LESOTHO PHC REVITALIZATION

SERVICES AVAILABILITY AND READINESS ASSESSMENT

INTEGRATED SUPERVISION REPORT –

BY THE MOHSW ASSESSMENT/STUDY TEAM

For copies of this report please visit www.health.gov.ls or request such copies from the Principal Secretary's office @ 22312836 or 22326230

For additional copies of this report, please email info@pitsong.org.ls visit our website at www.pitsong.org.ls or call us at 28326777

Report authors:
Mamatebele Setefane – MOH
Bulara Mojakhomo – MOH
Nthati Moorosi – PIIR
Mamojalefa Matsoara- MOH
Matthew Kukla - HFG
Moitlisi Mafaesa – MOH
Shoeshoe Lemphane- MOH
Tsietso Motsoane - MOH
Nthekeleng Motsoane- MOH
Katiso Ramalebo – PIIR
Themba Fobo – MOH
Lebohang Mothae- CHAL
Matumaole Ramochela - MOH
Mpopo Tsoele - PIIR

Recommended Citation: Lesotho Ministry of Health. July 2014. *Lesotho PHC Revitalization- Services Availability and Readiness Assessment- Integrated Supervision Report –MoHSW Assessment Team*.

LESOTHO PHC REVITALIZATION

SERVICE AVAILABILITY AND READINESS ASSESSMENT-INTEGRATED SUPERVISION REPORT

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Government or any of its agencies USAID, PEPFAR, and CDC. The view expressed in this publication are those of the Ministry of Health.

CONTENTS

List of Tables

List of Figures

ACRONYMS AND ABBREVIATIONS

ABC	Abstinence Be Faithful and Condomise
ABC	All Basotho Convention
AIDS	Acquired Immuno-Deficiency Syndrome
AIS	AIDS Indicator Survey
ALAFA	Apparel Lesotho Alliance to Fight AIDS
ANC	Anti-Natal Care
APRM	African Peer Review Mechanism
ART	Antiretroviral Therapy
ARV	Antiretroviral
AU	African Union
BCC	Behaviour Change Communication
BCG	Bacillus Calmette-Guerin
BNP	Basotho National Party
BOS	Bureau of Statistics
BSS	Behavioural Surveillance Survey
CBO	Community Based Organisations
CC	Community Council
CCAC	Community Councils AIDS Committees
CCM	Country Coordinating Mechanism
CCP	Comprehensive Condom Programming
CCS	Community Council Secretary
DCS	District Council Secretary
CDC	Centre for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CGPU	Child and Gender Protection Units
CHBC	Community Home Based Care
CHAL	Christian Health Association of Lesotho
CHW	Community Health Worker
CITC	Client Initiated Testing and Counselling
CPWA	Children's Protection and Welfare Act (2011)
CRC	Convention on the Rights of the Child
CRIS	Country Response Information Systems
CS	Civil Society
CSO	Civil Society Organisations
DA	District Administrator
DAC	District AIDS Committee

DC	District Council
DC	Democratic Congress
DFID	Department for International Development
DGHS	Director General of Health Services
DHS	Demographic and Health Survey
DHTs	District Health Teams
DPHN	District Public health Nurse
DPSC	Directorate of Policy Strategy and Communication
ED	Electoral Division
EID	Early Infant Diagnosis
EML	Essential Medication List
ESP	Essential Services Package
EU	European Union
EPI	Extended Programme on Immunisation
FBO	Faith Based Organisations
FGD	Focus Group Discussion
FIDA	Federation of Women Lawyers
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS Tuberculosis and Malaria
GOL	Government of Lesotho
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immune Virus
HMIS	Health Management Information Systems
HRIS	Human Resources Information Systems
HAS	Health Service Area
HSS	Health Systems Strengthening
HTC	HIV Testing and Counselling
IEC	Information Education and Communication
IEC	Independent Electoral Commission
LCD	Lesotho Congress for Democracy
LCS	Lesotho Correctional Services
LDC	Least Developed Countries
LDF	Lesotho Defence Force
LDHS	Lesotho Demographic and Health Survey
LGA	Local Government Act
LRCS	Lesotho Red Cross Society
M&E	Monitoring and evaluation
MCC	Millennium Challenge Corporation
MCH	Maternal and Child Health

MCHC	Maternal and Child Health Care
MDG	Millennium Development Goals
MMP	Mixed Member Proportionality
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
MS	Microsoft
MTCT	Mother to Child Transmission
NGO	Non-Governmental Organisation
NHTC	National Health Training College
NSDP	National Strategic Development Plan
NDSO	National Drug Service Organisation
NOCC	National OVC Coordinating Committee
NOP	National Operational Plan
NSP	National Strategic Plan
NSPVC	National Strategic Plan for Vulnerable Children
NTCP	National Tuberculosis Control Programme
NUL	National University of Lesotho
PEP	Post Exposure Prophylaxis
PEPFAR	President's Emergency Plan For Relief
PHC	Primary Health Care
PHDP	Positive Health Dignity and Prevention
PIIR	Pitsong Institute of Implementation Research
PITC	Provider-initiated Testing and Counselling
PLWHA	People Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission (of HIV)
PNC	Post Natal Clinic
PPP	Public Private Partnership
PR	Proportional Representation
PRSP	Poverty Reduction Strategy Paper
PSC	Public Service Commission
PSI	Population Services International
QA	Quality Assurance
SAHCD	Southern Africa Human Capacity Development Programme
SBCC	Social and Behaviour Change Communication
SPSS	Statistical Package for Social Sciences
SOA	Sexual Offences Act
SOP	Standard operating procedures
SRH	Sexual and Reproductive Health

STI	Sexually Transmitted Infections
SW	Sex Worker
SWAPs	Sector Wide Approaches
TasP	Treatment as Prevention
TB	Tuberculosis
TBAs	Traditional Birth Attendants
TB/HIV	Tuberculosis/Human Immuno Deficiency
TIP	Trafficking in Persons
TTI	Transfusion Transmissible Infections
TWG	Technical Working Group
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV and AIDS
UNDP	United Nations Development Programme
USAID	United States Agency for International Development
USG	United States Government
VHW	Village Health Worker
VMMC	Voluntary Medical Male Circumcision
VCT	Voluntary Counselling and Testing
WB	World Bank
WDI	World Development Index
WHO	World Health Organisation

ACKNOWLEDGMENTS

The comprehensive health centre and MCH assessment is the brain child of the Hon Minister of Health Dr. Pinkie Manamolela and the Principal Secretary of Health Mr. Lefu Manyokole. They are both acknowledged for the time, energy, visionary leadership and visible political commitment they accorded to this assessment.

This assessment was conducted by the Ministry of Health (MOH) and the Ministry of Local Government and Chieftainship and Parliamentary Affairs (MOLGCPA); the Christian Health Association of Lesotho (CHAL), the Red Cross in collaboration with Pitsong Institute of Implementation Research (PIIR) and the Health Finance Governance Project (HFG). The assessment was funded by the United States Government (USG) through the Centre for Disease Control (CDC) under cooperative agreement Funding: 5U2GPS002076-04 between the MOH and CDC. The Ministry of Health and its aforementioned partners wish to whole-heartedly thank the United States Government (USAID/PEPFAR, CDC and HFG) mission to Lesotho, for supporting the conception and ultimate implementation of this assessment. In particular, the Ministry notes the support and leadership received from H.E. Carl Fox (Charge d'Affaires), Ms Karen Kasan (Regional HIV/AIDS Programme Director, USAID), Mr. David Brown (USAID/PEPFAR Programme Director), Mr. Reuben Hyllat (PEPFAR Coordinator), Mr. Hilary Mwale (USAID HSS advisor), Dr. Nicholas Gaffa (CDC Country Director), Mr. Sello Chesitsi (CDC Cooperative Project Manager), Ms. Hlapase Morojele (Programme Management Specialist), Mr. Yohannes Eshete (Laboratory and Blood Safety Advisor). Our gratitude for a job well done also goes to the Health Finance Governance Project (Matthew Kukla, Eddie Karisa, Milly Kayongo; Altea Cico, Adetayo Omoni) and Pitsong Institute of Implementation Research (Mpopo Tsoele, Nthati Moorosi, Mosa Ntau, Matsiu Lekopa, Katiso Ramalebo and George Ts'upane).

The study would have not been possible without the dedication and leadership of the following programmes and individuals within the MOH, CHAL and the Red Cross.

Name and Surname	Title	Role in the assessment	Department
Piet McPhershon	DGHS a.i.	Team leader overall	Health Services
Libetso	DGLGS	Team leader MOLGCPA and me	
Moitlisi Mafaesa	Administrator	Coordinator – Mafeteng district	Administration
Mamajara Lehloenya	Local Government officer	Coordinator at MOLGCPA	Local Government services
Shoeshoe Lemphane	Head Public Health Nusing	Coordinator Mokhotlong District and report author	Nursing Services
Lebohang Mothae	Deputy Exec. Sec. CHAL	Coordinator - Maseru and report author	
Popo Ntjona	EPI programme Manager	Coordinator – Quthing District	Family Health division
Matumaole Ramochela	Financial Controller	Coordinator – Botha-bothe district	Finance and accounts
Themba Fobo	Environment	Coordinator – Mohaleshoek district	Environmental Health
Tsietso Motsoane	Director Lab	Coordinator – Qachasnek district	Lab services
Nthekeleng Motsoane	Quality Assurance	Coordinator - Qachasnek district	Quality Assurance
Ernest Mapitsi…..	Human Resources Officer	Coordinator - Maseru district	Human Resource department

Name and Surname	Title	Role in the assessment	Department
Cecilia Khechane	Head CHW Programme	Coordinator - Mafeteng district	Family health division
Florence Mohai	Head Family Health	Coordinator – Leribe district	Family Health division
Matsoara Mamojalefa	Pharmacists Regulation	Coordinator – Leribe district	Pharmaceuticals
Tabalingata Qhobela	Coordination Pharmaceutical Decentralisation	Coordinator - Thaba-tseka district	Pharmaceuticals
Khasiane Kabi	Public Health Nurse	Coordinator - Maseru district	DHMT
Mpopo Tsoele	Decentralisation practice Mnager PIIR	Project management and secretariat to the assessment	DG's office
Katiso Ramalebo	Data specialist and manager	Training of on data managment	PIIR
Mateboho Mosebekoa	Public Relations Officer	Coordinator – Media houses	Administration
Makoa Mathaha	Senior research officer	Coordinator – Mokhotlong district	Disease control
Adelina Moshabesha	Senior Nursing Officer	Coordinator – Thaba-tseka district	Mental services
Dr.NavoLinjewile - Marealle	HDPH	Coordinator - Berea district	Dental services
Ntsepeng Tsita	PHN	Supervisor – Mokhotlong district	DHMT - Mokhotlong
Nthati Moorosi	Communications specialist	Project publicity and report write up	PIIR
Ramakhunoane Susan	PHN	Supervisor – Botha-bothe district	DHMT - Botha-bothe
Mpho Khutsoane	PHN	Supervisor – Leribe district	DHMT - Leribe
Keneuoe Kali	PHN	Supervisor - Berea district	DHMT - Berea
Bulara Mojakhomo	PHI	Supervisor – Maseru district	DHMT - Maseru
Mary Letsie	PHN	Supervisor – Mafeteng district	DHMT - Mafeteng
Julia Makhabane	PHN	Supervisor – Mohaleshoek district	DHMT– Mohaleshoek
Tjale Maile	Princ. Pharm Tech	Supervisor – Quthing district	DHMT - Quthing
Mapuseletso Pharoe	PHN	Supervisor – Qachsnek district	DHMT - Qachsnek
Matefo Tefo	PHC	Supervisor – Thaba- tseka district	DHMT – Thaba-tseka
Thabelo Masithela	Princ.Pharm Tech	Supervisor - LFDS	LFDS
Makoae Mathaha	PHN	Supervisor – Thaba- tseka district	DHMT – Thaba-tseka
Montseng Rantsane	PHCC	Data collection, entry, cleaning and analysis	PHN
Matefo Tefo	PHCC	Data collection, entry, cleaning and analysis	PHN
Makabelo Nkabi	PHN	Data collection, entry, cleaning and analysis	PHN
Matseliso Ntoi	PHCC	Data collection, entry, cleaning and analysis	PHN
Tebello Kolobe	DHI	Data collection, entry, cleaning and analysis	PHI
Julia Makhabane	PHN	Data collection, entry, cleaning and analysis	PHN
Nchaba Moleko	SHE	Data collection, entry, cleaning and analysis	PHN
Malekhetho Motenalapi	Surveillance Officer	Data collection, entry, cleaning and analysis	Princ. Pharm Tech
Matebello Ntsiki	PHN	Data collection, entry, cleaning and analysis	PHN
Thabelo Masithela	PPT	Data collection, entry, cleaning and analysis	PHC
Maamohelang Kalane	PHCC	Data collection, entry, cleaning and analysis	Princ.Pharm Tech
Mapuseletsoe Pharoe	PHN	Data collection, entry, cleaning and analysis	PHN

Name and Surname	Title	Role in the assessment	Department
Tjale Maila	PPT	Data collection, entry, cleaning and analysis	
Chabatsane Khoaeane	Health Inspector	Data collection, entry, cleaning and analysis	DHMTS Representatives
Keneuoe Kali	PHN	Data collection, entry, cleaning and analysis	PHCC
Makoae Mathaha	SRD	Data collection, entry, cleaning and analysis	PHCC
Ntseke Makutoane	DHI	Data collection, entry, cleaning and analysis	PHN
Lietitia Tanka	PHCC	Data collection, entry, cleaning and analysis	PHCC
Nthateng Mojila	HRC	Data collection, entry, cleaning and analysis	DHI
Mamajone Khutsoane	PHN	Data collection, entry, cleaning and analysis	PHN
Mary Letsie	PHN	Data collection, entry, cleaning and analysis	SHE
Mothisi Lerotholi	PHN	Data collection, entry, cleaning and analysis	Surveillance Officer
Bulara Mojakhomo	DHI	Data collection, entry, cleaning and analysis	PHN
Mantsoaki Sekhesa	PHC Coordinator	Data collection, entry, cleaning and analysis	PPT
Mamakone Mohlalisi	PHC Coordinator	Data collection, entry, cleaning and analysis	PHCC
Bahlakoana Mokoatle	Driver	Data collection, entry, cleaning and analysis	PHN

.....

Limpho Maile (Dr.)
Director General Health Services

.....

Mrs ' Matiisetso Libetso
Director General Local Government Service

General observations from the study: Hon Dr. Pinkie Rosemary Manamolela (Minister of Health)

The overarching policy framework for the provision of health services in Lesotho is articulated through the Government of Lesotho (GOL) National Vision – Vision 2020, which provides that "*The country will have a good quality health system with facilities and infrastructure accessible and affordable to all Basotho, irrespective of income disabilities, geographical location and wealth*". The overall goal of the Ministry of Health (MOH) is to increase access to quality preventive, curative and rehabilitative health care services in Lesotho. According to the MOH Strategic Plan 2012, the MOH wishes to achieve the following goals;

- Contribute to the reduction of morbidity and mortality and mitigate physical, mental, and social deprivation.
- Increase access to quality promotive, curative, preventive, and rehabilitative health and social welfare on the basis of equity and social justice.
- Provide and administer an effective and efficient system of disease and catastrophes surveillance for both local and global concerns.
- Coordinate partnership and regulate, monitor, and evaluate delivery of health and social welfare services in the country.
- Effectively mobilize, allocate, and efficiently manage health resources within the MOH.

After going through the findings and recommendations of this Study, I strongly believe that the biggest challenge facing the MOH in relation to service delivery is not the 'WHAT', referring to the technical know-how, but the 'HOW', referring to strategy or context within which the Ministry's interventions are designed and implemented. The Study has revealed that our challenge is not only the limited[1] resources the GOL allocates to the health sector, but how those resources are utilized to improve service delivery. The Ministry has, over the years, failed to use the limited resources effectively and efficiently. The resource envelope dedicated to the MOH has over the years increased. However, the return to this investment does not match the level of investment. Some of my initial observations from this study are as follows;

- That generally all staff at the MOH (at all levels)[2] do not have performance based service contracts. The MOH has set its own service delivery indicators, but programme heads do not have service contracts in line with the targets the Ministry wishes to achieve.
- That supportive supervision is very weak at all levels of the health system. Even where supervision exists, it is not integrated.
- That programme heads are not appraised and held accountable or not accountable for the performance of the health sector.

[1] Although the extent to which they are limited is also debatable
[2] Excluding project staff in some cases

- That we are still missing some key HRH positions, for example, the DGHS, pharmacy technicians, lay councillors to mention but a few. At the same time, we are still failing to optimally utilize and manage the existing human resources. For example, despite having full staff complement of nurses in the majority of our health centres, only a few (on average two) were on site during the study.
- That our health management information management system is still not able to support the collection of routine data and there is still heavy reliance of surveys. That data is being collected but not analysed to inform decision-making and resource allocation at the health centre and district level.
- That a majority of our health centres still do not have access to their budgets.
- That generally our service delivery patterns were observed to be satisfactory but inconsistent and not predicable.
- That the Ministry has been operating without a strategic plan for at least two years. This implies that we have not given direction to the DHMTs and the DHTS and more importantly to our cooperating and implementing partners. The absence of a strategic plan has had serious implications in terms of donor coordination and resource allocation, programme design and program implementation.
- That a greater percentage of our budget resources at still not directed to the primary level where the Ministry offers over 60% of the services. For example, health centres still do not have transport and they still have no direct access to their budgetary resources.
- That the village health worker programme is fragmented and uncoordinated.
- Health centres have committees but the committees are not necessarily giving direction and oversight of the proper functioning of the health centre.
- That the involvement of local government structures and District Administrators in health remains very limited.

Notwithstanding these challenges, the findings of this Study epitomize a good beginning in the health sector. Now we know what our challenges are. That means we are half-way through removing the bottlenecks towards efficient service delivery. This Study was an opportunity for the MOH to self introspect with a purpose of defining an improved approach to designing and implementing health programmes. The Ministry has fully introspected and is in a position to institutionalize a series of reforms in line with recommendations of this study.

I wish to thank, the Right Honorable The Prime Minister, Dr. Motsoahae Thabane for his unwavering support in our course to reform the health system for improved health outcomes. My gratitude also goes to the Deputy Prime Minister and Minister of Local Government – Mr. Mothetjoa Metsing and his team; Principal Chiefs; Local Authorities and the District Administrators that took part in the launch of this exercise. The Christian Council of Lesotho, our implementing partners CHAL and Red Cross have also contributed significantly to the course and for that we are very grateful. I would like to thank the United States Government (CDC-PEPFAR-USAID) for its generous and meaningful contribution to the Lesotho health sector improvement reform programmes and particularly for supporting this integrated supervision. I promise that my office will oversee the timely and successful implementation of recommendations of this Study. Our partners at the level of community systems strengthening, Pitsong Institute of Implementation Research (PIIR), are acknowledged for supporting the Ministry's efforts to collect, document and communicate evidence for improved health systems strengthening and decision-making.

Last and more importantly, I wish to credit the Principal Secretary Mr. Lefu Manyokole and the acting DGHS – Dr. Piet McPherson for overseeing the successful implementation of this assignment. Tsoarang joalo ho ea pele. You now have empirical evidence let us work together and change this historical wrong – our nation has hope – I remain optimistic that it can be done.

……

Pinkie Rosemary Manamolea (Dr.)
Hon Minister for Health

Taking health to the people – revitalizing primary health care: Mr Lefu Manyokole – Principal Secretary

The Ministry of Health (MOH) has over the years undertaken a number of surveys to understand service delivery patterns with a view of informing the Ministry's strategy and programming. This tradition continues unabated with the result of the Annual Joint Review 2013/2014 expected to be shared and discussed not later than July 2014. Generally, all these surveys indicate that the provision of health services has over the years declined. It is important to note that the provision of health services depends on the proper functioning of seven core building blocks of health systems strengthening: finances, health workforce, health management information systems, leadership and governance (including community participation), medical products, infrastructure and technologies and quality assurance. A proper combination of the aforementioned building blocks improves Equity, Access, Quality, Efficiency and sustainability in the provision of Health. Our weakness as a Ministry has over the years been the inability to understand the current strengths, weakness, opportunities and threats of each of the core building blocks in relation to the functioning of all Clinics and hospitals in Lesotho. Without knowledge on how the different building blocks were each contributing to the decline or health services in Lesotho, the Ministry of Health has failed to put in place appropriate strategy to guide programmatic interventions, For example we have in the past been accused of investing a greater percentage of health resources at the secondary and tertiary levels of care despite the fact that 60% of health care is offered at the primary health care level where we have dedicated less than 20% of the health sector resources.

We are made to understand that Lesotho was characterized and known for a proper functioning and delivering health system in the 1970s and we are informed that this was as a result of the adoption of the Primary Health Care Approach which Lesotho ratified in Almata in 1978. We have also noted that sometime in the early 90s the health systems abandoned the PHC approach and since then, the sector has struggled to deliver services as effectively and as efficiently compared to the early 70s. This is despite an increase in resources and budgets allocated to the health sector. Noting these inherent challenges in the health systems, particularly the absence of strategy, the Ministry under the leadership of Honourable Pinki Manamolela (Dr.) decided to once again adopt Primary Health Care as an overarching strategy for health systems strengthening. Primary health care shifts the emphasis of health care to the people themselves and their needs, reinforcing and strengthening their own capacity to shape their lives. Hospitals and health centres then become only one aspect of the system in which health care is provided. As a philosophy, primary health care is based on the **overlap of mutuality, social justice and equality**. As a strategy, primary health care focuses on individual and community strengths (assets) and opportunities for change (needs); maximizes the involvement of the community; includes all relevant sectors but avoids duplication of services; and uses only health technologies that are **accessible, acceptable, affordable** and **appropriate**. Primary health care needs to be delivered close to the people; thus, should rely on maximum use of both lay and professional health care practitioners and includes the following eight essential components.

Through this Study, the Ministry has gathered evidence that will inform the PHC revitalization programme and thus bring provision of health services closer to the ownership and control of the end user – the ordinary Mosotho men and women. This report should help the reader understand the health system and the direction the MOH is taking moving forward.

……

Lefu Manyokole
Principal Secretary Health

EXECUTIVE SUMMARY

A year and half in office, with a visibly ailing health system, the new leadership of the MOH took a decision to revisit the role of primary health care (PHC) as an approach to revitalize and improve provision of health services. The decision on what aspects of PHC the MOH would address required empirical evidence on the current status of the health system. To inform this process, the MOH determined to undertake a health services assessment across different sections of the primary health care system in Lesotho. The Assessment would build on previous work including the Lesotho Health Systems Assessment HSA (2010); but with a distinct focus on exploring service availability and readiness at the local health facility/centre levels. The goal was to understand the contributions and constraints within the primary health care system as a whole.

The assessment approach and methodology were developed and agreed upon based on the understanding of the multiple dimensions of a health system. This assessment did not explore health systems strengthening (HSS) functions at the macro level, as is typical with traditional HSA, but rather focused on exploring issues required to improve service availability and readiness at the primary health care level. As such the main findings of this assessment are presented with a focus on the service availability; resources and infrastructure that support quality services delivery. The report presents key findings, general observations and makes recommendations for consideration by the MOH.

