007/2008, Lesotho experienced vast improvements in the ART rollout program, although uptake by some districts has been relatively poor. The cumulative number of all patients increased by about 78 percent (33,613 to 59,958), and the cumulative number of

¹⁸ MOHSW, USAID, Irish Aid. Lesotho Health Systems Assessment 2010 pp 41.

¹⁹ MOHSW, USAID, Irish Aid. Lesotho Health Systems Assessment 2010 pp 23.

children increased by 90 percent. However, nearly one-half (30,000) of that total were living in urban areas and/or in relatively more urbanized districts (i.e., Maseru, Leribe, and Mafeteng). Seven district hospitals had fewer than 100 pregnant women on ARV prophylaxis in 2008. At the AJR 2009/10 it was reported that coverage of ART rollout had dropped from 78 to 52 percent due to increase in CD 4 count cut off point from entry of 200 to 350 which increased the denominator.

Judging from peer review comments of GF R10 proposal for Lesotho (WHO-IST 2010), the HIV and AIDS crisis is not sufficiently utilized as an opportunity to promote sound public health practices at individual, community and societal levels. Effective interventions such as ABC, male circumcision and focus on most at risk populations need to be active areas of effective collaboration and advocacy with the National Aids Commission (NAC).

Tuberculosis

Incidence and Prevalence

TB Case notification has been increasing over the years and it remained high in 2009. The number of new smear positives seem to be stable (about 4000 per year) since 2004. However, there is over the years a proportion (15.7% in 2009) of cases that were not diagnosed through smear. This proportion could well affect the incidence that is assumed to be stable.

In 2009, the National Tuberculosis Programme (NTP) registered 13 520 TB cases of which 11 550 were new. Of the 11,550 notified new cases, 3976 (34%) were new pulmonary sputum smear positive, 3269 (28%) new smear negative, new smear not done were 1819(15.7%) and 2486 (22%) were extrapulmonary cases. The remaining 1970 (17%) cases registered in 2008 were relapses, after default, failure and others category.

According to the 2009 WHO Global Tuberculosis Report Lesotho has maintained a case detection rate above 80% for the past three years (2007-2009), against the WHO-recommended rate of 70 percent. The country had 640 incident TB cases per 100,000 populations in 2008. The country is rated 5th among 15 countries of the world with the highest per capita incidence.

The NTP registered 3858 sputum smear positive cases for TB treatment in 2008, 74% of which were successfully treated. This falls short of the Global target of 85% treatment success rate. High death rate of 11%, defaulter rate of 4%, failure rate of 2% transfer rate of 2% and 7% not evaluated are the main unfavorable outcomes affecting the treatment success rate. Although the default rate of 4% is below the WHO benchmark of 5%, efforts should be maintained to aim at further reduction. The Treatment Success Rate (TSR) declined from 73% in 2005 to 67% in 2007 and the TSR rate from the 2008 cohort is 74%.

MDR/XDR-TB

The Number of MDR TB patients enrolled on treatment is rapidly increasing since 2007. A total of 160 new MDR-TB cases were enrolled and all of them were under Green Light Committee support (GLC) at the end of 2009 making a total of ever enrolled MDR-TB cases to be 385. The MDR-TB/HIV co-infection rate remained at 62% by the end of 2009. MDRTB related deaths recorded in 2007, 2008 and 2009 were 14, 40 and 25 respectively. There was no confirmed case of XDR-TB in 2009. More than 1451 household contacts were screened and 7 were found to have MDR-TB. A 2007 cohort analysis revealed that of the 42 patients enrolled 24 were successfully treated (59.5%), 14 died (33.3%) and 1 defaulted treatment (2.4%)(AJR 2009/10).

Maternal Health

According to LDHS 2009 it was found that 92% of women who had a pregnancy received antenatal care from a professional. However protection against Neonatal Tetanus was only 74% and less than half (47% of the women) received iron tablets or syrup during the most recent pregnancy. From the same survey fifty nine per cent (59%) of births were delivered in a health facility. The proportion of women who know where to go in the event of complications was reportedly good, but only a small proportion actually knew at least two danger signs in pregnancy. The percentage of pregnant women who attended ANC at least once was high at 92 percent (MOHSW 2009), but only 48 percent made the recommended four ANC visits—22 percent less than the 70 percent reported by WHO in 2005. Overall this is an indication that the quality and utilization of ANC services in the country remain sub-optimal. The macerated still births rate, an effective measure of the quality of services and care received by pregnant mothers during the antenatal period, was recorded in seven facilities nationwide to be 66 percent, a very high figure²⁰. The 2010 AJR records still births at 41% in QE II, 65% at St Joseph, 84% at Paray, 50% at Scott and 33% at ST. James denominator variations noted. The macerated still births rate found in seven facilities is certainly an indication for in depth study of the problem. On the positive side, LDHS 2009 findings registered almost half (47%) of currently married women use a method of contraception. Compared to selected Sub-Saharan Countries (Zambia, Mozambique, Swaziland, Zimbabwe and Namibia) Lesotho has the lowest total fertility rate as noted earlier.