Key observations:

a. Ineffective health policy and planning at the senior level was identified as contributing to wider service delivery issues. The Assessment revealed that the MOH has been operating without a strategic plan for at least two years. There is inadequate guidance and direction provided to the DHMTs and the DHTS and more importantly to cooperating and implementing partners on critical government priorities and areas of focus. The absence of a strategic plan has had serious implications in terms of donor coordination and resources allocation, program design, implementation, and management

b. Human resource management challenges affect large aspects of health service delivery in Lesotho. The Assessment revealed that the majority of MOH staff (at all levels)[3] do not have performance based service contracts. While the MOH has defined HR standards, many technical and program leads do not have service contracts to meet the targets set by the MOH. Supportive supervision is very weak at all levels of the health system; and even where it exists, service supervision is not conducted in an integrated manner. In addition, accountability measures are very lax, and program heads are not appraised or held responsible for sub-optimal performances within the health sector.

c. Human resource staffing levels and distributions are inadequate. At least 70% of health facilities have staffing shortages, and almost 50% of health workers and their respective managers reported poor job satisfaction. Key HRH positions are missing at different levels, including the DGHS office and essential staff, such as pharmacy technicians, HIV lay counselors, dental assistants, etc. At the same time, there are problems in the optimal use and management of the existing human resources. For example, despite having full staff complement of nurses in the majority of health centers, only a few were available and on site during the study.

[3] Excluding project staff in some cases

d. At the district management levels, financial planning and budget constraints affect the management of health activities. The majority of health centers still do not have access to allocated budgets. Resources are not directed to the primary level where 60% of service delivery is done. For example, many health centers do not have transport, there is poor security management, and local asset/inventory data is not maintained. Despite these challenges, the structures and administrative procedures are in place (health committees, staff housing, etc.) and these strengths could be leveraged to address the identified problems.

e. The current health information systems do not adequately collect routine data and there's a heavy reliance on surveys. Where available, the data is often not analyzed to inform decision making; or impact resource allocation at the health center and district level. There is a lack of service delivery guidelines and protocols at the health facility level for most of the main technical health areas. The exception is HIV/AIDS services, for which appropriate protocols for HIV prevention, care and treatment are in place.

f. The community /village/ health worker (CHW) program has increased community participation in health. However many aspects of the village health worker program are fragmented and uncoordinated. Health centers committees are existent, but many do not receive the direction and oversight required to support the proper functioning of the health centers. In addition, CHW roles are not well defined, and there is lack of clarification on key responsibilities. Less than 15% of CHW reported receiving payments on time. There's also limited involvement of local government structures and district administrators in health.

Service Availability and Readiness

- **HIV Prevention and Testing and Counselling Services (HTC services)** – The overall delivery of HIV prevention services, education, and counselling is fairly strong. Nearly all health facilities conduct PITC for both adults and children. At least two thirds of health facilities countrywide have rapid test kits with availability for three months. A large proportion (72%) of health facilities have personnel protective equipment and trained counselors are available at the majority of sites (87%). Most health facilities provide HIV treatment and care, with focus on management of TB-HIV co-infection. 90% of health facilities do DNA/PCR for EID and conduct CD4 testing for all HIV positive clients. The main issues identified were around low levels of supplies; otherwise the essential equipment and staff are adequate.

- **Maternal New born Health and PMTCT Services** – Health services for women living with HIV are strong. A large percentage of health facilities provide HIV education and counseling to pregnant women; conducting HTC and initiating timely ART care. Most health facilities have the infrastructure and resources for the delivery of PMTCT services, i.e., health education materials, cotrimoxazole chemoprophylaxis and ART drugs. All pregnant women living with HIV are initiated on treatment during the first visit or post natal visit while 85% of sites re-test all HIV negative women at 36 weeks as stipulated in the national PMTCT guidelines.

  Some of the areas of concern include limited focus on management of TB co-infection among women living with HIV. Only 43% of sites offer INH prophylaxis; this was largely observed in Maseru district with some issues in Botha Bothe, Leribe, Mafeteng, Mohale's Hoek and Thaba Tseka districts. As opposed to PMTCT, broader maternal new born health services require more attention. Facility deliveries are still low and 30-50% of health facilities do not have the appropriate drugs for the management of key obstetric complications like pre-eclampsia/eclampsia. Only a quarter of health facility staff had received refresher training on essential new-born care and resuscitation in the past year.

- **Child Health and Nutrition, including Pediatric HIV/AIDS** – Most of the staff have received basic training on the delivery of child health services. There are systems in place to support the early identification of children exposed to HIV/AIDS, although the delivery of actual services is limited. At least two-thirds of health facilities have systems in place to trace children who are HIV exposed. However, technical updates through in-service training are limited. Only 65% of health facilities staff had received updated training on IMCI in the past three months. There are significant issues with the availability of essential supplies and medicines for the management of common childhood illnesses. For examples, systems for oral rehydration to manage diarrhea are lacking; only 16% of health facilities have a functional oral rehydration corner, while 85% of health facilities did not have oral rehydration supplies.
- **Family Planning / Reproductive Health** – Most of the sites have the infrastructure to provide the basic reproductive health and family planning services. Consultation rooms ensure privacy, and there is availability of key equipment for basic services. Contraceptive stock outs are common, especially for Long Acting and Permanent methods (LAPM); only a quarter of health facilities could offer Intra-Uterine Devices (IUCD), and even less could offer progesterone implants. Only 10% of facilities assessed could offer voluntary surgical contraception; appointment scheduling was only done by 41% of health facilities. In addition almost 70% of sites do not have materials for the diagnosis and management of cervical cancer.
- **Disease Surveillance and Infectious Disease Management** – The majority of health facilities have the adequate materials (catchment maps; stock cards etc. for disease surveillance) but the actual work is hardly done. Vaccine and immunization records are not maintained, and common diseases are not mapped and tracked. While external quality assurance is conducted for PoC (point of care testing) for infection control - corrective actions are not taken to address problems.
- **Health Promotion** – Most of the health facilities had the basic infrastructure to maintain a clean and well-functioning health site- with clean toilets; constant water supply and well-kept grounds. There is an inadequacy of key health promotion materials (in local languages); and most of the available materials are too outdated and poorly organized to have direct benefit. Health sanitation as a critical component of health promotion was a major focus of the assessment. Most facilities didn't have adequate waste management systems, lacking incinerators, sluice rooms and training for staff on waste management.
- **Allied Health: Mental Health/Oral health** – Typical with many PHC level services, these services do not get the priority at lower level health centers. Only about half of health facilities in all districts provide preventive oral health services, with 25% promoting dental hygiene. Mental health training is lacking in the majority of health facilities; operational plans for mental health exist in only 10% of health facilities and less than 20% of health facilities have had staff training in mental health.

On the whole, the assessment has provided a detailed picture into the specific issues affecting primary health care delivery across the country, highlighting service delivery challenges and related system functions. The major health system functions impacting service availability and readiness are leadership and governance; human resources management and supply chain issues.

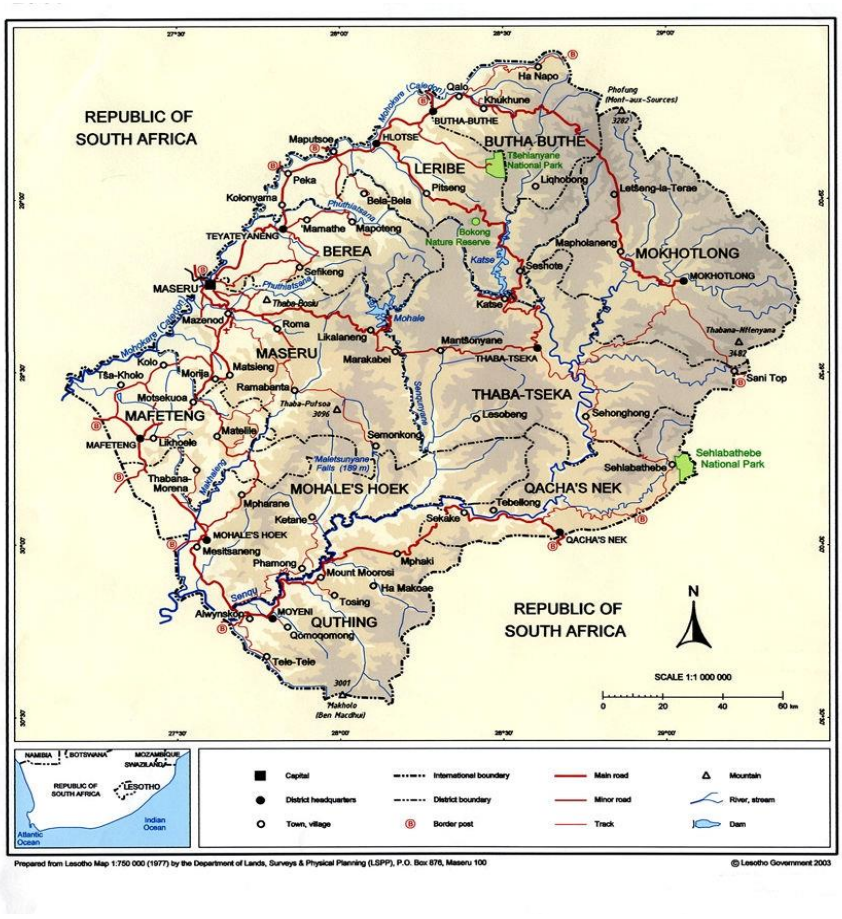
Key recommendations to the MOH are to prioritize factors related with internal management and institutional reorganization. The study concludes that leadership for strategic planning, human resource management, quality assurance and community participation are critical elements that should be addressed immediately. The MOH should move beyond adopting PHC in principle and focus on supporting the operationalization of a PHC approach that informs key decisions on well-defined program priorities, resource allocation, and quality delivery of the essential services package.

1. BACKGROUND

This section outlines the broad context within which the objectives and the ultimate implementation of the assessment were undertaken. This section presents the Lesotho's general profile, and its health services profile. The health services situation/profile will outline the goals of the MOH, the health services situation that justified the undertaking of a comprehensive assessment. This context was useful for determining the process and methodology the assessment adopted. The findings and recommendations of this assessment are also meant to maximize the opportunities and strengths presented by the macro context of the study.

1.1 Geo-physical Characteristics

Lesotho is a landlocked mountainous country in located in Southern Africa. It is completely surrounded by the Republic of South Africa. However, historical and cultural ties bring Lesotho closer to other Southern African countries notably Botswana and Swaziland. The country covers a total surface area of about 30,335 Km^2, 25% of which is lowland (in the west), and 75% highland. It is a high altitude country, with the lowest elevation being 1,388m above sea level, while the highest point reaches an altitude of about 3,482m at Thabana-Ntlenyana in the Maluti Range, which forms the eastern boundary with the KwaZulu-Natal Province of South Africa. The mountain ranges run from north to south and those in the central area, the Maluti, are the spurs of the main Drakensburg, which they join in the north, forming a high plateau that varies in height from 2,700m to 3,400m. It is this terrain that has earned it a unique nickname that Basotho are proud of - **Kingdom in the Sky**. The lowlands on the west are broken by rivulets and "dongas" caused by heavy soil erosion (MOLGPA 2013)



1.2 Economy and Economic Governance

Lesotho is classified among the Least Developed Countries (LDCs) with a per capita Gross National Income (GNI) of M6,853 (US $ 910) and per capita GDP of M4,795 (US $ 635) according to UN and National Statistics, 2009. The economy comprises the primary sector (which includes agriculture, mining and quarrying), which contributed 17.3% of GDP in 2011; the secondary sector (manufacturing, electricity and water, and building and construction), which contributed 23.9% of GDP in 2011; and tertiary sector, which contributed about 60.7% of GDP in 2011. Economic growth for 2013 is estimated at 4.7%, which suggests progressive recovery from 3.8% in 2012 and 3.7% in 2011. Exports contributed only 3.3% to growth in 2012, largely from textiles and garments as well as diamonds. Tourism, of which Lesotho has a huge potential, grew at 6.14% in 2012 (higher than the 4% global growth rate) underscoring its potential to transform Lesotho's economy. Despite job losses from retrenchment, labour remittances remain significant source of inflows, as South African mines still employ more than 41,000 Basotho miners. (Global Economic 2013)

In terms of economic governance, the private sector plays a critical role in various areas, including the provision of public utilities (water, energy, communication) that have been privatized. Public-private partnerships are an important economic model used in various investments including infrastructure development in transport, communication, mining, energy and water services. Nonetheless, private sector influence on governance activities remains limited, although the sector is organized through Chambers of Commerce and small business associations. Outside Maseru, the private sector presence is limited to a few service providers (e.g. hotels, retailers) and micro enterprises. Because of low private investment, upcountry towns remain under-developed and unemployment is higher compared to Maseru city. (Global Economic 2013)

Lesotho is one of the most unequal countries in the world (UNDP, Human Development Report, 2009), with a Gini coefficient of 0.52. Indeed, poverty has remained widespread although Lesotho's annual real GDP growth has averaged 4.2% since 1980 (GoL, 2004). This, however, represents a considerable improvement from 0.6 in 2004, attributed to pro-poor programs (such as labour intensive public works programme) implemented under the Poverty Reduction Strategic Plan (PRSP) 2004/5-06/7. This income inequality paradox is attributed, inter alia, to the highly skewed wealth distribution whereby most growth is concentrated in the capital, Maseru; inefficiencies in the public sector; slow improvement in agricultural productivity due partly to increasingly unfavourable climatic conditions; and inadequate coordination of development programmes. These bottlenecks to faster and equitable growth underscore the urgent need to decentralize governance and service delivery to local entities that are closer and more familiar with citizens' problems (i.e. unemployment, food insecurity, HIV/AIDS and poverty) and are more accountable to citizens. (Global Economic 2013)

Lesotho's economy is linked to that of its larger neighbour, South Africa, through remittances from miners and other labourers, customs revenues from the Southern African Customs Union, and the sale of water to South Africa (World Bank 2009). However, remittances from miners employed in South Africa have declined in recent years, and the economy relies on a small manufacturing base (based on farm products that support the milling, canning, leather, and jute industries), as well as on a rapidly expanding apparel-assembly sector (CIA 2010). According to the World Bank, real per capita GDP growth averaged 3.3 percent over 1991-2007, above the sub-Saharan Africa average. However, Lesotho's growth path has been closely linked to the external environment, weather conditions, and the strength and weakness of the rand to which the Maloti is pegged (World Bank 2009). Lesotho also faces extreme income distribution inequality as the country's economy is still primarily based on subsistence agriculture, especially livestock (CIA 2010). Table 1.1 provides an overview of income and inequality indicators in Lesotho, compared to sub-Saharan Africa averages.

Table 1.1. Income and Inequality Indicators in Lesotho, Compared to Sub-Saharan Africa

	Source of Data	Lesotho	Year of Data	Sub-Saharan Africa Average	Year of Data
GDP per capita (constant 2005 US$)	WDI	902.8	2011	978.1	2011
GDP growth (annual %)	WDI	3.7	2011	4.5	2011
Health expenditure per capita, PPP (constant 2005 international $)	WDI	218.8	2011	154.6	2011
Private expenditure on health (PvtHE) as % of THE	HNPD	25.9	2011	54.9	2011
Out-of-pocket health expenditure (% of private expenditure on health)	WDI	69.0	2011	67.0	2011

Sources: World Bank World DataBank (http://databank.worldbank.org/data/home.aspx)

Lesotho's transportation infrastructure is composed of road, air, and water, with a small privately owned rail linkage at the border of South Africa. Road transport predominates, and, as of 2006, there were 7,437 km of existing roads, of which 16 percent were paved, 51 percent were gravel, and 33 percent were earth/other (World Bank 2006). As a land-locked country, Lesotho recognizes the link between economic growth and the need for adequate transport infrastructure and is currently using funds from the World Bank and European Commission to strengthen its transportation system and improve access to economic opportunities and services. Table 1.2 contrasts the adult literacy rates in Lesotho and Sub-Saharan Africa. Compared to the average of other countries in the region, Lesotho has a significantly higher adult literacy rate (89.65%).

Table 1.2. Education Indicators in Lesotho, Compared to Sub-Saharan Africa

	Source of Data	Lesotho	Year of Data	Sub-Saharan Africa Average	Year of Data
Literacy rate, adult total (% of people ages 15 and above)	WDI	89.65	2010	59.8	2011

Sources: World Bank World DataBank (http://databank.worldbank.org/data/home.aspx)

1.3 Demographic and Socio-cultural Characteristics

As of 2012, Lesotho had a population of 2,051,545 people (www.worldbank.org), 52% of whom are female and 48% male. The population is relatively young (with more than half (57.5%) being under 25 years) and predominantly rural (77.4% of the population live in rural areas and only 22.6% are categorised as urban[4]). The country is 30,355 sq. km, with highlands constituting a majority (80%) of the territory and making ground travel difficult. Although 72 percent of the population lives in rural areas, less than 10 percent of the land is arable (Table 1.3 provides an overview of basic demographic indicators).

Table 1.3. Demographic Indicators in Lesotho, Compared to the Sub-Saharan Africa Regional Average

	Source of Data	Lesotho	Year of Data	Sub-Saharan Africa Average	Year of Data
Population, total	WDI	2,051,545	2012	911,126,155	2012
Population growth (annual %)	WDI	1.08	2012	2.70	2012
Population ages 0-14 (% of total)	WDI	36.75	2012	3.09	2012
Population ages 65 and above (% of total)	WDI	4.20	2012	43.18	2012
Rural Population (% of total)	WDI	71.70	2012	63.22	2012
Urban Population (% of total)	WDI	28.30	2012	36.78	2012

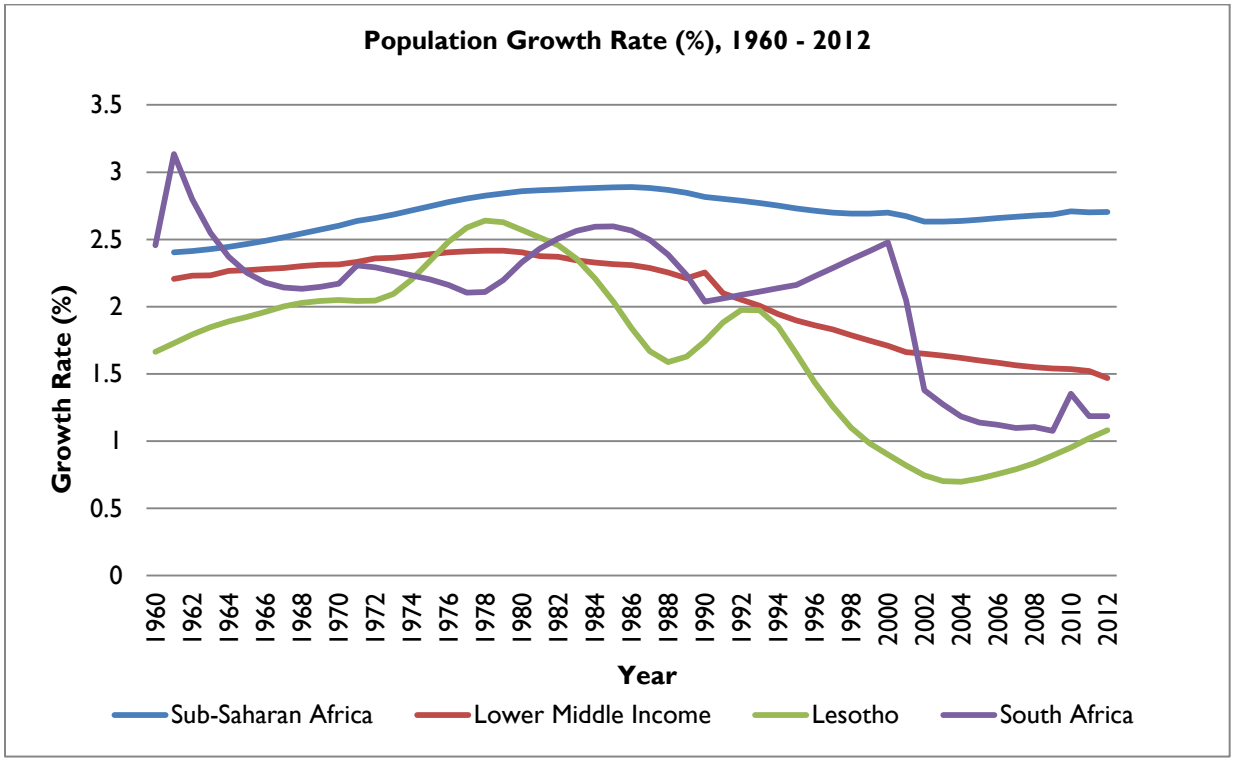
Source: World Bank World DataBank (http://databank.worldbank.org/data/home.aspx)

Lesotho's population is growing at a rate of 1.08 percent, compared to the regional average of 2.70 percent. As shown in Figure 1.1, Lesotho's population growth trends mirror those of neighbouring South Africa—demonstrating strong economic and epidemiological ties between the two countries. The sharp population growth decline, which began in 1999, is attributable to increased mortality due to HIV/AIDS. Despite relatively low overall population density (62 persons per sq. km), population density in arable land areas is extremely high (averaging 688 persons per sq km), yet 75% are rural-based and dependent on agriculture. This highlights the challenge of poverty eradication and social transformation of an agrarian rural economy. More than half (56.6%) of the population live below the poverty line. Poverty reduction efforts have been slow with only 10% lifted out of poverty during the last 2 decades (from 66.6% in 1994). Food security is a challenge, and nearly a quarter of the population in Lesotho is vulnerable to food insecurity. Underlying is limited arable land and inadequate access to modern agricultural technologies. Gross Primary school enrolment is 103%, which is slightly higher than Sub-Sahara Africa's. Life expectancy at birth is 48 years. Poverty and social vulnerability in Lesotho have been exacerbated over the last decade, by increased mortality associated with HIV/AIDS-related deaths[5] and reduced incomes as a result of loss of jobs in South African mines that used to employ a large proportion of Lesotho's labour force (UNDP, 2011).

[4] Lesotho Population Datasheet, 2010.

[5] In 2008, 23.2% of the population aged 15-49% was infected with HIV/AIDS, which also accounted for 28% of male institutional deaths and 34% of female institutional deaths (MOHSW 2009 In Takondwa et. al, 2010).

Figure 1.1. Comparison of Population Growth Rates



Source: World Bank (2013)

Lesotho is socio-culturally united by many factors, including one language (Sesotho) that is also a national language, and a tradition that revolves around the King. The royal family and the institution of chieftainship have an important place in the social, cultural and political life of Lesotho and its people – the Basotho.

1.4 Political and Administrative Governance

Lesotho is a constitutional monarchy, with the King as Head of State who is a symbol of national sovereignty, identity, heritage and unity. It's a multiparty parliamentary democracy with more than 20 registered political parties active at all levels. The government comprises of an executive branch headed by a Prime Minister, the legislature and an independent judiciary headed by a Chief Justice. The legislative branch is bicameral with a 120-seat member National Assembly (of whom 80 are directly and democratically elected and 40 are nominated) and a Senate (comprised of 22 Principal Chiefs and 11 people nominated by His Majesty the King on the advice of the State Council and the Prime Minister to represent the wider interests of society). The judiciary branch consists of the Court of Appeal as the highest court, High Court, Magistrates' Courts, and local courts. The Prime Minister is appointed from a party or coalition of parties with majority of seats. The current Government whose term runs from 2012 to 2017 is a coalition of 3 political parties namely All Basotho Convention (ABC), Lesotho Congress for Democracy (LCD) and Basotho Nationalist Party (BNP). Elections are held every 5 years, organised by an Independent Electoral Commission (IEC).

The country adopted a new electoral model i.e. Mixed Member Proportional model (MMP) prior to the 2002 general elections. This is a combination of first past the post (FPP) and proportional representation (PR) systems. Two thirds (80) of the National Assembly members are directly elected through FPP while

one third (40) are nominated after the elections through the PR model[6]. The Senate acts as a "Watchdog" charged with protecting the peoples' interests, among its core functions, by ensuring that potential excesses of the National Assembly are pointed out and appropriately mitigated before they can negatively impact society.

At the local level, there are 4 council structures, which are legally independent of each other i.e. 10 District Councils, 11 Urban Councils, 1 Municipal Council, and 64 Community Councils. Maseru City, with an estimated population of about 250,000 people, is the country's capital and largest urban area. Community Councils are the lowest level of government. Service delivery in nearly all domains is undertaken through de-concentrated offices at the district level. At the lowest level (village), however, chiefs remain the centre of all aspects of governance. They are responsible for community security, community mobilisation for development and administration of restorative justice.

All four categories of local councils namely: 10 District Councils, 1 Municipal Council, 11 Urban Councils and 64 Community Councils are elective. Presently, there are 194 district councilors, 164 urban councilors and 1,256 community councilors. The Councils are headed by Chairpersons elected at the first sitting following elections. The lowest level is the Community Council (CC) and Urban Council (UC) which comprise of directly elected councilors, including 2 Chiefs in each council (elected by gazetted chiefs). These constitute electoral colleges for the District Councils (DC). The structure of each council is summarised as follows:

- ***District Councils***: are constituted by councilors indirectly elected through electoral colleges. The electoral college comprises of community and Urban Councils within the district. Council resolutions are expected to be implemented by the District Council Secretary (DCS) who acts as the Head of the Council Secretariat and chief executive officer in the district.
- ***Urban Council***: With the exception of Maputsoe and Semonkong towns in Leribe and Maseru districts respectively, all other urban councils serve as seats of district headquarters, Urban areas are considered and must be positioned as centres of modernisation and development in respective districts.
- ***Community Council***: Community councils are the lowest formal government structures in the hierarchy of Government. They are constituted by Councilors who are elected to represent Electoral Divisions (EDs). These EDs are clusters of 2-3 villages depending on the population of a village. Since 2011, Community Councils are aligned to parliamentary constituencies.

The delineation of boundaries for these administrative/political entities has been done by MoLGCPA through a Boundaries Commission appointed by the Minister responsible for Local Government. The criteria on which the recent demarcation includes population, but is generally not clear to many stakeholders.

Despite overlapping jurisdictions, these councils work independently of each other and each Council is a body corporate according to the Local Government Act, 1997 as amended in 2004. The LG structures at different levels and associated features (physical and demographic size) are presented in table 1.4.

[6] Party lists based on a mixed member proportional model. This is arrived at by first-past-the-post (FPP) and proportional representation (PR). The system is based on the aggregate of votes each party gets.

Table 1.4. Local Government Structures by District

	District	Area (Km2)	Population (2006)	No. of Councils	No. of Directly elected Councilors	No. of Political Groups in Councils
1	Butha-Buthe	1,767	110,320	5	68	7
2	Leribe	2,828	293,369	13	167	7
3	Berea	2,222	250,006	9	97	7
4	Maseru	4,279	393,154	12	116	6
5	Mafeteng	2,119	192,621	8	92	4
6	Mohales' Hoek	3,530	176,928	8	105	4
7	Quthing	2,916	124,048	6	84	4
8	Qachas' Nek	2,349	69,749	4	65	2
9	Thaba-Tseka	4,270	129,881	6	89	5
10	Mokhotlong	4,075	97,713	5	73	4
	Total		1,876,633	76	926	

Data Source: IEC Records

As shown in the table 1.4 above, local councils reflect the country's diverse political groupings. The political diversity in councils has, however, been blamed for undermining local development as councilors often support or oppose plans or proposals based on petty party rivalries. A sizeable number of councilors in all districts stood as independent candidates, and this has been attributed much more to internal party wrangles and dissatisfaction by political contenders within parties than to ideological differences or political independence of candidates. It underscores the importance of political parties in decentralization and local governance.

In terms of functioning, the DCS is the head of the Council Secretariat whose main function is to support Local Councils and put in practice the resolutions and directions of district Councils. The Community Council Secretary (CCS) and Town Clerk play a similar role at community and urban council respectively, although they report to the DCS. The District Administrator (DA), on the other hand, is the overall head of the district, overseeing and coordinating all Government functions in the district- both Central and Local Government. Source: MOHSW (2007)

Lesotho was among the first African Countries to subject themselves to the African Peer Review Mechanism (APRM). Because of Lesotho's progressive multi-party democracy, it was one of the few African Countries that benefited from the United States of America (USA)'s Millennium Challenge Account (MCA) support. In 2007, Lesotho was selected as one of 16 lower income countries eligible for the U.S. government's (USG) Millennium Challenge Corporation (MCC) assistance. Eligibility for MCC assistance is based on 17 policy indicators that demonstrate a commitment to policies promoting political and economic freedom, investments in education and health, the sustainable use of natural resources, control of corruption, and respect for civil liberties and the rule of law. Water and private sector development comprise 55 percent of the 2007 five-year, $362.6 million dollar MCC compact, highlighting the importance of these two areas for development and the relative need for improvement. The MCC compact program's objectives are to improve the water supply for industrial and domestic needs and enhance urban and rural livelihoods through improved watershed management and to stimulate investment by improving access to credit, reducing transaction costs, and increasing women's participation in the economy (MCC 2007). According to the Heritage Foundation, private sector development is limited by government involvement in economic activity. Weak property rights, limited

access to finance, and bureaucratic red tape stifle the entrepreneurial environment (Heritage Foundation 2010).

1.5 Health Services in Lesotho

This section outlines the broad context within which the comprehensive assessment was undertaken.

The overall goal of the Lesotho MOH is to achieve a sustainable increase in access to quality preventive, curative and rehabilitative health care services in Lesotho. According to the MOH Strategic Plan 2012, the MOH wishes to achieve the following;

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

1.6 Hon Minister's Priority Statement

After assessing the current situation of health services, the Honourable Minister of Health has outlined the priority of the Ministry of Health as revitalizing PHC and strengthening the community health worker programme. The Minister argues that the biggest challenge facing the MOH in relation to service delivery is not only the 'WHAT' referring to the technical know-how, but the 'HOW' referring to strategy or context within which the Ministry's interventions have to be channeled. The Minister asserts that the MOH has over the years failed to strike a balance between leading a strong curative programme and a viable decentralized prevention programme. Furthermore, the MOH has failed to take advantage of the inherent opportunities presented by community participation and ownership of the health system (MOH 2013).

1.7 Health Services Organization

The formal system of Lesotho health facilities are divided into the national (tertiary), district (secondary), and community (primary) levels. (Table 3.7 provides information on these health system levels.) The community level includes both health posts and health centers. The district level comprises hospitals that receive patients referred from the community level and filter clinics. The national level consists of one referral and two specialized hospitals. In Lesotho, 42 percent of the health centers and 58 percent of the hospitals are government owned, 38 percent of the hospitals and 38 percent of the health centers fall under the control of the Christian Health Association of Lesotho (CHAL), and the remaining facilities are either privately owned or operated by non-governmental organizations (NGOs), including the Lesotho Planned Parenthood Association, the Lesotho Red Cross Society (LRCS), and Population Services International (PSI) (MOHSW 2013).

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

National level: At the national level, Lesotho has three tertiary-level hospitals: Queen Elizabeth II Hospital, Mohlomi Mental Hospital, and Bots`abelo Leprosy Hospital. Queen 'Mamohato Memorial Hospital is the national referral hospital. Any cases that cannot be treated at Queen 'Mamohato Memorial Hospital are referred to South Africa. (HSA 2010)

District level: Districts have filter clinics and district hospitals. Filter clinics are a first point of care intended to lighten the load of district hospitals and function as "mini-hospitals," offering curative and preventive services and limited inpatient care. These clinics are especially important in Maseru, where the national referral hospital doubles as a district-level hospital. Unlike health centers, filter clinics are staffed by doctors and some have pharmacy technicians. They also offer selected laboratory and radiology services (administered through the hospitals). (HSA 2010)

Although district hospitals provide inpatient and outpatient care, their services vary widely depending on the availability of financial resources, equipment, and human resources. Treatment and diagnostic services are more complex at this level. These facilities provide minor and major operative services, ophthalmic care, counseling and care of rape victims, radiology, dental services, mental health services, and blood transfusions as well as preventive care. Some specialized care is also available for TB, HIV, and non-communicable diseases. (HSA 2010)

Community level: Communities offer health posts and health centers. Health centers are the first point of care within the formal health system. Staffed by nurse clinicians with comprehensive skills in preventive and curative care and in the dispensing of medication, health centers offer curative and preventative services, including immunizations, family planning, and postnatal and antenatal care on an outpatient basis (with the exception of services to expectant mothers). Their mandate also extends to supervising the community public health efforts and training volunteer community health workers (CHWs). (HSA 2010)

Health posts provide community outreach services and are typically managed by volunteers. Generally, health posts are opened at regular intervals (not daily) and provide health promotion, prevention, and rehabilitation care in addition to organizing health education gatherings and immunization efforts. Volunteer CHWs include traditional birth attendants and community-based condom distributors, among others. (HSA 2010)

1.8 Ownership of Health Facilities

Health facilities in Lesotho are either owned by the Government of Lesotho, Christian health Association of Lesotho (CHAL) or privately owned. The Government owns majority of facilities countrywide with the second highest being CHAL. Most of the facilities provide primary health care at the village level and secondary health care at the district level. Some of these facilities are found in the Urban, Peri Urban and Rural areas of Lesotho. Table 1.5 summarizes facility ownership by district. Appendix II captures a list of health centers surveyed by name, district and proprietorship.

Table 1.5. Facility Ownership by District

DISTRICT	Health Center Ownership				
	CHAL	Government	MCC	Private	Total
BEREA	11	5	1	1	18
BOTHA BOTHE	3	9	0	0	12
LERIBE	15	13	0	0	28
MAFETENG	7	11	0	0	18
MASERU	14	21	0	3	38
MOHALE'S HOEK	4	11	0	0	15
MOKHOTLONG	2	8	0	0	10
QACHA'S NEK	5	6	0	0	11
QUTHING	3	6	0	0	9
THABA TSEKA	9	10	0	0	19
Total (N)	73	100	1	4	178
(%)	41.0%	56.2%	0.6%	2.2%	

1.9 Health Services Decentralization Reform

The MOH is currently implementing a series of health sector improvement reforms including decentralizing legal responsibility of providing primary health care to the Local Authorities (LA). The on-going health decentralization programme is considered central to these on-going health sector reforms and is considered a key driver of the Government of Lesotho's (GOL) Public Improvement and Reform (PSIRP) Programme; Service Delivery Agenda (SDA) and the Vision 2020.

The Health Services Decentralization Strategic Plan 2009 assumes that decentralizing the provision and management of primary health care to local authorities will achieve inter alia the following objectives:

- Promote community participation in health development
- Provide quality primary health services
- Strengthen health support systems including its governance

1.10 Community Based Health Services in Lesotho

According to the HSA 2010, another problem leading to poor delivery of health care in Lesotho is the inability of government to engage civil society (CS) in health issues. The HSA 2010, the Annual Joint Reviews 2009-2012 recommend the immediate engagement of CS in the health service delivery processes. The community health worker programme (CHW) that was and is still regarded the cornerstone of PHC, has, over the years, met a series of challenges due to inadequate funding, increased burden of disease and the absence of a clear policy framework (HSA 2010). The same report indicates that CHWs are not involved in the health planning and policy processes at the ministries of Health and Social Development. According to the HSA 2010 another problem leading to poor delivery of health care in Lesotho is the inability of government to engage CHWs in health and social development issues. This is despite the fact that NSAs are readily available and willing to work in health services. Refer to box 1 below for select HRH challenges that necessitate a concerted effort to support and organize the informal community based health service providers.

CHW systems have proved to be sine qua non to health services delivery challenges in Lesotho. Not only are CHW sources of hope for poor communities residing in hard to reach rural areas of the Lesotho, but they are also pull factors gradually undermining the migratory push factors—poverty and lack of basic services that mirror the urban-rural development inequalities in Lesotho. According to an assessment on the effectiveness of CHWs conducted by DFID in 2006, the CHW system has demonstrated to be very responsive, relevant, affordable and promises more accountability to local communities. According to the same study, the effectiveness of different CHW programmes has been compromised by the lack of a regulatory framework to provide strategy and coordination for all community based and led health interventions. There is no specific strategic framework to coordinate and to regulate the work of CHWs working \ in Lesotho. Facilitating agents government and civil society organisations have the discretion to determine what, who and how CBWs systems operate. As a result there is a proliferation of CBWs often duplicating, undermining and very rarely complementing the work other CBWs. The lack of policy framework has also meant that issues of recruitment, selection, remuneration/incentives, focus, accountability, supervision and capacity building have not been coordinated properly compromising on the very work the CBWs are expected to perform (DFID 2006).

Box 1. Notable HRH Challenges

There are no official mechanism in place to ensure active engagement of the community in the management of the health and social development system and the delivery of services (**National Health Policy 2011)**

The community health worker programme and the backbone of health services has over the years had a series of challenges due to inadequate, supportive supervision, funding for operations and commodities, lack of a policy framework
(Health Systems Assessment 2010)

Lesotho is faced with critical human resources shortages due to high attrition rates of health professionals and the scourge of the HIV and AIDS. 60% of health care production is supplied at primary care level, however less than 20% of the formal sector labor supply works at this level. Given this scenario facility driven Prevention efforts are increasing becoming difficult due shortage of formal health workforces this is further compounded by a non-functional community health worker programme **(Health Human Resources Strategic Plan 2005-2025**

The 2012 CHW Policy calls for the revitalisation of the Primary Health Care Approach. The policy states that improved health services will depend on the ability of the MOH to develop supervise and coordinate CHWs. The policy points to the fact that CHWs are agents of community participation and that their effectiveness is enhanced through their ability to link with health facilities, community based systems at the local government and Councils themselves.

According to the CHW 2012 Policy

The MOH will

- Institutionalize Community based Health governance
- Set up a system for community ownership and participation in health services
- Avail communities of a cadre of health workers that provide services at community level
- Provide the necessary technical support to CHWs
- Provide community based public health services in priority communicable and non-communicable and reproductive health services as well as health

The 2011 National Health Policy states that the MOH in consultation with the Councils and NSAs will define and promote a package of health interventions to be implemented at community and household levels. Furthermore, that the MOH will advocate for uniform benefits and rewards for CHWs and will also undertake systematic assessment and documentation of the effectiveness as well as quality of health care. The Local Government Act 1997 (LGA 1997) entrusts councils with the full legal responsibility of overseeing the provision of public

health services[7]. The same ACT describes Councils as bodies that can sue and be sued for performance or non-performance of functions entrusted onto them. The role of the District Administrator is defined as the custodian of the interests of central government interests at central level. Congruent to implementing the spirit of the LGA 1997, the MOH is currently implementing a series of health related sector reforms including decentralization. The Health Services Decentralization Strategic Plan 2009 assumes that decentralizing the provision and management of primary health care to Councils will achieve inter alia the following objective: promote community participation in health development.

1.11 PHC Revitalization Plan 2011-2017

After almost thirty years since the adoption of Primary Health Care (PHC) as the foundation for health development in Lesotho and following the country's participation in the International Conference on Primary Health Care and Health Systems in Africa: Towards the Achievement of the Health Millennium Development Goals in April 2008, a thorough revitalisation of PHC and Health Systems Strengthening was essential. As part of this laudable reform process, the MOH in May 2010 commenced the process of developing and implementing the PHC Revitalization Action Plan 2011-2017 with technical support from WHO. The PHC revitalisation action plan was adopted by Cabinet in October 2013 and is the basis for MOH's current programming.

1.12 Health Services: Programme Indicators

1.12.1 Reproductive Health

Table 1.6 below provides a snapshot of Lesotho's reproductive health indicators. Compared to the average of other countries in the region, Lesotho has a significantly higher contraceptive prevalence rate (47%), lower total fertility, and higher utilization of antenatal care (ANC).

Table 1.6. Reproductive Health Indicators in Lesotho, Compared to the Sub-Saharan Africa Region

	Source of Data	Lesotho	Year of Data	Sub-Saharan Africa Average	Year of Data
Contraceptive prevalence (% of women ages 15-49)	WDI	47	2009	24.31	2009
	DHS	47	2009	--	--
Unmet need for contraception (% of married women ages 15-49)	WDI	23.3	2009	--	--
	DHS	23	2009	--	--
	WB	--	--	26	2000-2009
Fertility rate, total (births per woman)	WDI	3.27	2009	5.29	2009
	DHS	3.3	2009	--	--
Pregnant women who received 1+ antenatal care visits (%)	DHS	89.8	2009	--	--
	WHO	91.8	2009	--	--
	--	--	--	77	2007-2012
Pregnant women who received 4+ antenatal care visits (%)	DHS	70.4	2009	--	--
	WHO	70.4	2009	--	--
	--	--	--	46	2007-2012

Sources: World Bank World DataBank (http://databank.worldbank.org/data/home.aspx), Lesotho Demographic and Health Survey 2009, WHO Global Health Observatory Data Repository (http://apps.who.int/gho/data/node.main), World Bank Unmet Need for Contraception March 2010, UNICEF Statistics and Monitoring (http://www.unicef.org/statistics/index_24183.html)

[7] See Section 5 and read Schedules 1 and 2

1.12.2 Mortality

Lesotho has a low life expectancy rate (46.63 years), compared to the regional average of 54.75. This is due mainly to the extremely high levels of HIV and tuberculosis (TB). Table 1.7 summarizes selected mortality indicators in Lesotho.

Table 1.7. Mortality Indicators in Lesotho, Compared to the Sub-Saharan Africa Region

	Source of Data	Lesotho	Year of Data	Sub-Saharan Africa Average	Year of Data
Life expectancy at birth, total (years)	WDI	46.63	2009	54.75	2009
Mortality rate, infant (per 1,000 live births)	WDI	79.3	2009	70.50	2009
Mortality rate, under-5 (per 1,000 live births)	WDI	112.7	2009	110.48	2009
Maternal mortality ratio (per 100,000 live births)	WDI	1200	2009	500	2010

Source: World Bank World DataBank (http://databank.worldbank.org/data/home.aspx)

Lesotho has been severely affected by the HIV pandemic. In 2012, 23.1 percent of the adult population (aged 15-49) was HIV positive, the second highest rate in the world (UNAIDS 2013). This corresponds to an estimated 72 new HIV infections and 42 deaths due to AIDS per day (UNAIDS 2013). HIV accounts for 28 percent of male institutional deaths and 34 percent of female institutional deaths (MOHSW 2009).

In 2012, TB cases were estimated at 424 cases per100,000 population (WHO Global Health Observatory Data Repository). Poverty and high rates of labor migration drive the HIV and TB epidemics. Table 1.8 summarizes the top causes of morbidity and mortality in Lesotho, as documented by WHO in 2004.

Table 1.8. Major Causes of Mortality in Lesotho, 2004

Cause of Death	Rank	Estimated deaths per 100,000 population	Estimated DALYs per 100,000 population
HIV/AIDS	1	801.4	23,386
Perinatal conditions	2	60.5	2,399
Malignant neoplasms	3	56.8	520
Cerebrovascular disease	4	52.4	428
Ischemic heart disease	5	44.0	344
Respiratory infections	6	40.8	473
Unintentional injuries	7	38.3	1,382
Tuberculosis	8	35.1	792
Diarrheal diseases	9	20.7	490
Diabetes mellitus	10	20.6	220

Source: WHO Disease and injury country estimates (http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html)

Table 1.9 lists the top four reasons for inpatient admissions in 2009, with 2007 comparison data.

Table 1.9. Top Four Causes of Inpatient Admissions, 2007 and 2009

Cause of Inpatient Admission	2007	2009	Difference
HIV/AIDS	13.9%	19.0%	+5.1%
Pulmonary tuberculosis	15.2%	16.9%	+1.8%
Pneumonia	6.2%	16.7%	+10.4%
Diarrhea and gastroenteritis	5.8%	13.1%	+7.3%

Source: Lesotho Bureau of Statistics, Health Statistics Report 2007 and Health Statistics Report 2009 (http://www.bos.gov.ls/)

In the 20-year period between 1990 and 2010, the mortality among adult females and males in Lesotho increased by 136 percent and 96 percent, respectively, from an average of 261.9 to 616.8 per 1,000 for females and 310.4 to 607.7 per 1,000 for males (World Bank 2013). Although the mortality in males and females in Botswana is higher, Lesotho still compares poorly, on average, with other countries of similar size and socioeconomic development in the region, as indicated in Table 1.10.