The Lesotho Maternal and New Born Morbidity and Mortality Reduction Road Map (2007-2015) has noted that teenage pregnancy contributes to maternal and new born morbidity and mortality as 52% of births are among teenagers and 17% of maternal deaths are among adolescents. More recently DHS 2009 shows 21% of deliveries are of teenage pregnancy.

Performance with respect to safe delivery is also poor, especially in the public sector where the maternal case fatality rate is much worse than in CHAL facilities²¹. The HSA 2010 report further noted that although the maternal case fatality rate recorded in all facilities in the country was less than 1 percent of total deliveries in 2008, the majority of GOL facilities (77 percent) reported maternal deaths. This compared very poorly with CHAL, which recorded no maternal deaths in 75 percent of its facilities: Noteworthy those critically ill patients are usually sent to public facilities. Facility-based estimates of safe delivery, however, mask the true magnitude of the problem as many women are not delivering in facilities. The emergency obstetric care is only available at 7 out of 19 hospitals (EMoC study 2005). Taking into consideration the poor roads, inaccessibility of vehicles for referrals and the unavailability of emergency obstetric care at many of the hospitals that women would be referred to from the health centers, accessibility, availability, and quality are likely significant factors in the high maternal mortality ratio. As part of ongoing efforts to improve RH-related service delivery and address the high maternal mortality, the MOHSW has implemented a number of initiatives. The technical capacity of the Reproductive Health Unit has been strengthened by two consultants, with the support of development partners including the UN. The MOHSW has established a Committee on Confidential Enquiries into Maternal Deaths, conducted trainings of committee members and distributed copies of the obstetric record to all facilities for the proper management of labor. Also Doctors and nurses have been trained on Emergency Obstetric and Neonatal Care

²⁰ MOHSW, USAID, Irish Aid. Lesotho Health Systems Assessment 2010 pp 88

²¹ Op cit pp 88

(EmONC). However, no evidence exists that the obstetric record is being used with a focus on continuity of care, and the patient retention level of the 'maternal record page' post-delivery is only 45 percent.

Child Survival

Malnutrition is the highest cause of institutional deaths among children in the country (22 percent) and the third highest cause of institutional admissions (11 percent). In response, the MOHSW has instituted steps to increase the coverage, access, and utilization of services (MOHSW 2009). The MOHSW has established 77 Integrated Management of Acute Malnutrition pilot sites, under the Child Survival Program, with distribution of supplements/products to hospitals and health centers. The Ministry has also developed an Infant and Young Child Feeding Curriculum and an Infant and Young Child Feeding Policy to standardize feeding practices.

Diarrhea in children is the highest cause of childhood admissions at 14 percent and the second highest cause of institutional deaths (17 percent) after malnutrition, posing a very serious challenge to the health sector.

In 2009, the MOHSW introduced the pentavalent vaccine (DPT-HB) in all districts and trained health workers and communities in measles and polio surveillance. The country also experienced an improvement in the DPT3 immunization coverage, from 83 percent in 2008 to 91 percent in 2009 (WHO 2009). Performance in this decade, however, has been relatively stagnant, with no change from the 83-percent coverage recorded in 2003 until the increase recorded in 2009. In, BCG coverage was 80 percent and coverage of other vaccines was less, varying between 73 percent and 76 percent. (HSA, 2010 pp 89).

Mental Health

The Mental Health Program provides promotive, preventive, curative and rehabilitative mental health services.

The MOHSW through the Health VI project embarked on strengthening of the mental health services to include Child services, Geriatric and Forensic services at Mohlomi hospital. The buildings at Mohlomi hospital have been upgraded to accommodate these services. Professionals trained through this project have been reabsorbed into the system and those who were trained from outside were absorbed through creation of positions. There was training of doctors and nurses on modules on handling key mental disorders have been done: The modules are disseminated to all health facilities.

With regard to strengthening of mental health services with human resource, 11 General Nurses and 3 Nursing Assistants were deployed to Mohlomi. However the Psychiatric Nurses who were working at Mohlomi have been promoted to positions of Senior Nursing Officer and they had to be deployed in the districts. This has to lead to a challenge of training more Psychiatric Nurses.

Of the 43137 mental health patients contacts seen at OPD in 2009, Epilepsy was the most common disease making 42% of the total followed by schizophrenia 29%, neurotic, psychosomatic 11%, mood disorders 7% while HIV Neuropsychiatric disorders constituted 2% (MOHSW AJR – 2008/09).

Oral Health

Oral Health has a large component of both curative and public health services. In 2002, the first National Oral Health Policy was drafted following a Situational Analysis on oral health that was conducted in 1998 using a rapid epidemiological method. Three survey tools were developed to collect facility based data, school children data and focus group discussion data. The facility based data indicated that for all age groups, dental caries was present in 92-98% of people and that the most frequent mode of treatment delivered was extraction (93% of all cases seen) (National Oral Health Policy Draft – 2002). The school children data showed a similar trend when it came to treatment as 64% of the children had received extraction and only 4% restorations.

Oral Health services show that most patients presented at facilities with dental caries and 75% of the procedures conducted in 2009 were dental extractions as compared to 73% in 2008. Conservative treatment represented only 3% in 2009 as compared to 4% in 2008 (AJR 2009/10).