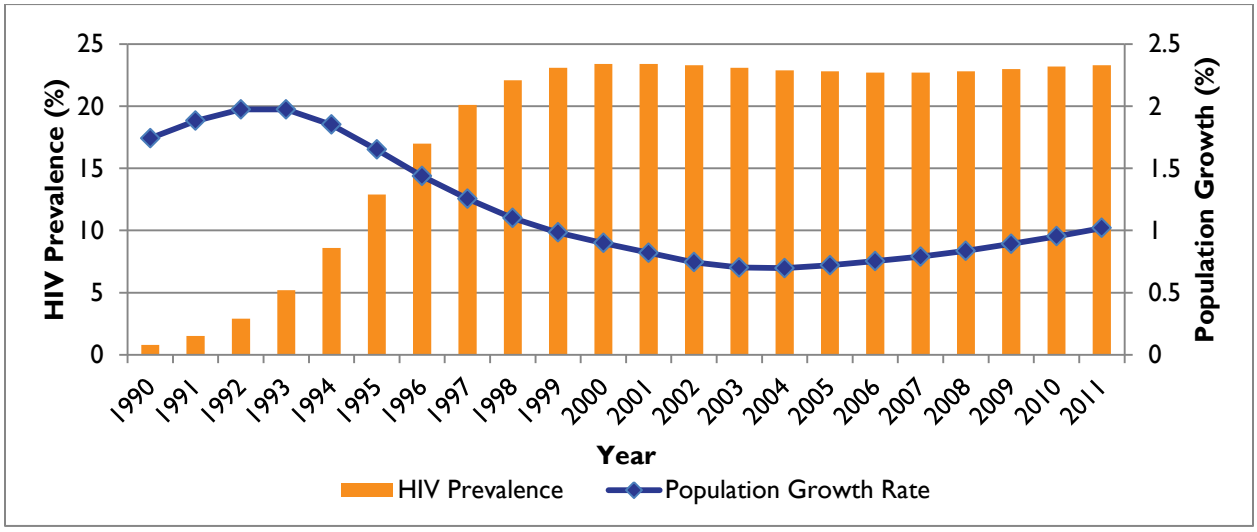
Table 1.10. Mortality per 1,000 in Female and Male Adults (Select Countries)

Country	1960		1970		1990		2010	
	Female	Male	Female	Male	Female	Male	Female	Male
Lesotho	381.1	438.5	354.2	409.6	261.9	310.4	616.8	607.7
Botswana	333.6	398.7	289.3	350.3	240.1	326.2	728.0	712.4
Swaziland	398.7	472.7	356.1	425.9	264.8	315.6	580.1	562.4
Mozambique	479.4	539.1	429.4	491.2	383.4	441.8	475.3	497.8

Source: World Bank World DataBank (http://databank.worldbank.org/data/home.aspx)

Figure 1.2 shows a juxtaposition of the HIV prevalence rates with the population growth rates between 1990 and 2011. It demonstrates the huge impact of HIV on Lesotho's population. Shortly after the HIV prevalence began stabilizing at around 25 percent, the population growth rate declined from 2 percent to 1 percent over a 10-year period, largely due to excess mortality caused by HIV.

Figure 1.2. Comparison of Population Growth Rates vs. HIV Prevalence Rates between 1990 and 2011



Source: World Bank (2013)

1.13 Health Systems Challenges: Observations of the HSA 2010

Lesotho and the Ministry of Health (MOH) achieved great strides in improving its health indicators from 1966-1990, with life expectancy rising from 40-years old to 59-years old. However, this trend was reversed because of the HIV and AIDS pandemic. According to the United Nations Development Programme (UNDP) Lesotho, Lesotho's progress vis-à-vis achieving country specific MDGs is mixed with notable challenges in Health sector related MDGs. Attempts to reduce child mortality are off track. The targeted improvement in maternal mortality is also off track. It is critical is to understand why the performance of the Health sector has declined overtime. To do this, the MOH has to have access to critical information on the strengths and limitations of **the health system**. The health system is defined by WHO (ww.who.org) as consisting of all organizations, people and actions whose primary intent is to promote, restore and maintain health. WHO defines the health system using six building blocks: leadership and governance, health financing, service delivery, human resources for health (HRH), medical products, vaccines and technologies, community participation and ownership and health information systems. According WHO, each building block by itself does not constitute a functioning health system; rather it is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them – that covert these blocks into a systems.

In 2010, the MOH carried out a health systems assessment to identify key system strengths and weakness, as well as opportunities and threats and to propose health system strengthening interventions for government and/or donors to support. The assessment is based on the core principles health services delivery – human resources, finances, quality assurance, essential services delivery, supply chain, health management information systems, leadership and governance including community participation, and health technologies and infrastructure.

A summary of the broad weakness of the current health:

- Sector plans are not results based, nor are they adequately coordinated with the donor community. This means that health sector activities conducted are not contributing to the overall goals of the health system and are not contributing to easing systemic bottlenecks.
- The quality of the service delivery in Lesotho is severely affected by resource allocation including systemic bottlenecks in use of allocated resources, critical shortages of HR, drug stock-outs, lack of information, and challenges in implementing strategies at the central level.
- MOH funds a hospital-based and centrally organized health care system, and this could be said to be an allocative inefficiency of limited financial resources.
- Although several functional mechanisms to improve rational use of drugs, such as NPTC, HPTCs, STGs, and NEML, exist at both the hospital and central levels, STGs are not consistently used for basic and in-service training of health personnel.
- Access to information and planning/policy processes is also limited in Lesotho.
- Supervision and quality assurance programme within the MOH are weak or virtually non-existent.
- Pharmaceutical management in Lesotho has been plagued by an insufficient amount of qualified human resources, a lack of financial resources, and poor information concerning use of drugs and commodities.

The key weaknesses in the health system as identified by the HSA 2010 are summarized in Appendix III.

2. SERVICE AVAILABILITY AND READINESS ASSESSMENT

This section of the report outlines the broad scope of the assessment, as well as its objectives and methodology.

2.1 Purpose, Objectives and Scope

A year and half in office, and with a visible ailing health system, the new leadership of the MOH took a decision to adopt primary health care as an approach to revitalize and improve provision of health services. The decisions on what aspects of PHC the MOH would revitalize require empirical evidence on the current status of the health system. The health system is used here to refer to status on the essential services; human resources, pharmaceuticals and supply chain, health finances, quality assurance, community participation and health management information systems. It is against this background that the MOH decided to carry out a comprehensive facility based health systems assessment.

The **purpose** of this assessment was that by the end of the assessment programme heads would have collected enough empirical evidence to use for the development of a PHC revitalization programme.

The objectives of the assessment were as follows:

- To carry out comprehensive participatory health centre based assessment of the 7 health system components in Lesotho and produce a detailed report. The assessment will identify key system strengths and weakness, as well as opportunities and threats per health centre.
- Use the assessment process to undertake a rigorous social mobilization exercise to encourage the political and administrative leadership of Lesotho to support the delivery of improved health outcomes.
- Propose health centre specific interventions (interventions whose ultimate goal is to strengthen the system for sustainable improvement in service delivery) for government and/or donors to support using the information collected from the assessment.
- Use the assessment process to help local authorities to understand the vision and objectives of the MOH.
- Use the assessment process to define the roles of Councils and councillors, private NGOs, CSOs, and Chiefs in health and agree on a programme of action to support them.
- Use the assessment process to define the role and possible contribution of the private sector in health.
- Develop operational plans based on the key findings of the assessment.

This assessment was carried out by the Ministry of Health, CHAL, and the Red Cross. The assessment process was supported by Pitsong Institute of Implementation Research and the Health Finance Governance (HFG) Project. The study was undertaken through CDC's support to the MOH under cooperative agreement: 5U2GPS002076-04.

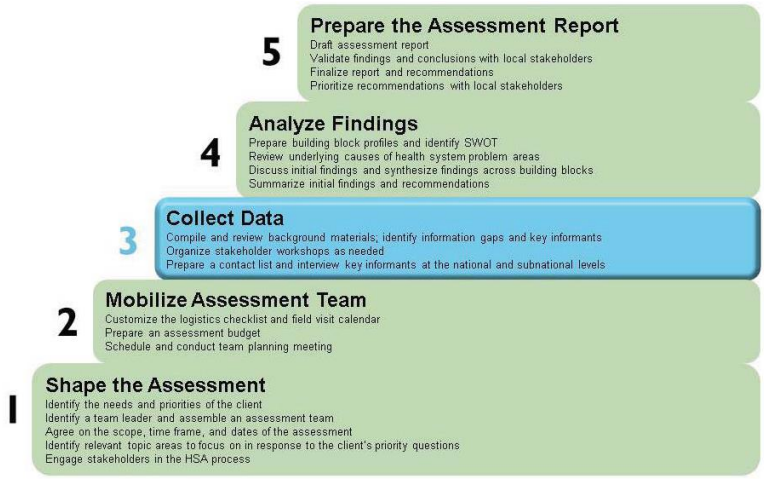
The study covered all health centres in Lesotho. The MOH used public health nurses and nurses working with district council secretaries to plan and carry out the assessment. The assessment focused on collecting qualitative and quantitative data on the following issues:

- quality assurance,
- service delivery,
- Human resources for health,
- Medical products, vaccines and technologies,
- Health information management systems,
- Health finance
- Health infrastructure
- Community health worker programme

2.2 Methodology

This section outlines the methodology adopted to conduct the comprehensive health centre assessment. It describes the overall process/framework; the assessment team/committees; description of the assessment tools and instruments; questionnaire development process, study population and sampling procedures; data capturing and report writing processes; limitations and strengths of the assessment.

2.2.1 Overall process



The study was conducted in five phases. The first phase focused on the defining the scope of the assessment including objectives and instruments the assessment would adopt. The methodology, instruments and tools proposed for the study were submitted and endorsed by the ethics committee of the MOH. The second phase involved mobilization of key stakeholders including local government structures, church organizations, district administrators, public health nurses and other members of the DHMT. The study team also pre-tested the assessment tool and revised it accordingly based on observation during pretesting. The third phase involved the data collection or carrying out the assessment in all the health centers in Lesotho. The fourth phase of the assessment included data entry, cleaning and analysis. The fifth and final phased was dedicated to report writing and presentation and sharing of the assessment findings and recommendations.

2.2.2 Study Population and sampling procedures

A census of all health facilities in Lesotho was carried out as part of this assessment. The composition includes all facilities in the urban areas, peri and rural areas of Lesotho. In addition, the coverage included facilities owned by Government, CHAL and those by the Red Cross. The concept of sampling did not apply as this study covered all health facilities in Lesotho. The survey covered a total of 178 health facilities in Lesotho. Please see Appendix 11 for a list of facilities covered.

2.2.3 Description of assessment tools/methods

A baseline assessment was conducted in all health facilities in Lesotho by interviewing nurses in charge of the different health centres. Quantitative and qualitative data were collected using structured questionnaires, check lists, observation and interviews guided by public health curses and representatives of central programmes of the MOH. Focused group discussions around issues and initial observations captured in the questionnaires were conducted with public health nurses and other representatives of the DHMTS. Secondary literature was reviewed and key informant interviews conducted with some members of the senior management within the MOH.

2.2.4 The assessment teams and committees

Within the current structure of the MOH, the responsibility to design, implement, supervise and evaluate health systems falls within the scope and mandate of the DGHS. The DGHS performs these responsibilities through its team of clinical and public health specialists and support programmes (Human Resources, Finances, Infrastructure, Health Management Information Systems). At the district level (DHMT) the responsibility for supportive supervision falls within the scope and job purpose of the District Public Health Nurse (DPHN). The DPHN is the key officer responsible for planning, supervision, coordination, monitoring and promotion of public health services as outlined in the Essential Services Package as well supervision of staff based at health centres. In addition, the DHPN is also key to ensuring the co-ordination of home-based care activities and the supervision of community health workers (CHWs). It is however acknowledged that in order for effective sustained supportive supervision to be undertaken, collaboration, co-ordination and support is vital and necessary. Whilst the core responsibility for supportive supervision, at district level, lies with the DPHN, the DPHN will need to engage with other members of the DHMT i.e. District Health Inspector, District Health Educator and District Social Worker and Programme Managers/Coordinators in order to discuss service delivery problems and issues that arise at facility and community levels. The decision on how the different teams would be composed was informed by the aforementioned understanding. Furthermore, the MOH is in the process of decentralizing health services to local authorities. It is against this background that the different teams and committees were constituted to lead this integrated supervision.

The assessment team was led by the DGHS – Dr. Piet McPherson and the DGLGS – Mrs. Matiisetso Libetso. The assessment team was composed of representatives of programmes with the MOH and the MOLGC. The assessment team was composed of the following teams and committees:

- **Central Government Steering committee** – Deputy Prime Minister and Hon Minister of MOLGCPA, Hon Minister of Health, Principal secretaries MOH and MOLGCPA.
- **Lead team and secretariat** – DGHS, DGLGS, Director Human Resources, Director Finance, Head Quality Assurance, Head of Family Health Division, Head of the Village Health Worker Programme, Head of Public Health Nurse, a representative of the private sector, Director Disease Control, Director Pharmaceuticals, Deputy Executive Secretary CHAL secretariat and Executive Secretary Red Cross, representatives of PIIR, representative of USAID.[8]
- **District Steering committee** – District Administrators (DAs), District Council and Urban Council Chairperson, District Medical Officer, Head of DHMT and Public Health Coordinators (CHAL and Red Cross).
- **District lead team** – DHMTSs, DHTSs, PHC coordinators and DCS and Community Council Secretaries.

[8] Depending on the role USAID/PEPFAR wants to play in the process

2.2.5 Responsibilities of the different teams

Central Steering Committee

- Provide the necessary political leadership to the ensure that assessment is carried out as expected and that all the political objectives of the reform are met and adhered to
- Oversee that the findings of the assessment are used to inform future programming with the MOH
- Mobilise the necessary leadership to be part of the assessment process

Lead team supported by Secretariat

Under the leadership of the DGHS and the DGLGS the lead team was charged with the following responsibilities:

- Preparing the initial scope and objectives of the assessment
- Shape and determine the scope and timeline of the assessment
- Support the team leader to assign different teams to lead the assessment
- Support the team leader to constitute appropriate teams
- Support the team leader to communicate the vision behind the assessment
- Support the team leader to ensure timely completion of the assessment
- Support data collection (ensure consistency of data collected, analysis (synthesizing findings)
- Support the write up of district specific assessment reports
- Support the programmes to consolidate district reports into one national assessment report

District Steering Committee

- Provide the necessary political leadership to the ensure that assessment is carried out as expected and that all the political objectives of the reform are met and adhered to
- Oversee that the findings of the assessment are used to inform future programming within the MOH
- Mobilise the necessary leadership to be part of the assessment process

District lead team

- Support health centres to carry out own assessment
- Support health centres to produce health centre specific reports
- Develop field calendar
- Analyse data
- Consolidate health centre reports in the district
- Produce one report for the district consolidating the assessment findings in all the health centres in that district

2.2.6 Limitations and Strengths of the Study

The assessment was led by the MOH from the design, implementation and report write up. First, the scope of this assessment was very broad; the study aimed to collect information and understand the linkages within and between health system components (pharmaceuticals and finance, HMIS, ESP, leadership and governance, community participation and governance, etc.). Second, this approach is nationally representative in scope. It provides a comprehensive review of the Lesotho health system. Third, the assessment was conducted in a participatory manner, involving government stakeholders at the central, district, and facility levels, private sector providers of health care, NGOs, donors, and development partners. Fourth, the recommendations generated from the assessment aim exclusively to provide guidance to national and international partners on HSS investments and interventions. The assessment was able to leverage numerous evaluations and studies that have been conducted in Lesotho in recent years and proposed action-oriented, achievable, and implementable recommendations for government and other interested stakeholders.

Every assessment has limitations. Although valuable data were collected from the district and facility levels, there were a number of data issues. For roughly 90 percent of indicators/questions, there was a small amount of missing data. This does not have a significant impact on the results. For the other 10 percent of indicators/questions, a significant amount of data is missing. Most of these indicators/questions were qualitative and required long answers, though some of them required "yes/no" quantitative responses. Indicators/questions with a significant amount of missing data were left out and not analysed, because the findings would not be accurate or representative of all facilities. The implication is that it's impossible to understand the entire "story" and assess exactly what is causing deficiencies in health service delivery at the facility level. However enough data was gained to give a broad picture that will be useful to the Ministry of Health for policy and program planning.

The assessment experienced delayed starts and delays in implementation due to lack of timely disbursement of funds within the MOH. The assessment also had leadership challenges. The department of planning was not part of the assessment despite constant invitations sent to the director of planning. This issue was never addressed by the leadership of the MOH. The absence of leadership was also visible during the data entry and analysis stage with districts like Maseru and Leribe failing to complete their qualitative analysis of the initial findings from the structured interviews.

2.2.7 Questionnaire Development and Pretesting/Piloting

The integrated supervision questionnaire used to conduct this study was developed by central programmes of the MOH. The programmes developed a comprehensive set of closed–ended, pre-coded questionnaires. The draft questionnaires were pre-tested by means of a pilot study at two heath centres – Domiciliary and LDF. The piloting exercise gave insight on the time it was likely to take to administer the questionnaire. This gave the study team an idea of when and how to go about administering the questionnaire. Caution was placed on ensuring that the survey does not affect the daily operations of the health facility.

2.2.8 Sampling of Facility Staff

Interviews conducted at the health centre were done with the most senior staff member on location. Respondents were mainly the persons in charge of the facilities. The names of the interviewers and the respondents were captured. The designations and names of the respondents were captured.

2.2.9 Length of Interviews

Details of the starting time and finishing time of interviews at the health centres were captured. On average it took 2 hrs 30 minutes to administer the questionnaire per health centre.

2.2.10 Data Collection Forms

PIQ – Provider Interview Questionnaire – The provider interview questionnaire was designed to cover essential services and supporting functions. A list of the areas covered and an overview of the information captured by the provider interview questionnaire is included in Appendix IV.

2.2.11 Data Capturing

Data was captured using MS Access and analyzed using SPSS version 17. Descriptive analysis and correlations were carried out to assess direction and relationship between variables. Data processing tools were developed in Microsoft Access (MS Access) because it is end-user-friendly while also compatible with any computer with Microsoft Office package. Choice of MS Access was considered critical as it allowed DHMTs to run their own reports without need to purchase additional special tools (software) which may be expensive and complex to use.

Guidance ranging from designing data processing tools, training DHMTs on data capturing and reporting based on the expected analysis was provided. The first step of the activity was to translate all data collected through questionnaires by capturing it through a well-organized MS Access data entry screen. The screen had inbuilt validations to minimize any errors that can result during capturing. Also, the screen was developed in such a way that there is an order in which sections stacked in the questionnaire follow to allow for smooth transition between sections.

Teams were divided into groups each resembling DHMT, although there was division of work in cases where certain districts had too many questionnaires to capture. The screen also had a pull down menu with pre-coded responses (see Appendix V) to speed up data capturing process while also controlling for typo errors.

Databases were developed to house the data and report views for data analysis. For all 10 districts, report views were developed for all 17 sections of the questionnaire to easily observe what story the data tells. This process was very helpful because DHMTs were able to make operational plans for their respective districts as analyses portrayed by the data could tell where the gap is per health facility per district, enabling them to determine necessary action and mitigation.

3. KEY FINDINGS AND RESULTS

The health system is defined by WHO (ww.who.org) as consisting of all organizations, people and actions whose primary intent is to promote, restore and maintain health. WHO defines the health system using sex building blocks – leadership and governance, health financing, service delivery, Human resources for Health (HRH), medical products, vaccines and technologies, health information systems (HMIS) and demand creation/community participation. According to WHO 2007 each building block by itself does not constitute a functioning health system; rather it is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them- that covert these blocks into a systems. The data collection instruments and methodology for conducting this assessment were developed and agreed based on this understanding of the health system. The key findings of this assessment are presented with the aforementioned understanding of the health systems. The key findings are therefore presented by service, resources and infrastructure that support the delivery of such a service and lastly by systems and support process that can influence quality of services delivery.

3.1 HTC Services

This section summarizes findings on the provision of HTC services at health facilities. Facilities were assessed on the following six service delivery indicators: 1) Availability of rapid test kits (up to 3 months' supply); 2) Provision of education on drug and substance abuse; 3) Provision of DNA/PCR testing as part of Early Infant Diagnosis (EID) for HIV-Exposed infants; 4) Provision of CD4 testing for all HIV positive clients; 5) Provision of Provider Initiated-Testing and Counseling (PITC) for both adults and children; and 6) Provision of adherence counseling to clients before initiation of ART. Overall results are presented in the Table 3.1 below:

Table 3.1. HTC Service Delivery Indicators

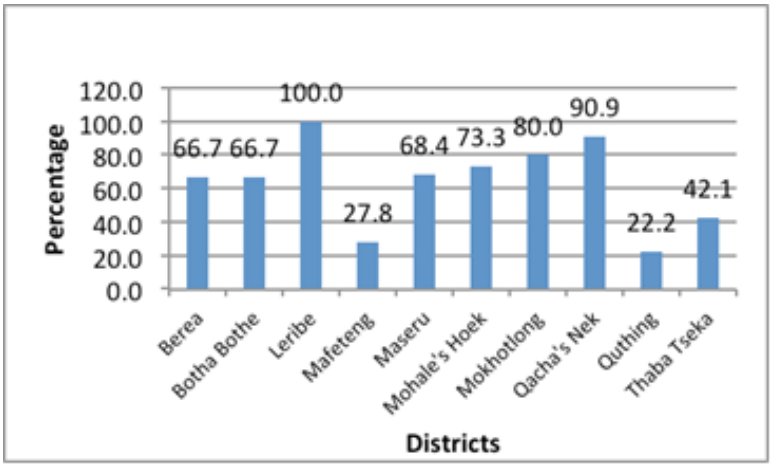
Indicator	Total
% of facilities with rapid test kits available up to 3 months	66%
% of facilities that provide education on drug and substance abuse	62%
% of facilities that perform DNA/PCR as part of EID for HIV-exposed infants	92%
% of facilities that provide CD4 testing for all HIV-positive clients	91%
% of facilities that provide PITC for both adults and children	
% of facilities that provide adherence counseling before ART initiation	90%

3.1.1.1 Resources and Infrastructure to Support HIV Testing and Counseling

Availability of well trained staff was used as a proxy for efficiency of delivery of testing services. Most of the facilities surveyed have the human resources required to deliver HTC services, with 87% of health facilities having trained counselors. However, there were some issues observed around availability of supplies.Frequent stock-outs of rapid test kits which limit continuous quality service provision. Overall, only about two-thirds of facilities have rapid test kits available and enough for 3 months. Variations in availability of rapid test kits in facilities across districts were observed, with Quthing, Mafeteng and

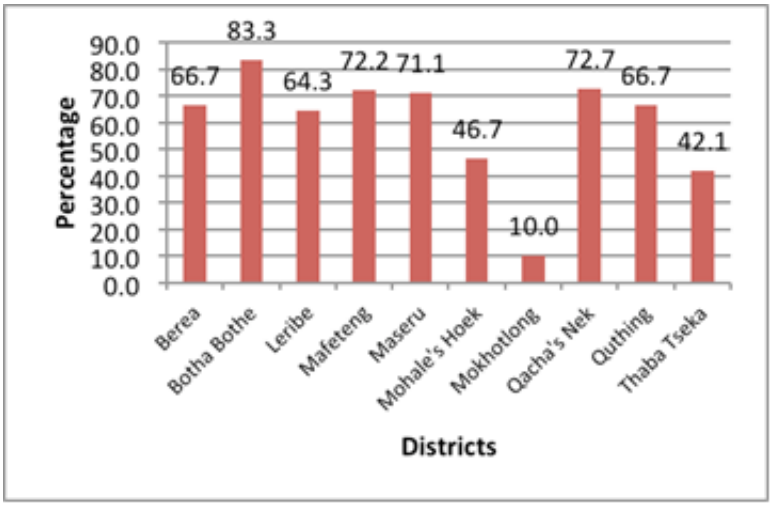
Thaba Tseka having the poorest availability (22%, 27.8% and 42.1 respectively, Figure 3.1). Major reasons cited for shortage of rapid tests kits in most facilities was non-availability of trained counselors who are needed to improve on reporting and supply chain/logistics management. It was also observed that personal protective equipment (PPE) for staff was available in only 72% of facilities. There were variations in availability of PPE across districts, ranging from 40% in Mokhotlong to 90% in Qacha's Nek (data not shown).

Figure 3.1. Availability of Rapid Test Kits Enough for a Period of 3 Months in health facilities, by district



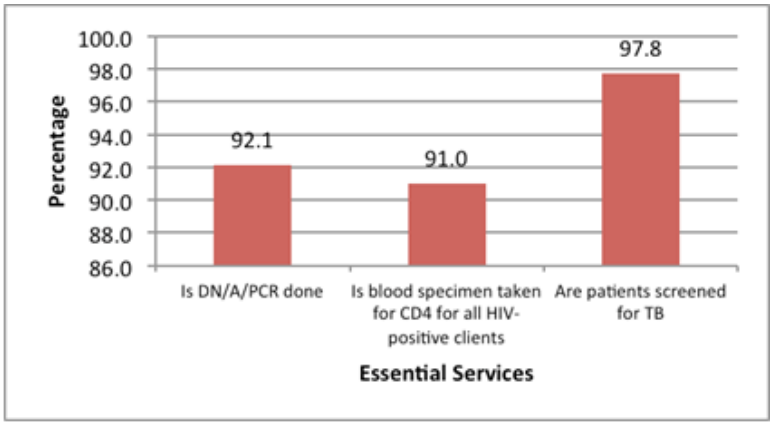
A key aspect of HTC services assessed was provision of health education. Overall, 80% of health facilities provide health education on HIV/AIDS prevention, correct and consistent use of condoms, TB and HIV co-infection and nutrition. However, only 62% of the facilities provide health education on substance abuse and HIV infection. Districts in the mountains such as Mokhotlong and Thaba Tseka had low percentages of facilities providing health education on substance abuse (10% and 42% respectively, Figure 3.2). The need to strengthen education on substance abuse cannot be over-emphasized, given the high levels of substance abuse among HIV positive patients which negatively impact on their recovery and adherence to treatment. The major reason cited for omission of this topic in educating clients is non-availability of a clear health education plan which includes drug and substance abuse content for health workers to administer.

Figure 3.2. Proportion of Health Facilities Providing Education on Substance Abuse, by District



Overall, the majority of health facilities in Lesotho adequately provide HTC services, though there is still need for improvements in some facilities. Nearly all health facilities conduct PITC for both adults and children; 91% of health facilities perform CD4 testing for all HIV-positive clients and 92% perform DNA/PCR testing for HIV-exposed infants (Figure 3.3). 90% of facilities provide adherence counseling before initiation of ART as well as ongoing adherence counseling. However, it was observed that only 74% of facilities do contact tracing for TB patients, with Maseru district having the highest proportion of facilities not tracing patients for TB (data not shown).

Figure 3.3. Provision of Key HIV/Testing Services in Health Facilities



3.2 Maternal and New born Health and PMTCT Services

Findings on the provision of maternal and new born health and PMTCT services are summarized in this section. Facilities were assessed on the following 8 indicators: 1) Provision of educational sessions to pregnant women; 2) Provision of CoTrim and INH prophylaxis as pre-ART care to HIV-positive ANC clients; 3) ANC registers correctly filled out; 4) Staff received refresher training in new-born care and resuscitation; 5) Provision of BCG and polio vaccine at birth before discharge from the H/C; 6) Initiation of ART (OPTION B+) for all HIV-positive pregnant women during first ANC visit; 7) Initiation of ART for all women testing HIV-positive during breastfeeding; and 8) Re-testing of all HIV-negative pregnant women at 36 weeks gestation as stipulated in national guidelines. Overall results are presented in Table 3.2 below:

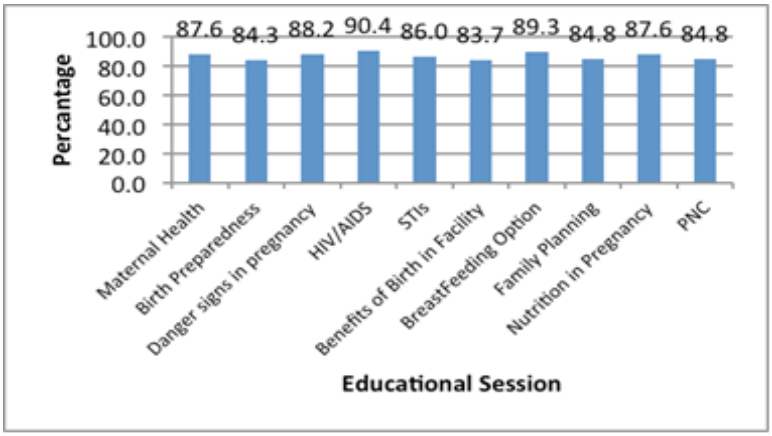
Table 3.2. MNH and PMTCT service delivery indicators

Indicator	Total
% of facilities that provide educational sessions to pregnant women	80%
% of facilities that provide Cotrimoxazole prophylaxis as pre-ART care to HIV-positive ANC clients	72%
% of facilities that provide INH prophylaxis as pre-ART care to HIV-positive ANC clients	43%
% of facilities that initiate ART (OPTION B+) for all HIV-positive pregnant women during first ANC visit	80%
% of facilities that initiate ART for all women testing HIV-positive during breastfeeding	80%
% of facilities that re-test of all HIV-negative pregnant women at 36 weeks gestation	85%
% of facilities with ANC registers correctly filled out	69%
% of facilities whose staff received refresher training in newborn care & resuscitation in the last 1 year	24%
% of facilities that provide BCG and polio vaccine at birth before discharge from the H/C	43%

3.2.1 Systems and Processes to Support the Delivery of MNH and PMTCT Services

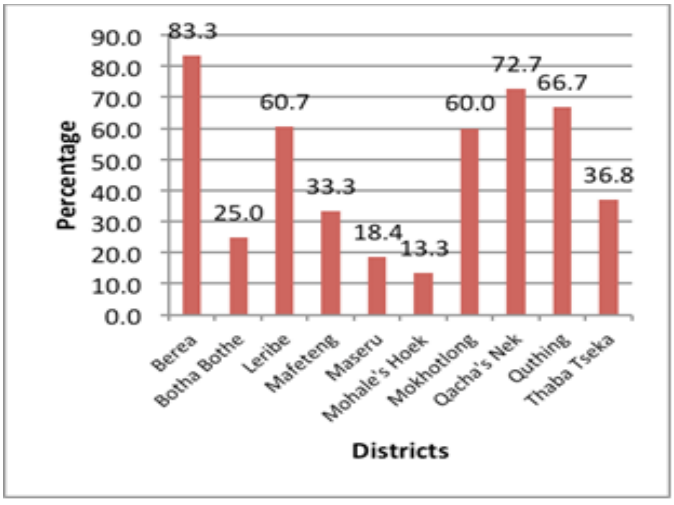
With high maternal deaths in the country, the assessment reviewed how primary health care can contribute to revitalizing maternal care with the aim of reducing the number of mother and child deaths. Results showed that on average, 80% of health facilities provide all forms of educational sessions to pregnant women attending ante natal care (ANC), including education on maternal health, birth preparedness, danger signs in pregnancy, HIV/AIDS, STIs, benefits of birth in facilities, nutrition in pregnancy, breastfeeding, family planning and post natal care (Figure 3.4). Results also showed that 96% of health facilities counsel pregnant women individually and offer HIV testing during routine ANC, while 90% of facilities ensure that all pregnant women are counseled and receive their HIV test results at the initial ANC visit (data not shown). 85% of health facilities re-test all HIV-negative pregnant women at 36 weeks as stipulated in the national PMTCT guidelines.

Figure 3.4. Provision of Educational Sessions to Pregnant Women



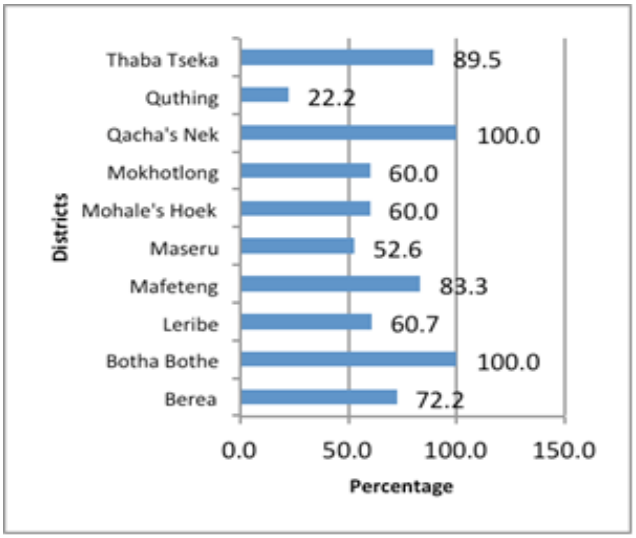
With regard to provision of medicines, 72% of health facilities offer cotrimoxazole chemoprophylaxis to all HIV-positive ANC clients; while 80% initiate ART for all HIV-positive pregnant women during first ANC visit or post natally during breastfeeding. However, only 43% of facilities offer INH prophylaxis to all HIV-positive ANC clients. Districts worst affected were Mohale's Hoek, Maseru, Botha Bothe, Mafeteng and Thaba Tseka with only 13.3%, 18.4%, 25.0%, 33.3% and 36.8% of their facilities, respectively, offering INH prophylaxis (Figure 3.5). Some of the reasons cited by health facilities were that drugs were not kept at the health centers thereby impacting on their immediate access when needed, while in some facilities, the drugs had only been distributed therefore indicating a lack of efficiency in supply chain.

Figure 3.5. Proportion of Health Facilities Offering INH Prophylaxis to HIV-positive ANC Clients, by District



Regarding maintenance of adequate ANC data, results showed that proper ANC registration was done by only 69% of health facilities across the country. While all the facilities in Qacha's Nek and Botha Bothe districts maintained adequate ANC data, Quthing had only 22% of its facilities correctly and completely filling out ANC registers (Figure 3.6). Similarly, Maseru (52.6%), and Mokhotlong (60%), Mohale's Hoek (60%) and Leribe (61%) all need to strengthen their HMIS in order to improve on reporting.

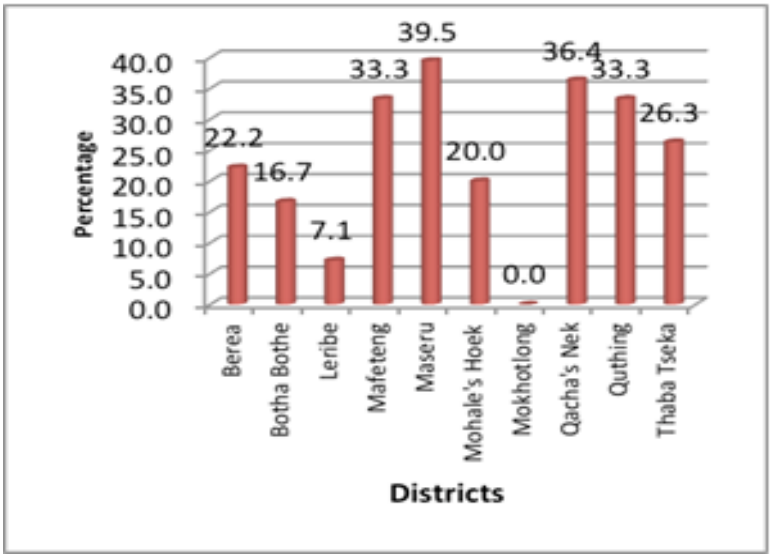
Figure 3.6. District Health Facilities with ANC Register Correctly and Completely Filled Out



3.2.2 Resources and Infrastructure to Support MNH and PMTCT Services

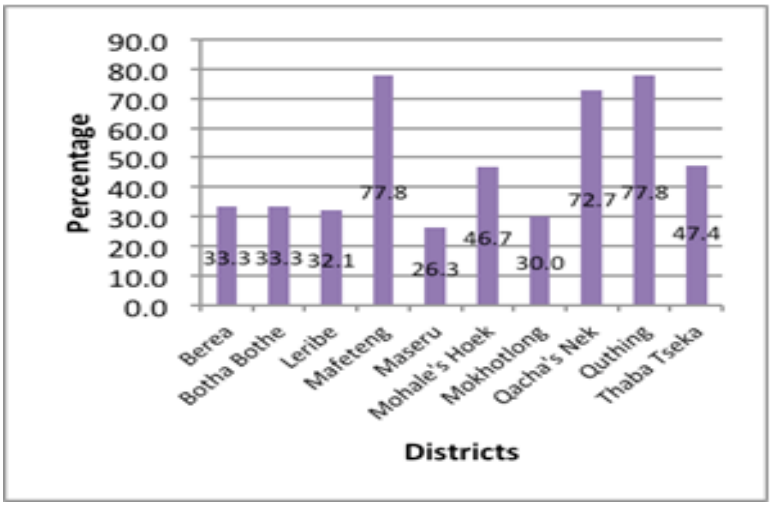
The frequency of staff refresher training in newborn care and resuscitation was assessed to determine facility readiness to deliver improved MNH services. Nationally, staff from only 24% of facilities had received training in newborn care and resuscitation in the past year, ranging from 0% in Mokhotlong to 39.5% in Maseru (Figure 3.7). Additionally, only 69% of the facilities have essential resuscitating equipment available and functional. This is evidenced by a lack of Ambu Bags, IV Fluids, and Nasogatric Tubes in health facilities across districts. Furthermore, only 50% of health facilities had essential medicines available - 32% had magnesium sulphate, while 49% had calcium gluconate (data not shown). Maseru district had the poorest availability, and only Qacha's Nek had the essential medicines available in all its facilities (data not shown).

Figure 3.7. Proportion of Facilities Whose Staff Received Refresher Training in Newborn Care and Resuscitation in the Past 1 Year, by District



It is noteworthy to mention that the assessment revealed that only 40% of health facilities nationwide conduct deliveries; and only13% of health facilities provide screening for cervical cancer (data not shown). Due to minimal number of facilities conducting deliveries, vaccination services such as BCG and polio vaccines given at birth before discharge from the health centers was also observed to be low, provided at only 43% of health facilities nationwide. However, this is expected to change given the Millennium Challenge Account Compact funding which has recently rehabilitated a large number of health centers as well as provided equipment to increase the number of facilities conducting deliveries. Mafeteng and Quthing districts had the highest proportion of health facilities offering BCG and Polio vaccines at birth before discharge (77.8%), while Maseru had the lowest proportion (26.3%, Figure 3.8).

Figure 3.8. Proportion of facilities giving BCG and Polio Vaccines at birth before Discharge from HC, by District



3.3 Child Health and Nutrition

This section summarizes findings on the provision of child health and nutrition services at health facilities. Facilities were assessed on the following 6 indicators 1) Daily availability of under-five services; 2) Facility staff trained in child survival and development skills; 3) Availability of oral rehydration supplies; 4) Availability of the key practice, protocols and guidelines for child health (IMCI, HTC EPI surveillance etc.); 5) Availability of Child Health booklets for growth monitoring; and 6) Availability of a system to track malnourished children that are receiving diet therapy. Overall results are presented in the Table 3.3 below:

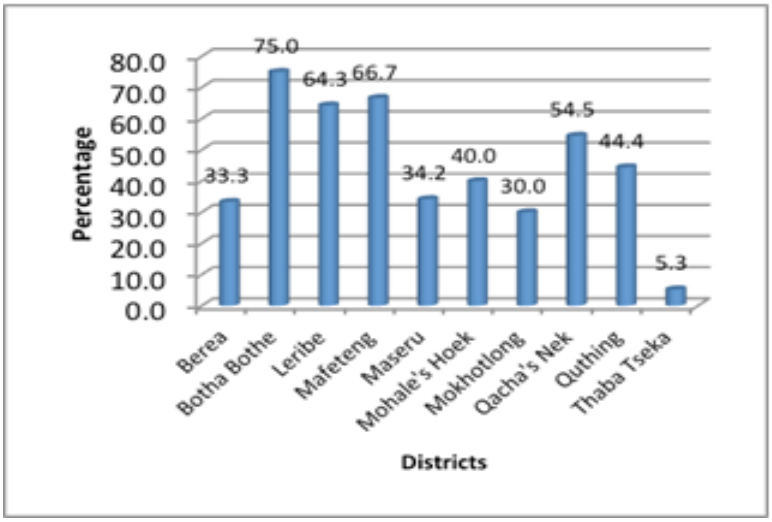
Table 3.3. Child Health and Nutrition Service Delivery Indicators

Indicator	Total
% of facilities with daily availability of under-five services	43%
% of facilities with staff trained in child survival and development skills	65%
% of facilities with availability of oral rehydration supplies	15%
% of facilities with availability of key practice, protocols and guidelines for child health	
% of facilities with availability of child health booklets for growth monitoring	
% of facilities with availability of a system to track malnourished children that are receiving diet therapy	

3.3.1 Systems and Processes to Support the Delivery of Child Health and Nutrition Services

The assessment examined services available for children under-five at the health facilities and how they were offered. It was observed that generally, under-five services are not commonly available daily in a number of health facilities. Results showed that across all districts, only 43% of health facilities provide under-5 services daily; ranging from just 5% of facilities in Thaba Tseka to 75% in Botha Bothe (Figure 3.9). Most facilities have systems in place to identify HIV/AIDS in children - 65% of health facilities have a system in place to trace children who are HIV exposed, while 67% have a triage system which identifies children who need urgent attention (data not shown).

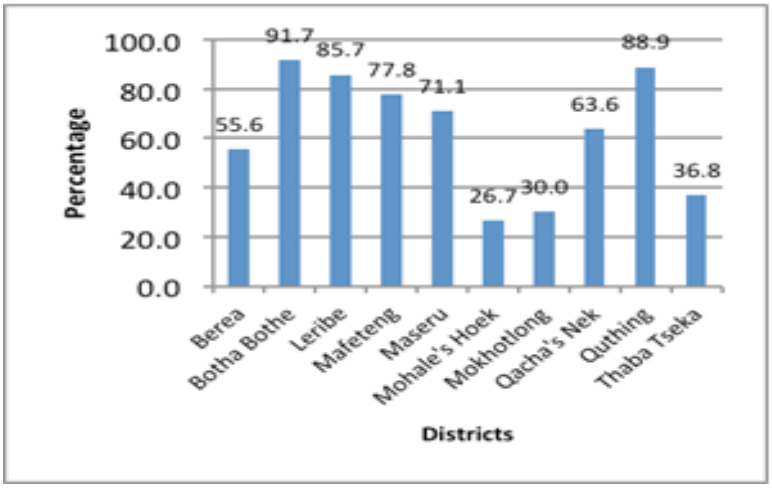
Figure 3.9. Proportion of Facilities with Daily Availability of Under-5 Services, by District



3.3.2 Resources and Infrastructure to Support Child Health and Nutrition Services

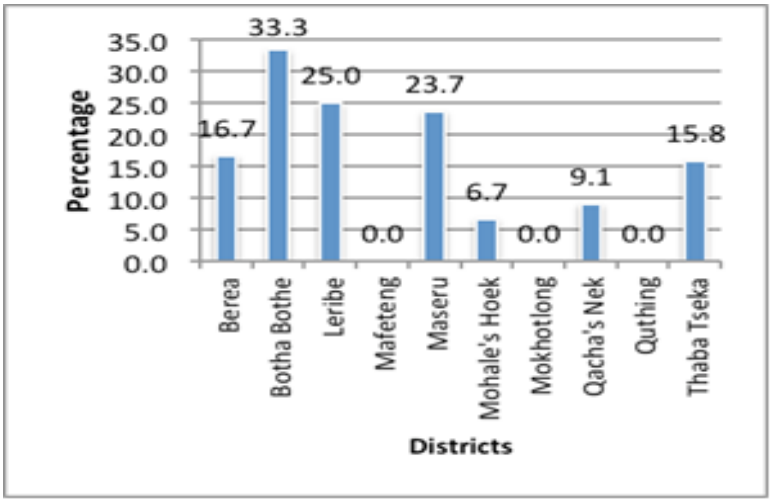
With regard to availability of trained human resources to deliver adequate child health services, results showed that on average, 65% of all health facilities had staff trained in Integrated Management of Childhood Illnesses (IMCI). As observed in Figure 3.10, Mohale's Hoek, Mokhotlong and Thaba Tseka districts recorded the lowest percentages of facilities with staff trained on IMCI at 26.7%, 30% and 36.8%, respectively.

Figure 3.10. Proportion of Health Facilities with Staff Trained in IMCI, by District



Poor availability of oral rehydration supplies was observed in health facilities nationwide. Across all districts, only 16% health facilities have a functional oral rehydration corner (data not shown) and only 15% have oral rehydration supplies available. As shown in Figure 3.11, none of the facilities in three districts (Mafeteng, Mokhotlong and Quthing) had oral rehydration supplies available. Botha Bothe district had the highest proportion of facilities with availability, still considered low at 33.3% (Figure 3.11).

Figure 3.11. Proportion of Health Facilities with Availability of Oral Rehydration Supplies, by District



3.4 Family Planning Services

This section summarizes findings from assessment of family planning services in health facilities. The following 5 indicators were used to assess facilities: 1) Staff trained in family planning; 2) Availability of a full range of contraceptive methods; 3) Extent of stock out of contraceptive methods at the facility level; 4) Availability of consulting and counseling rooms that have adequate privacy; and 5) Availability of guidelines for family planning information and counseling. Overall results are summarized in Table 3.4 below:

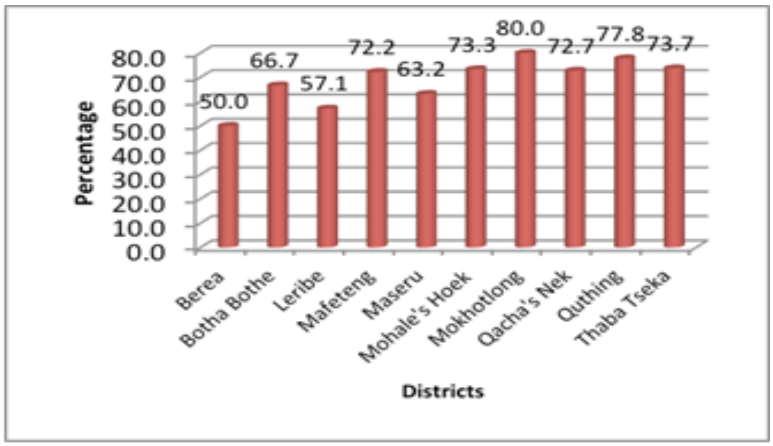
Table 3.4. Family planning service delivery indicators

Indicator	Total
% of facilities with availability of a full range of contraceptive methods	44%
% of facilities with staff who received refresher training in family planning methods	41%
% of facilities experiencing stock out of contraceptive methods	37%
% of facilities with availability of consulting and counseling rooms with adequate privacy	76%
% of facilities with availability of guidelines for family planning information and counseling	

3.4.1 Resources and Infrastructure to Support Family Planning Services

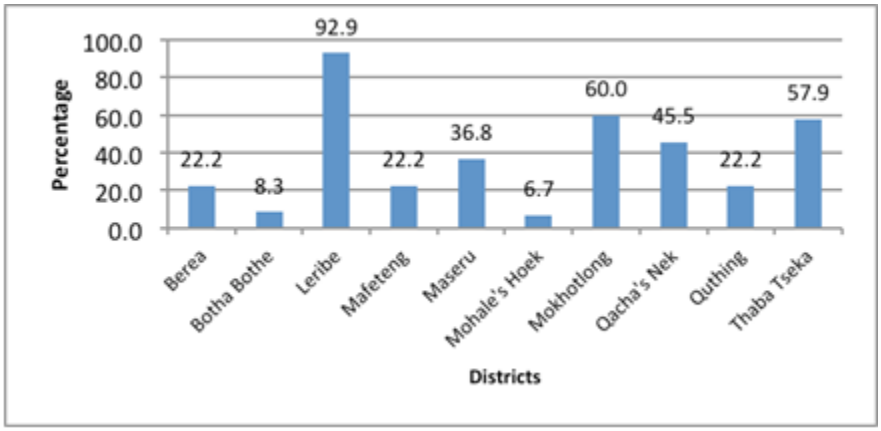
An assessment on family planning was undertaken to investigate what contraceptive methods are available in health facilities, and whether family planning services were delivered in an efficient manner by well skilled personnel with the right equipment. Overall, 44% of health facilities across the country offer a range of contraceptive methods as essential services. Condoms (male and female) were generally available across all districts, ranging from 50% availability in Berea to 80% in Mokhotlong (Figure 3.12). Across all health facilities irrespective of district, Intra-Uterine Device (25%), Progestrone Implants (19%) and Female and Male voluntary surgical contraception (11%) were the least offered methods of contraception (data not shown).

Figure 3.12. Proportion of Health Facilities Offering Condoms (Male and Female), by District



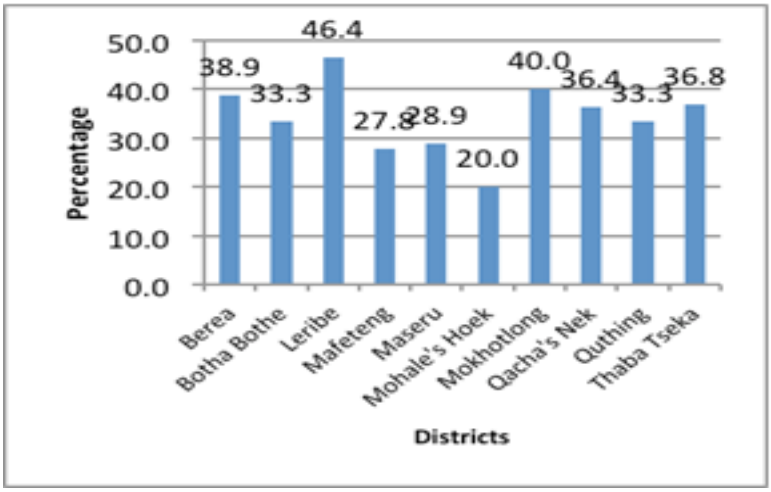
In order to provide high quality family planning services, appropriately trained human resource is required. Training of facility staff frequently and adequately is expected to provide more capacity to efficiently carry out essential family planning services. Overall, 41% of health facilities provided their staff with refresher training on family planning. There is a large variation between districts with regard to training of facility staff in family planning methods. For instance, in Leribe district, 93% of health facilities have staff had received refresher training on family planning, while in Mohale's Hoek, only 6.7% of health facilities have staff recently trained (Figure 3.13). There is therefore a need to provide training to staff across district facilities as this will augment service quality by not only providing improved counseling to patients, but also enable proper use of counseling equipment and efficient forecasting of supplies. The assessment also revealed that only 20% of health facilities across the country trained CBD agents in the past two years (data not shown).

Figure 3.13. Proportion of Health Facilities Whose Staff Received Any Refresher Training on Family Planning, by district



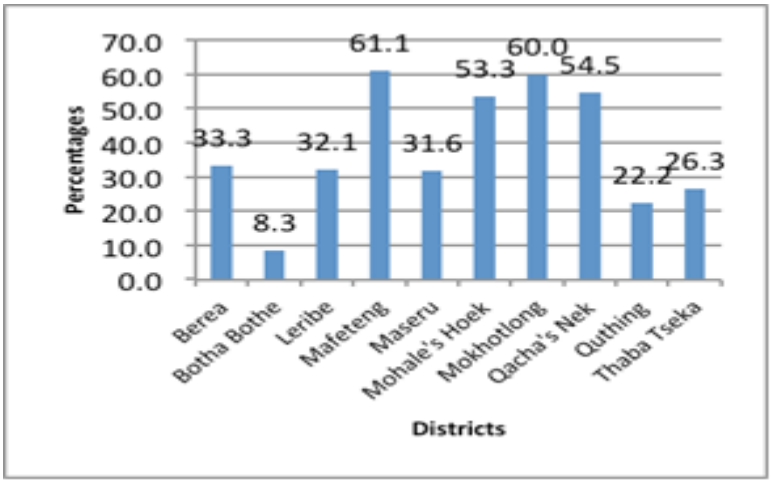
Equipment necessary to undertake counseling services was assessed for availability and functionality. Across health facilities nationwide, low percentages of available and working family planning equipment such as Ayre's spaculae, cervical brushes, slides fixative, IUCD insertion kit and counseling kits were observed. As shown in Figure 3.14, Mohale's Hoek had the lowest percentage (20%) of facilities with counseling kits available and working, while Leribe had the highest percentage with 46.4%, still considered low. PAP smear improvised register was available in only 18% of the health facilities (data not shown), while 83% of the health facilities had scales, sphygmomanometer, vaginal speculae, light source, gloves and all decontaminant requirements available and working for family planning (data not shown). Regarding availability of private consulting and counseling rooms, 76% of all health facilities had consulting rooms which provide adequate privacy.

Figure 3.14. Proportion of Health Facilities with Availability of Working Counseling Kits, by District



Across all districts, 37% of health facilities were experiencing contraceptive method stock-outs. Mafeteng and Mokhotlong districts were the worst affected, with 61% and 60% of their facilities, respectively, experiencing contraceptive stock-outs (Figure 3.15). The observed stock-outs could be attributed to lack of training of CBD staff with regard to proper forecasting of supplies. Regarding other aspects of supplies and drugs, over 60% of health facilities have child health booklets, offer injectibles, combined oral contraceptives, progesterone only pills, and male and female condoms (data not shown).

Figure 3.15. Proportion of Health Facilities Experiencing Contraceptive Method Stock-Outs, by District



3.4.2 Systems and Processes to Support the Delivery of Family Planning Services

It was observed that some processes, such as offering specific services and setting appointments, were rarely conducted. 26% of health facilities offer intra-uterine device, 19% offer progestrone implants and 11% offer female and male voluntary surgical services. Scheduling of appointments was only done by 41% of health facilities, while STI prevention services were widely provided (80% of facilities).

3.5 Oral Health Services

This section summarizes findings on the provision of oral health education and curative services. Facilities were assessed on several indicators, and those with most significant findings are discussed below:

- Availability of oral preventive and oral curative services
- Availability and display of oral health education materials at health facilities
- Health workers conduct screening for early detection of oral diseases at the facility

Table 3.5. Availability and Delivery of Oral Health Services

Indicator	Total
% of health facilities that deliver dental health services	30%
% of health facilities that offer preventative oral health services	57%
% of health facilities promote dental hygiene	25%
% of health facilities that offer curative oral services	29%

The table above represents national level data; however the trends across districts are similar. Some districts had significantly better performance as illustrated in the fig below- for example Botha-Bothe and ThabaTseka districts provided 60-70 percent of facilities did provide curative oral health services. The districts that performed lowest in the delivery of oral curative health services are Quthing, Leribe, Mokhotlong and Berea districts. Some of the reasons cited for this include a lack of dental health workers (dentist, dental assistants, oral hygienist, etc.). This affected the provision of key services, especially professional dental care like restorative treatment, scaling, filling and extractions across health facilities.

Figure 3.16 District Health Facilities that Provide Curative Oral Services

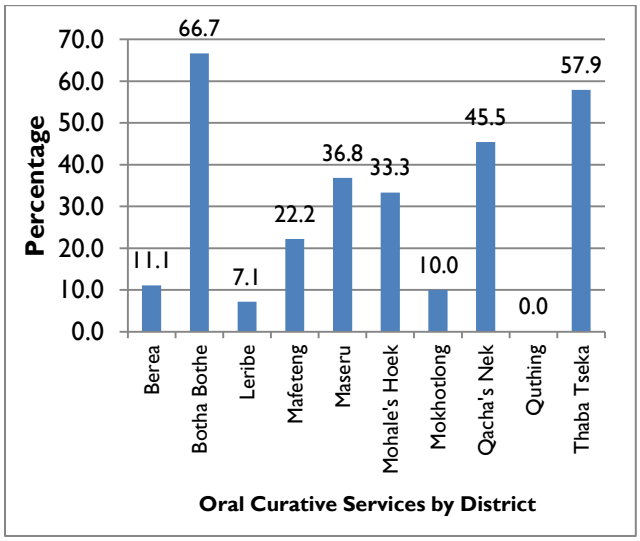
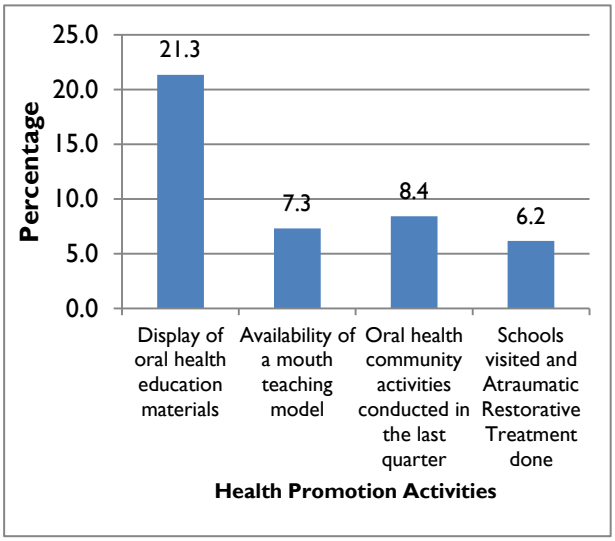


Figure 3.17 Health Promotion Activities by Health Facility (National)



Oral health promotion activities are conducted by a number of facilities although nationally though the figures are low. Display of oral health materials was commonly done in only 21% of facilities. Nationally, only 7.3% of health facilities had mouth teaching models, 8.4% had conducted oral health community activities in the past 3 months .See details on Fig 3.17.

The early detection of oral diseases is sub-optimal; nationally only 32% of health facilities conduct screening for early detection of oral diseases while 25% receive dental health referrals from CHWs. As with many of the other indicators, Botha Bothe districts had some of the highest performance- in number of facilities conducting screening for detection of oral diseases- while Qacha's Nek district performed the poorest. In terms of referrals received from CHWs, Thaba Tseka health facilities reported the highest at 47% while Leribe performed weakest at 7.1%. See details in figures below.

Figure 3.18. District Health Facilities Receiving Dental Health Referrals from CHWs

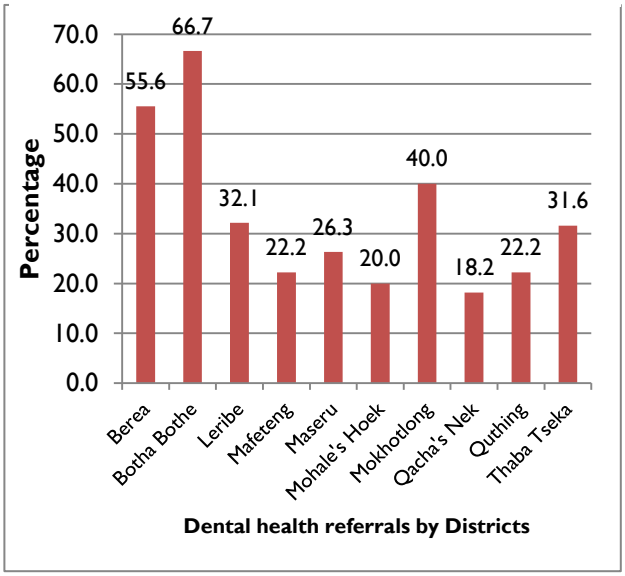
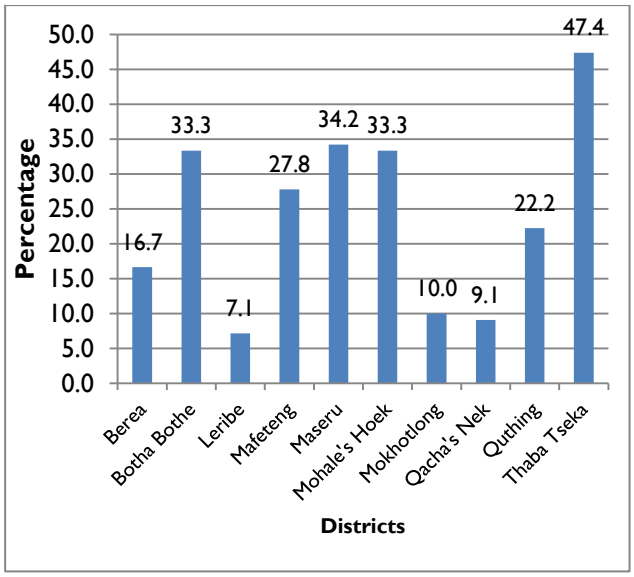


Figure 3.19. District Health Facilities with Health Personnel Conducting Screening for Early Detection of Oral Diseases



3.6 Environmental Health

This section summarizes the key findings and results of the assessment on environmental health and waste management. The primary indicators used are described below:

- Providers have received training on waste management in the past three months
- District health facilities with continuous power supply
- District health facilities experiencing interrupted safe water supply
- District health facilities with water tested monthly for portability
- Availability of a waste management plan at the facility
- Facility has a functional sluice room
- Availability of a patient waiting area that's adequately covered to provide shelter from rain/sun
- Availability of an emergency response team

3.6.1 Resources and Infrastructure to Support the Delivery of Environmental Health Services

A review of the data at the national level indicated that most of the health facilities have the key infrastructure for waste management and infection control. Proper sanitation is maintained at most of the facilities- toilets are available and are clean. Facility grounds are generally well maintained and patients have appropriate waiting areas with adequate ventilation and seating. However, there are no waste management processes or environmental inspections in many facilities even though most facilities are cleaned regularly. While there's constant power supply at the facilities; emergency readiness procedures are inadequate. Most health facilities that do not have regular power supply also lack functional generators. Many facilities lack rapid response systems in case of emergencies and many lack fire equipment .Very few have procedures in place for evacuation and drills.

In looking at the data more specifically by district, significant variations exist- Botha Bothe and Berea districts are high performing on many key indicators – especially waste management; while Mafteng districts performs poorest on safe water supply and training for waster care management. In particular data on water portability in some of districts were missing. See details in figs. below.

Figure. 3.20. Staff Trained on Health Care Waste Management

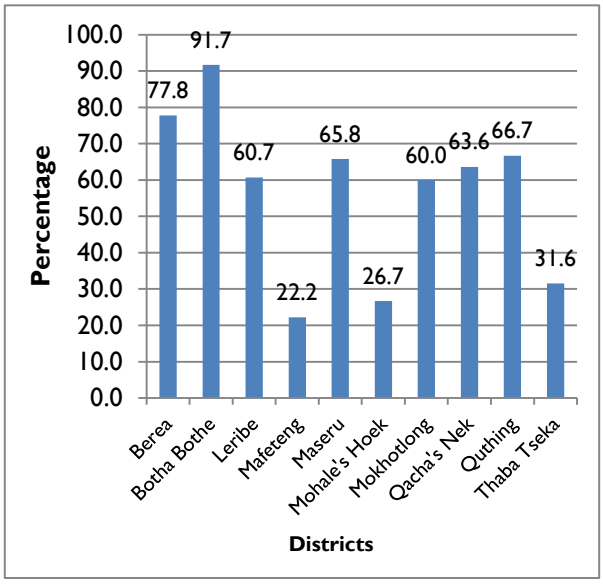


Figure 3.21. District Facilities with Continuous Power Supply

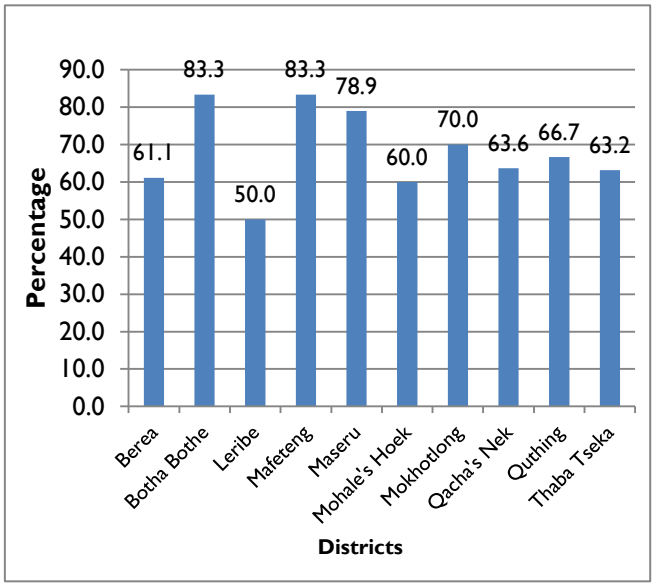


Figure 3.23. District Facilities with Water Tested Monthly for Portability

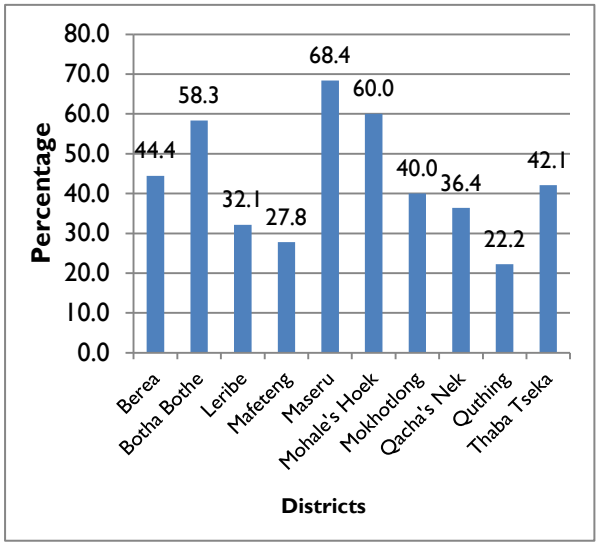
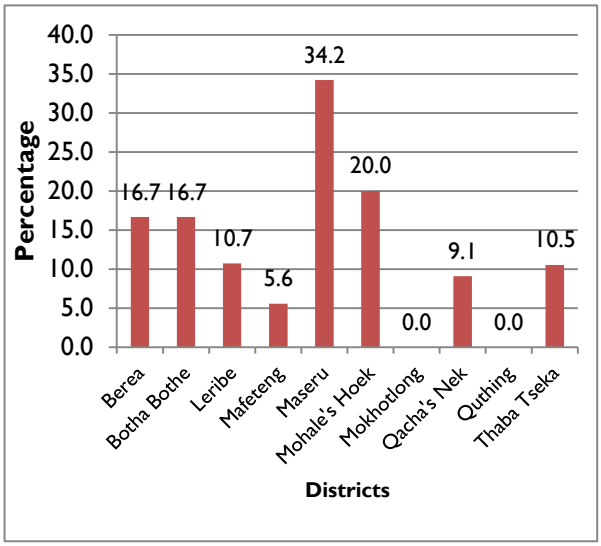


Figure 3.22. District Experiencing Uninterrupted Safe Water Supply



3.7 Infection Control

This section summarizes the procedures and processes performed at health facilities to ensure effective infection control- for the prevention of disease transmission and also protection of health workers as they perform different functions. The section was also described as "point of care testing"- which should be distinguished from POC testing as relates to specific HIV care and treatment. The indicators used include the following:

Selected Indicators

- Availability of an ongoing inventory of supplies along with documentation
- Quality Assurance Systems in place
- External Quality Assurance(EQA) performed as per documented procedures
- Infection control procedures in place including diagnostic testers vaccinated for Hepatitis B

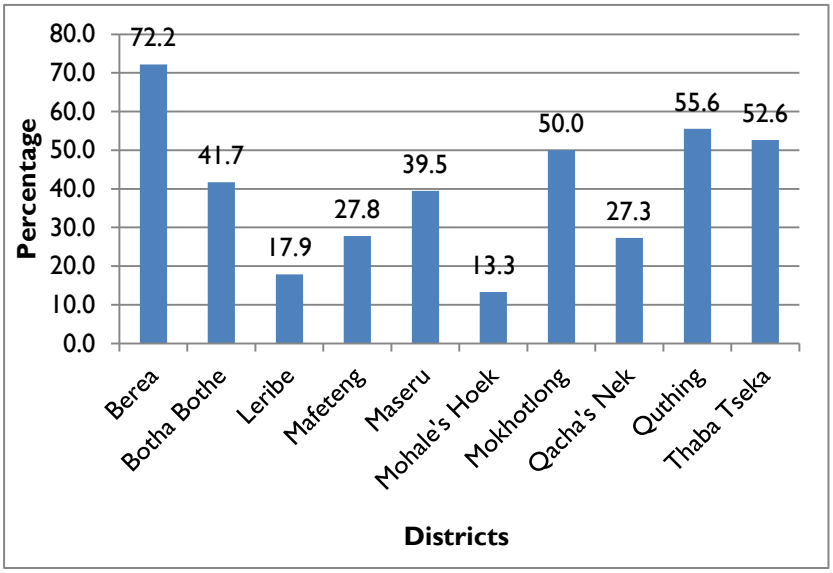
3.7.1 Resources and Infrastructure to Support the Management of Infectious Disease

In assessing the readiness for infection control, the goal was to explore in detail the efficiencies in point of care testing as relates to any infectious disease. The criteria include assessing availability of testers, storage facilities, turn-around time, quality control and EQA documentation.

At a national level – a large proportion of health facilities (78%) had appropriate handling (triple packaged) of specimens and transported them safely to the laboratories. Close to 75% of health facilities are informed upon interruption of lab services which demonstrates adequate adherence to guidelines. A large proportion of health facilities (78%) had also conducted training for testers and at least two thirds of health facilities meet the Stipulated Turnaround Time on delivering results. However, less than half (44%) of facilities have appropriate storage available for referred specimens.

At the district level, performance varies across districts on several indicators. Thaba Tseka performed highest (63%) on no. of facilities with appropriate storage for referred specimen, the lowest being Qacha's Nek at 27%. There are significant issues related to management of supply inventory and frequent drug and reagent stock-outs. Less than half of the sites maintained supply inventory; or competency tests available and 16% experienced reagent expiration.

Figure 3.24. District Facilities Maintaining Ongoing Inventory of Supplies along with Documentation

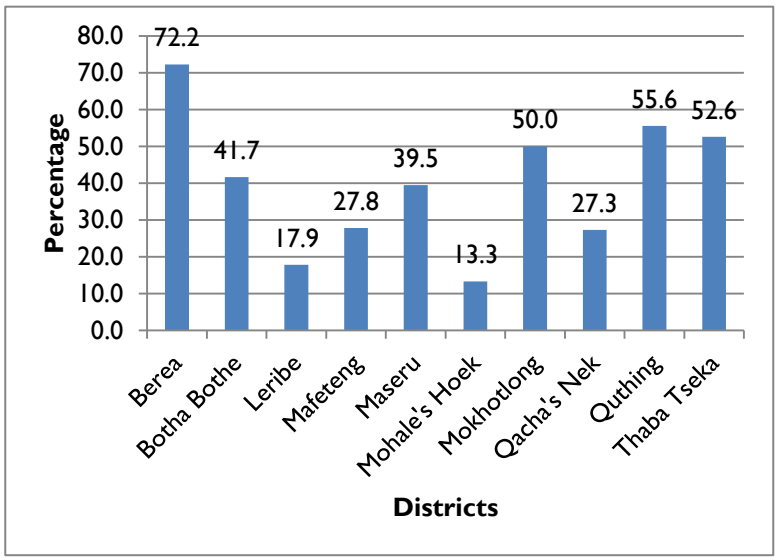


Large variations exist in maintenance and documentation of inventory of supplies - strongest performance by Berea and weakest in Mohale's Hoek and Leribe districts in (see Fig 3.24). The assessment did not look in detail at the availability of skilled workforce to ensure these activities are performed correctly. In follow up reviews- it's recommended that teams explore whether these areas in covered in supportive supervision visits, and whether key staff are assigned to these responsibilities.

3.7.2 Systems to Support the Management of Infectious Diseases

At a national level, competency assessments, review of quality controls and performance and documentation of External Quality Assessments (EQA) are rarely done by most of the health facilities. Effective supervision is not performed in many facilities- only 38% of health facilities reported to have their EQA reports reviewed by site supervisors and documentation done to enable corrective action where EQA failed. As noted in Fig 3.25 below- Berea is doing exceptionally well in terms of EQA reports reviewed to enable decisive action for change; while Mohale's Hoek (13.3%) and Leribe (17.9%) were the worst performing. Critical adherence to reporting and personnel available for task should be assessed across district health facilities for efficiency of reporting. With regard to quality assurance, more still needs to be done to improvement.

Figure.3.25 District Facilities with EQA Reports Reviewed by Site Supervisor and Documented for Corrective Action



3.8 Mental Health

This section summarizes the findings on the availability of mental health services at health facilities across the country. The facilities were assessed primarily on two key indicators- 1/District health facilities receiving training on mental health issues and 2/District health facilities that have daily services for new mental health patients.

3.8.1 Resources and Infrastructure to Support the Delivery of Mental Health Services

At the national level as a whole, mental health services are significantly deficient- one in five health facilities report lack of mental health training and even less have the resources to support mental health activities. Only 10% of facilities reported having operational plans for mental health and less than that for having medical control register. Most of the facilities that don't have services reported referring to higher level sites. At the district level, Mafeteng had the highest proportion of health facilities which had received some training on mental health, but all other facilities performed poorly. Availability of mental health services varied considerably by district; Mohale's Hoek, Thaba Tseka, Qacha's Nek performed fairly well- while the low performers were Berea, Leribe and Quthing doing very poorly. See details are illustrated in the figures below.

Figure. 3.26. District Health Facilities Receiving Training on Mental Health Issues

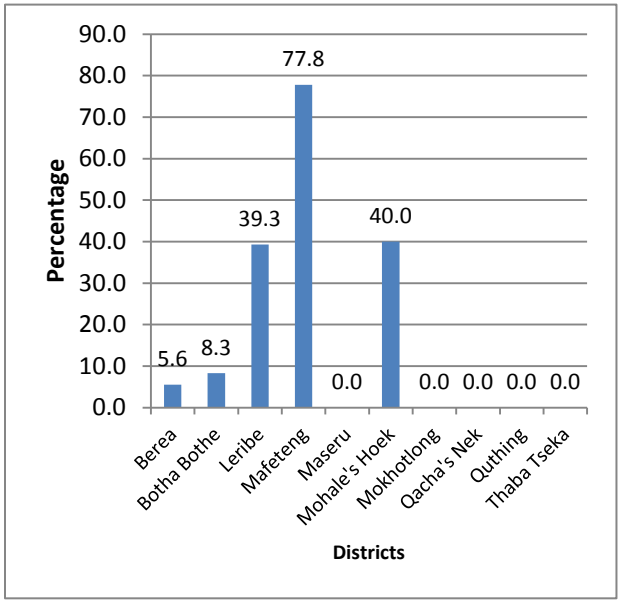
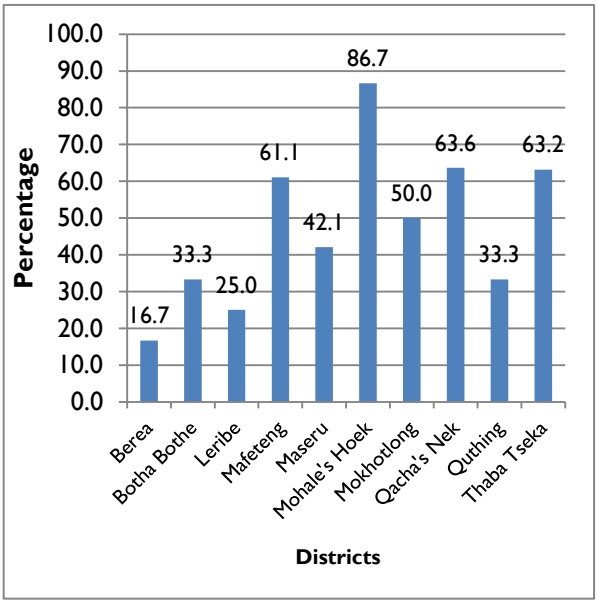


Figure 3.27. District Health Facility Services Available Daily for New Mental Health Patients



3.9 Management Systems for Quality Service Delivery

3.9.1 Health Promotion

This section summarizes the findings on health promotion and disease prevention activities through education and behavior change. This was assessed on three main indicators listed below:

- Health promotion activities conducted in the last 3 months
- Availability of demonstration vegetable garden- for nutrition education
- Evidence of health promotion activities at the facility
- Resources and infrastructure to support health promotion

At the national level, and in general- health promotion activities existed across all facilities to an extent. Some of the most common methods include health talks, campaigns and radio talks etc. However there were limited resources to support these activities- many health promotion materials are not available in the local languages and interactive methods such as use of vegetable gardens to promote health nutrition was limited. Nationally, less than one in 5 facilities had vegetable gardens. Facilities with vegetable gardens were skewed towards highland districts. Additional findings on health promotion are provided in Appendix VI.

Figure 3.28. District H/F which Conducted any Health Promotion Activities in the Last Quarter

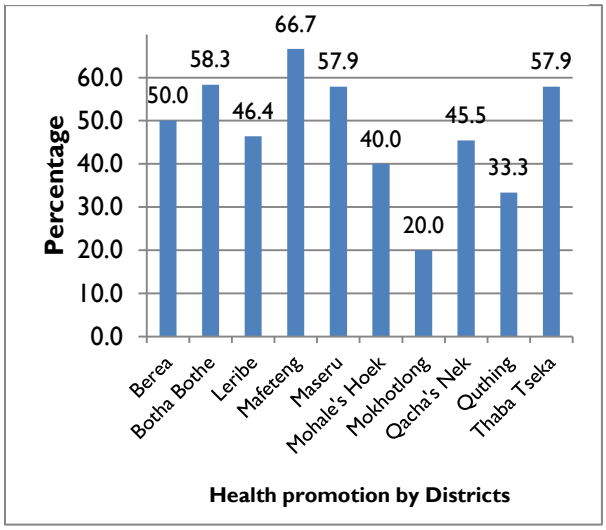
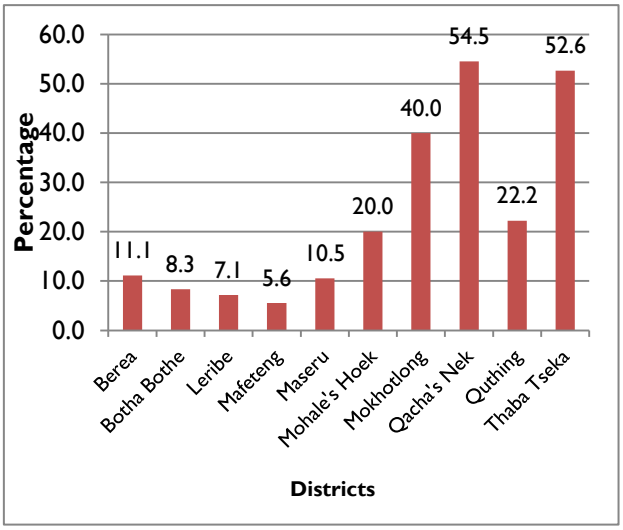


Figure 3.29. District Health Facilities Demonstrated to have Vegetable Garden at the Facility

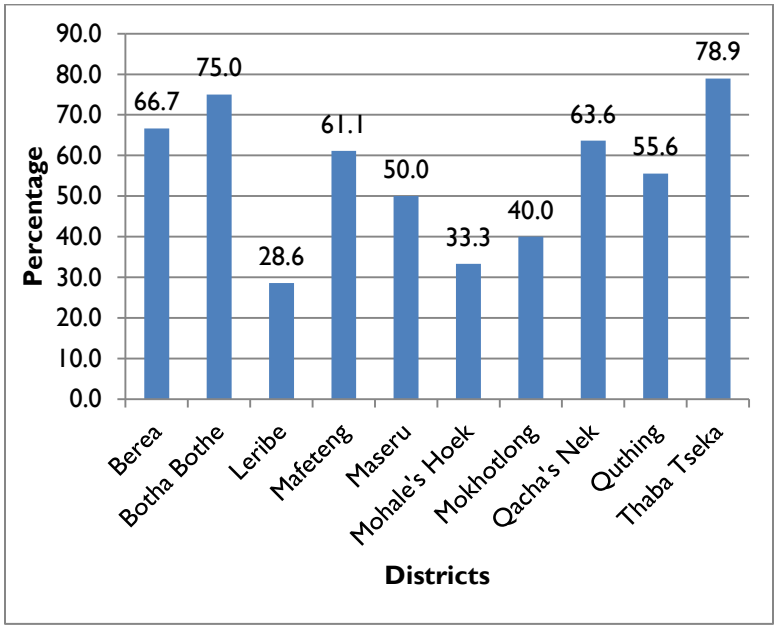


3.9.2 Human Resources

Findings with regards to the human resources which are currently in place to support the provision of health services are provided below. Facilities were assessed on the following human resource indicators: 1) Staff satisfaction with the supervision received; 2) Availability, sufficiency and relevancy of tools for staff; 3) Existence of job related guidelines for staff; and 4) Staff satisfaction with their job responsibilities.

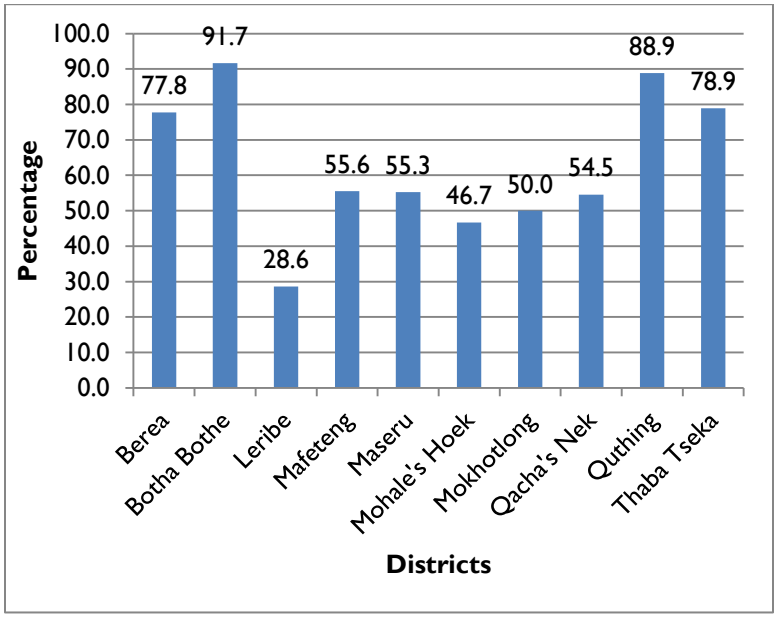
The quality of supervision in facilities was measured by assessing staff satisfaction with the supervision received. The staff's job satisfaction was also measured. Facilities in most districts experience problems with staff satisfaction with both the supervision received and their job responsibilities. Significant variation was observed across districts with regards to staff satisfaction. In Thaba Tseka (78.9%) and Botha Bothe (75%) districts, staff satisfaction with the supervision received is relatively high, compared with other districts. However, significant supervision issues were observed in Leribe (28.6%) and Mohale's Hoek (33.3%) districts, where staff satisfaction with supervision is the lowest, and well below the national average of 55%. Figure 3.30 provides an overview of staff satisfaction with supervision for all ten districts.

Figure 3.30. District Health Facilities with Staff Satisfied with Supervision they Received



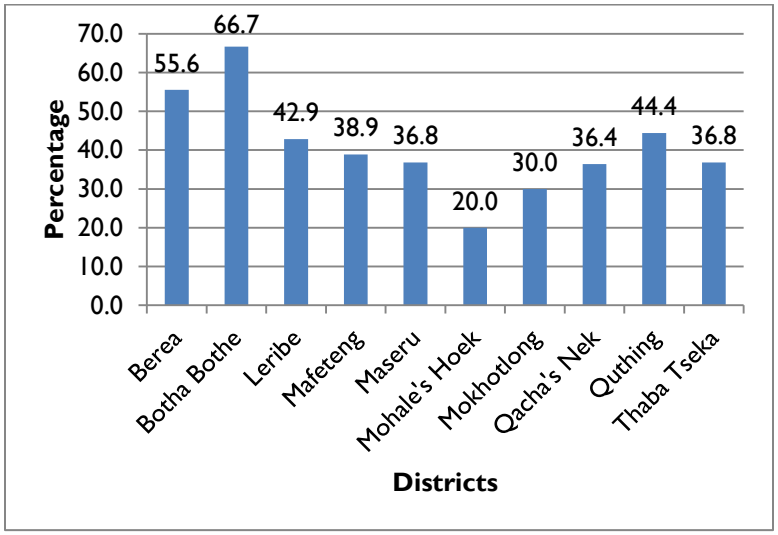
Job satisfaction also varies among the districts, but in that case the differences are more pronounced. Botha Bothe (91.7%), Quthing (88.9%), Thaba Tseka (78.9%), and Berea (77.8%) districts experience the highest levels of staff satisfaction with their job responsibilities, all being above the 75% level. However, Leribe district (28.6%) has very low staff satisfaction with their job responsibilities compared to all the other districts. In all the remaining districts, job satisfaction is close to 50%. An overview of staff satisfaction with their job responsibilities for all ten districts is provided in Figure 3.31.

Figure 3.31. District Health Facilities with Staff Satisfied with their Job Responsibilities



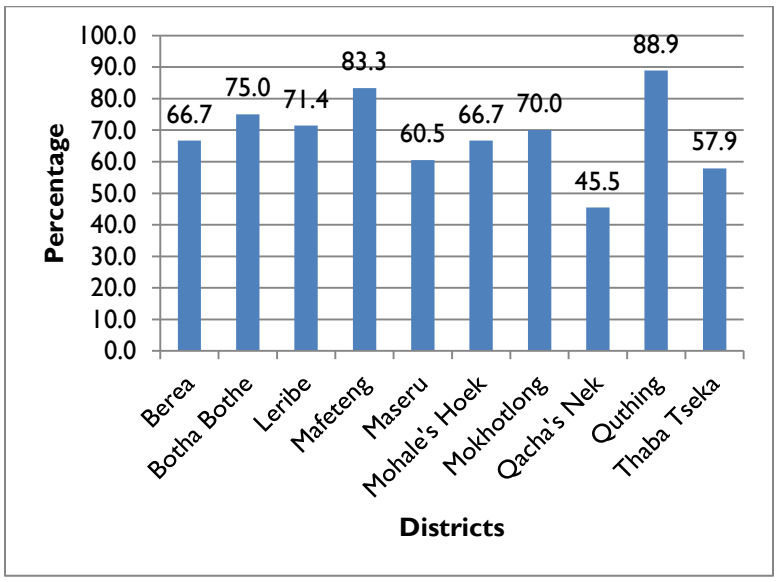
Another key aspect of human resources assessed was the availability of tools and guidelines which enable staff to perform their assigned job functions. The availability, sufficiency and relevancy of tools for staff are generally low across all districts. Botha Bothe (66.7%) is the only district where sufficient and relevant tools were reported to be available in over 60% of the facilities. The availability of such tools was extremely low in Mohale's Hoek district (20.0%). The results on the availability of tools across districts are presented in figure 3.32 below.

Figure 3.32. District Health Facilities Ascertaining Availability, Sufficiency and Relevancy of Tools for Staff



On the other hand, job related guidelines were available in more than 60% of facilities in all districts, with the exception of Qacha's Nek (45.5%) and Thaba Tseka (57.9%). Quthing district performs very well against this indicator, with job related guidelines available in 88.9% of its facilities. The results on the availability of job related guidelines across districts are presented in figure 3.33 below.

Figure 3.33. District Health Facilities with Staff with Job Related Guidelines

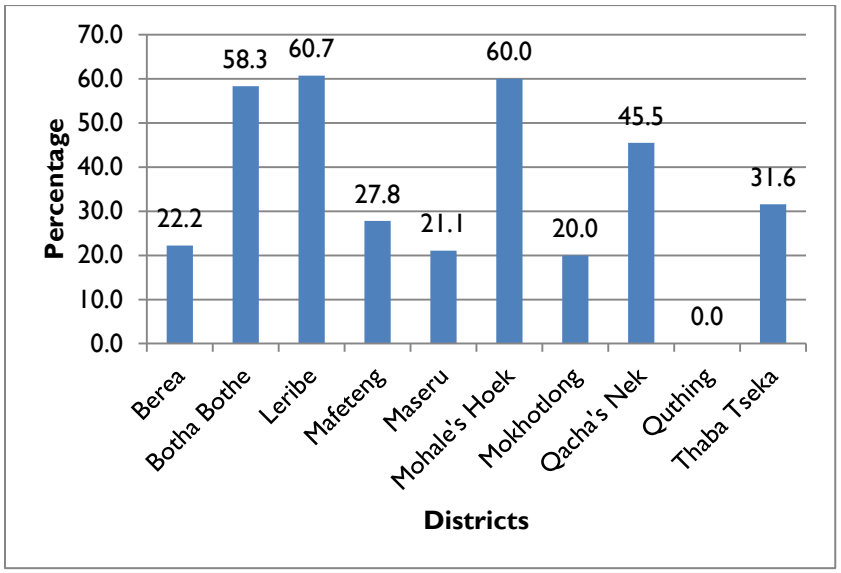


3.9.3 Community Health Workers

Findings with regards to the community health workers currently in place to support the provision of health services are provided below. Facilities were assessed on the following indicators related to community health workers: 1) Availability of copies of the job descriptions outlining roles and responsibilities of CHWs and VHWs; 2) Availability of data reporting tool for CHWs; 3) Timely receipt of incentives by CHWs; and 4) Availability of mechanisms/ systems to measure client satisfaction at the facility level.

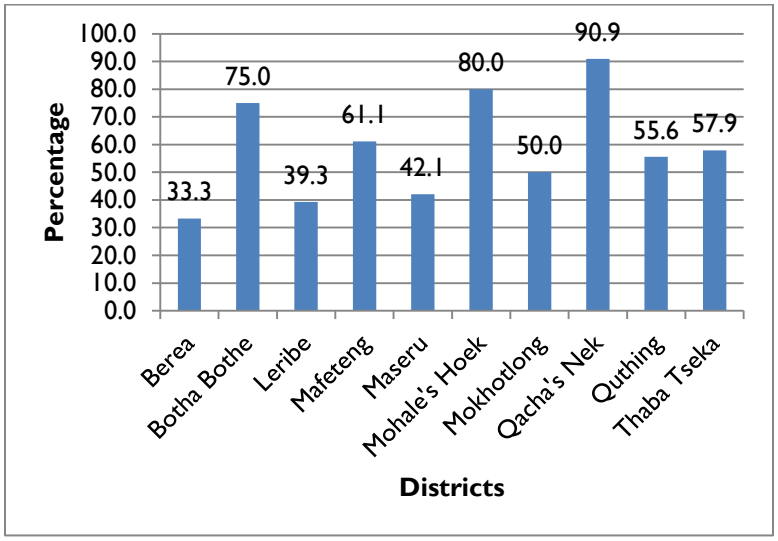
The availability of job descriptions outlining the roles and responsibilities of CHWs and VHWs was used as a measure of the clarity of the job responsibilities of those workers. Only in two districts (Leribe and Mohale's Hoek), over 60% of facilities have such job descriptions in place. In the remaining districts, the availability of job descriptions for CHWs and VHWs is low or very low, and in the case of Quthing district, such job descriptions do not exist at all. These results are presented in figure 3.34 below.

Figure 3.34. District Health Facilities with a Copy of Job Description Roles and Responsibilities of CHWs and VHWs



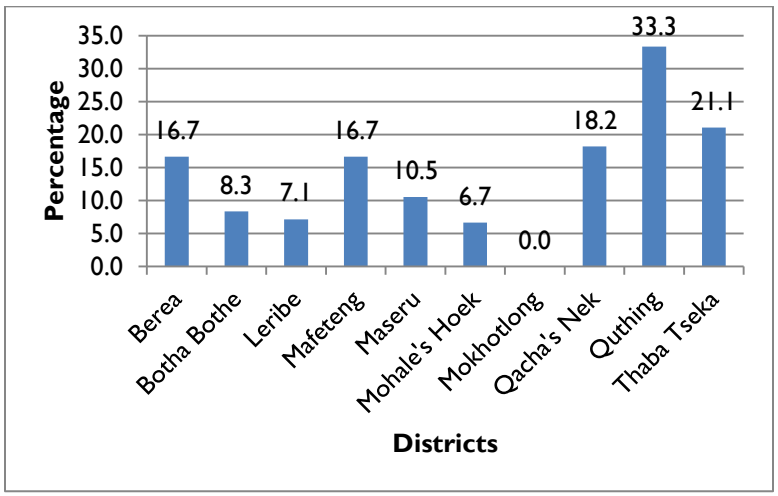
Another important indicator assessed with regards to CHWs was the availability of data reporting tools for CHWs. The availability of such tools varies across districts. In Botha Bothe (75.0%), Mohale's Hoek (80.0%) and Qacha's Nek (90.9%) districts, data reporting tools for CHWs are available in over 75% of the facilities. However, these tools are mostly unavailable in Berea (33.3%) and Leribe (39.3%) districts. The results on the availability of data reporting tools for CHWs across districts are presented in figure 3.35 below.

Figure 3.35. District Health Facilities with a Data Reporting Tool for CHWs



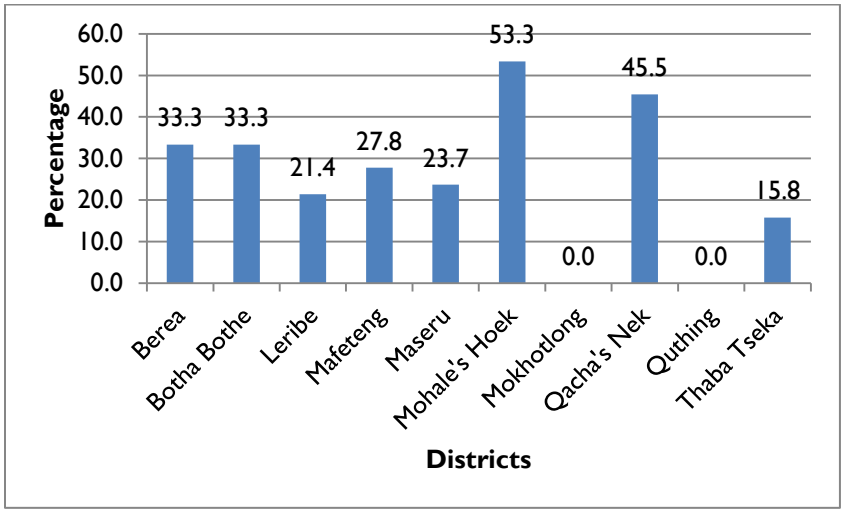
Timely receipt of financial incentives is an important motivational factor, which impacts the performance of community health workers. Generally, the assessment found that untimely receipt of financial incentives by CHWs is a problem across all districts. In Quthing district, which performs the highest on this indicator, only 33% of facilities reported that CHWs receive their incentives in a timely manner. For other districts, the percentage was even lower, and in one case (in Mokhotlong district) none of the facilities reported timely receipt of incentives by CHWs. These results are presented by district in figure 3.36 below.

Figure 3.16. District Health Facilities Ascertaining that CHWs Receive their Incentives in a Timely Manner



Client satisfaction is an important indicator of the performance and motivation of community health workers. The assessment found that most health facilities do not have systems or mechanisms in place to assess client satisfaction. Mohale's Hoek is the only district where more than 50% of facilities have such a system in place. In two districts, Mokhotlong and Quthing, none of the facilities have such systems or mechanisms in place. The results by district are presented in Figure 3.37 below.

Figure 3.37. District Health Facilities with a System or Mechanism to Assess Client Satisfaction



Additional findings on community health workers are provided in Appendix VI.

3.9.4 Finance and Accounting

This section summarizes findings on the finance and accounting functions which support the provision of services at health facilities. Facilities were assessed on the following finance and accounting indicators: 1) Availability of plan and budget for the current FY at the facility; and 2) Existence of the cash flow forecast and procurement plan at the facility. Overall results are presented in Table 3.6 below:

Table 3.6. Finance and Accounting Indicators

Indicator	Total
% of facilities with available plan and budget for the current FY	20%
% of facilities with existing cash flow forecast and procurement plan	22%

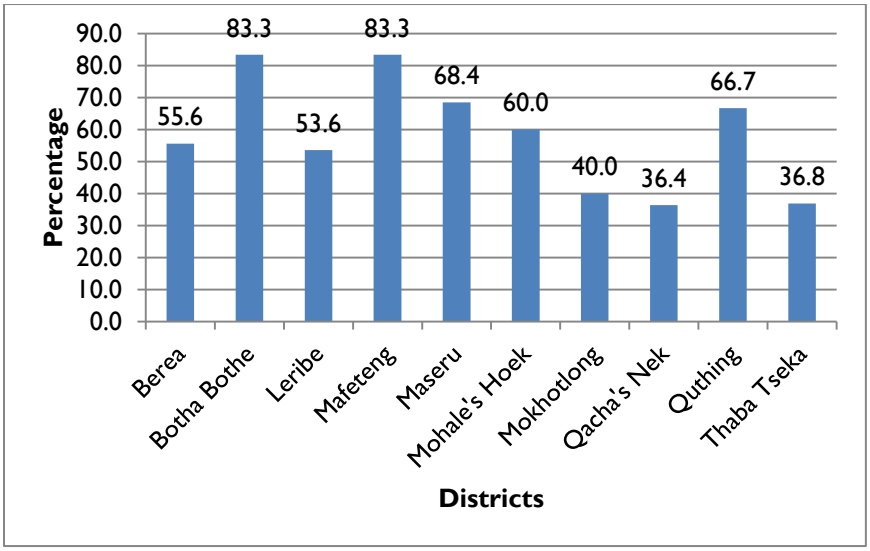
Performance against the finance and accounting indicators assessed is weak in nearly all health facilities in all the districts. Only 28% of facilities have budget plans, and only 22% have approved budgets. Cash and procurement plans are also generally unavailable at facilities—only 22% of the facilities had copies of such plans. Weak financial management capacity was further emphasized by the finding that only 24% of facilities were able to track revenue and spending over the past few months. Meetings about finances were rare and happened in only 12% of the facilities.

3.9.5 Administration and Planning

This section summarizes findings on administration and planning functions which support the provision of services at health facilities. Facilities were assessed on the following administration and planning indicators: 1) Well maintained infrastructure; 2) Availability of a vehicle; and 3) Availability of security services.

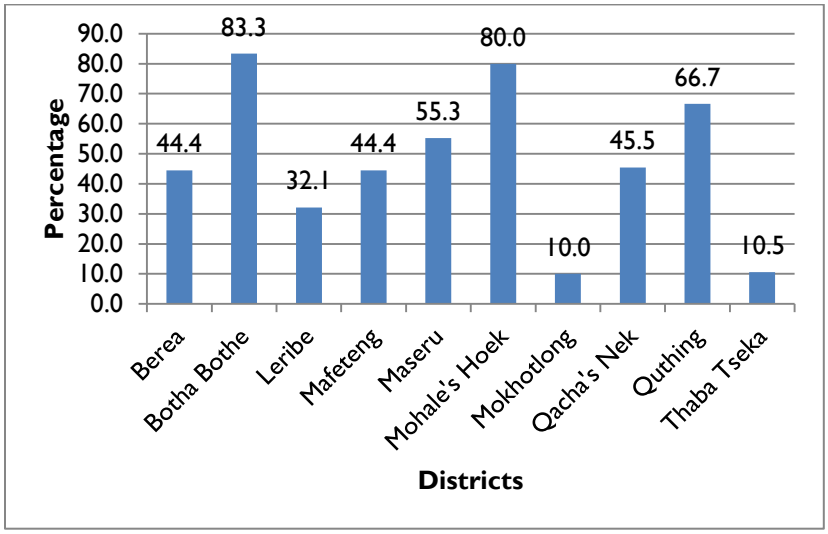
Good infrastructure plays a critical role in facilities' ability to provide health services. The assessment found that infrastructure maintenance in facilities varied by district. While in Botha Bothe and Mafeteng districts, 83.8% of facilities have well-maintained infrastructure, in other districts less than 70% do. Qacha's Nek and Thaba Tseka districts perform particularly poorly, as less than 40% of facilities in these districts have well-maintained infrastructure. These results by district are presented in figure 3.38 below.

Figure 3.38. District Health Facilities with Infrastructure Well Maintained



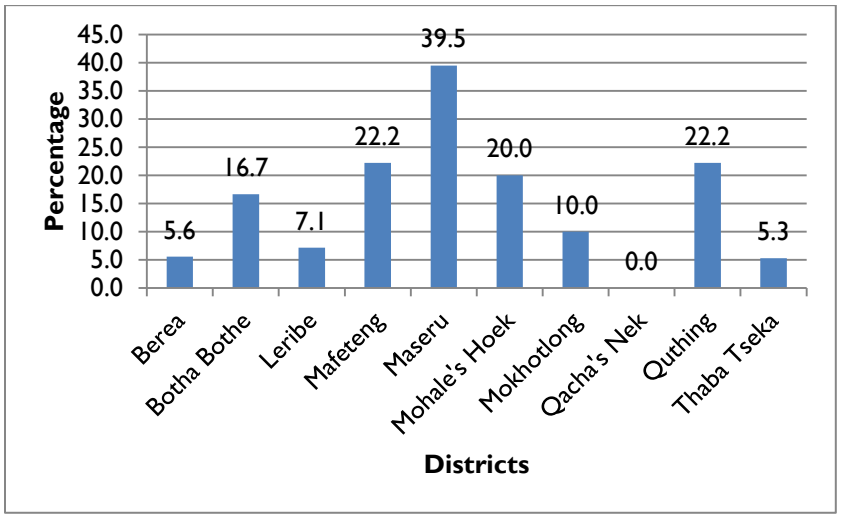
The presence of security services is essential to ensuring patient and provider safety in a health facility, and enabling effective provision of services. The assessment evaluated whether health facilities are fully equipped with security services. Variation by district was noted in the results. In only two districts (Botha Bothe and Mohale's Hoek), 80% or more of health facilities have fully equipped security services. In most other districts, less than 50% of facilities have such services, and in the cases of Mokhotlong and Thaba Tseka districts, only about 10% of facilities do. The performance of each district against this indicator is presented in figure 3.39 below.

Figure 3.39. District Health Facilities Fully Equipped with Security Services



Furthermore, the availability of a vehicle at health facilities was also assessed. All districts perform poorly against this indicator. In Maseru, the highest performing district in this case, only 39.5% of facilities have a vehicle. In half of the districts, 10% or less of the facilities have vehicles, and in the case of Qacha's Nek, none of the facilities had them. Results by district are presented in figure 3.40 below.

Figure 3.40. District Health Facilities with a Vehicle



Severe issues with asset/inventory and security management, laundry and furniture management, etc. were also identified by the assessment.

3.10 Immunization and Surveillance

This section summarizes findings on the immunization and surveillance support systems at health facilities. Facilities were assessed on the following immunization and surveillance indicators: 1) Comprehensive outreach services; 2) Daily availability of immunization services; 3) Recording of vaccine wastage; and 4) Staff training on EPI Surveillance in the past year. Overall results are presented in Table 3.7 below:

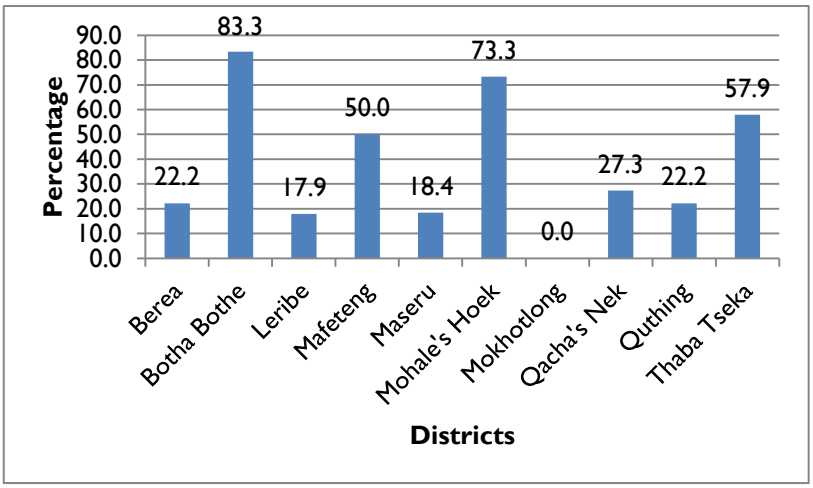
Table 3.7. Immunization and Surveillance Indicators

Indicator	Total
% of facilities conducting comprehensive outreach services	34%
% of facilities providing immunization services daily	43%
% of facilities recording vaccine wastage	60%
% of facilities where staff received EPI Surveillance training in past year	67%

Health facilities are responsible for providing immunization services to population in their catchment areas. Due to lack of proper infrastructure in a number of facilities, a lot of challenges are faced in terms of accessibility and availability of resources. The assessment investigated the availability of key immunization resources which include personnel, infrastructure, supply chain, supervision as well as reporting.

Less than a third (60%) of health facilities have catchment area maps available; however, slightly above a third (34%) conduct comprehensive outreach services. The verification done through an outreach plan indicated that Mokhotlong health facilities do not conduct comprehensive outreach services. Botha Bothe (83%) and Mohale's Hoek (73.3%) districts performed the highest in terms of the number of health facilities conducting comprehensive outreach services. It is observed across the facilities that, some of the barriers facilities face in conducting comprehensive outreach services includes limited staff to undertake the outreach services and lack of transport services (vehicles, motorbike, etc.) to undertake the activity. Results on the percentage of facilities conducting comprehensive outreach services in each district are presented in figure 3.41.

Figure 3.41. District Health Facilities Conducting Comprehensive Outreach Services



Less than half (43%) of the health facilities in the country provide immunization services daily. Berea district facilities perform the worst at 16.7%, followed by Thaba Tseka at 21.1%. Most facilities (91.7%) in Buoha Buthe district provide immunization services, making it the highest performing district in terms of this indicator. The observation for Botha Bothe supports the observed high percentage of its facilities conducting comprehensive outreach activities, and therefore indicating good performance. The low figures obtained in some districts can be attributed to the lack of staff, in which cases only under-5 immunizations were done. Data on the percentages of district health facilities providing immunization services is presented in figure 3.42.

Figure 3.42. District Health Facilities Providing Immunization Services

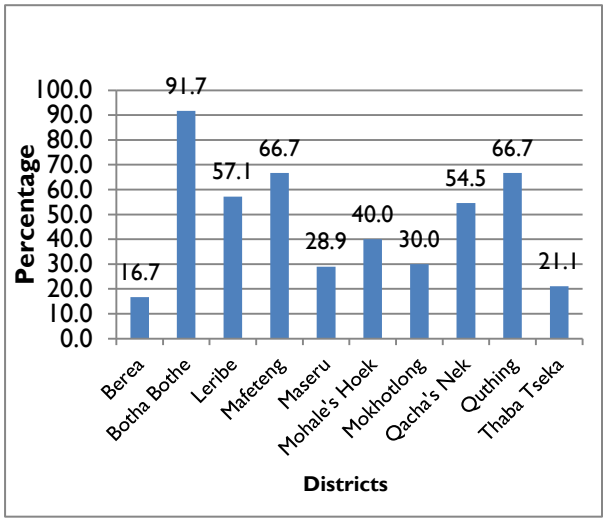


Figure 3.43. District Health Facilities Recording Vaccine Wastage

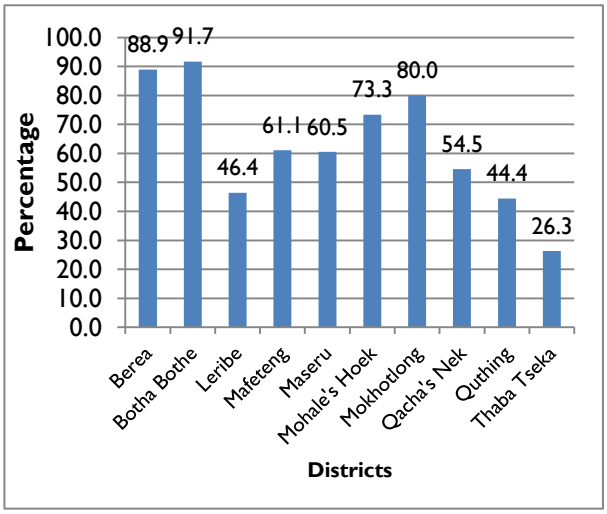
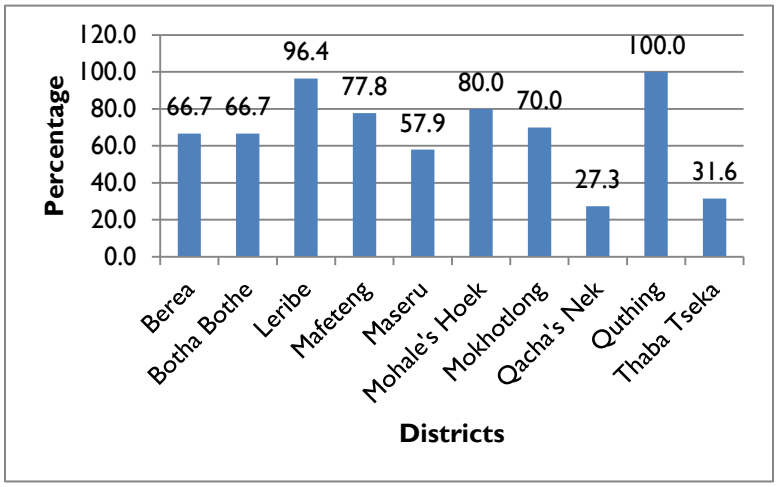


Figure 3.43 presents data of the percentages of district health facilities recording vaccine wastage. Vaccination monitoring charts are displayed in 46% of the health facilities nationally. In addition, around 64% of the health facilities have contingency plans in case of power failure. Vaccine wastage is recorded in only 60% of the health facilities. The highest percentage of health facilities with vaccine wastage recording was observed in Botha Bothe (91.7%) and Berea (99.9%), while the lowest was observed in Thaba Tseka (26.3%).

At the national level, 67% of facilities reported that their staff received any form of training on EPI surveillance in the last year. The majority of the districts had more than half of their facilities with staff trained on EPI surveillance. In the case of Quthing district, all the facilities reported that their staff received the training. Qacha's Nek and Thaba Tseka perform poorly on this indicator compared to the other districts, with only 27.3% and 31.6% of facilities reporting that staff received training on EPI surveillance. An overview of the results by district is presented in figure 3.44.

Figure 3.44. District Health Facility With Staff Who Received Any Form of Training on EPI surveillance in the last year



Issues of supervision and infrastructure; including adequacy of supply of auto distract syringes, vaccine stock outs, vaccine refrigerator and freezers and refrigerator thermometers; could account for the low percentages observed under immunization and surveillance.

3.11 Protocols and Guidelines

This section summarizes findings on the protocol and guideline support systems at health facilities. Facilities were assessed on the following protocol and guideline indicator: 1) Availability of standard treatment guidelines, including those for TB/ HIV/ PMTCT, etc.

There is a severe absence of protocols across nearly all service areas. This includes guidelines, standards, and policies. Outliers of good performance include HIV/AIDS related issues (ART, PMTCT, STI, FP). However, facilities are performing well in terms of stocking care and treatment cards.

There is consistency cross all districts, whereby most guidelines and protocols are missing. There is more variation among STGs, essential medicines lists, TB/HIV guidelines, HTC guidelines, infant feeding guidelines, IMCI guidelines, and Bukana card availability. Berea, Botha Bothe, and Mokhotlong districts perform well on most of these indicators, while the remainder of the districts fall in line with national averages.

An analysis of availability of protocols, guidelines and SOPs across various health facilities in the country was conducted. Significant variation between protocols, guidelines and SOPs available in facilities was observed. For instance, standard treatment guidelines, essential medicines list, TB national guidelines, HTC guidelines, IMCI guidelines and infant and young child feeding guidelines are available in more than 50% of health facilities countrywide.

Availability of the rest of the guidelines was low, with the health sector strategic plan being the least available at only 11% health facilities nationwide.

Botha Bothe district was observed to have the highest percentage (91.7%) of facilities with standard treatment guidelines available, followed by Berea (83.3%). Qacha's Nek does not perform well, with the percentage of facilities with STG at 45.5%. Further emphasizing Botha Bothe and Berea districts' good

performance in the availability of guidelines is the availability of TB/HIV national guidelines at 91.7% and 94.4% of health facilities in the districts respectively.

Results on the availability of TB/HIV national guidelines and STGs are presented in figures 3.45 and 3.46, respectively.

Figure 3.45. District Health Facilities with TB/HIV National Guidelines Available

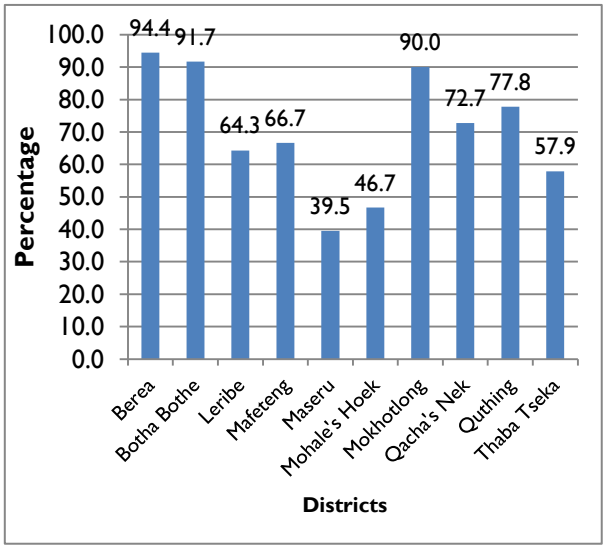
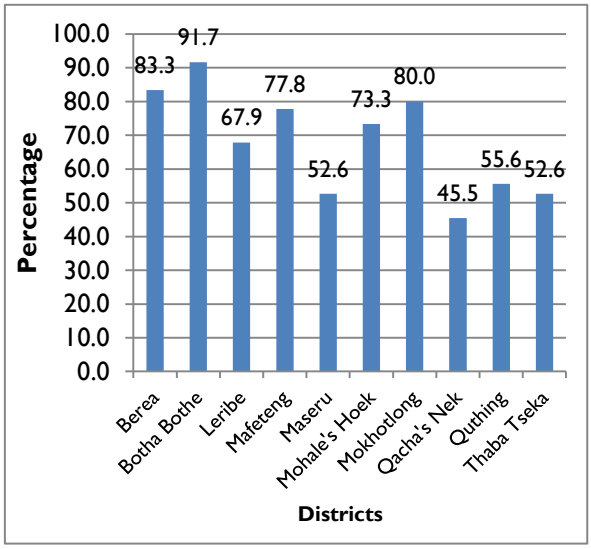


Figure 3.46. District Health Facilities with Standard Treatment Guidelines Available



3.12 Records Management and Information

This section summarizes findings on the records management and information support systems at health facilities. Facilities were assessed on the following records management and information indicators: 1) Availability of an organized record keeping / filing system; 2) Availability of defined patient referral system; 3) Complete and correct up to date maintenance of the health registers; and 4) Facility uses data to learn and improve the provision of healthcare services. Overall results are presented in Table 3.8 below:

Table 3.8. Records Management and Information Indicators

Indicator	Total
% of facilities with an organized record keeping/filing system	63%
% of facilities with defined patient referral system	31%
% of facilities with correct and up to date maintenance of the health registers	53%
% of facilities using data to learn and improve the provision of healthcare services	46%

Many facilities do not have a trained or established person to manage data. Only half actually have a record keeping system and cards are rarely available. Many facilities have key report forms and registers available. Severe problem with analyzing and utilizing data for decision-making are observed. Patient

referral system basically does not exist in facilities, indicating poor care coordination. While reports are completed and submitted on time, registers are monitored and updated only occasionally.

Compilation of data for use by health facilities to improve provision of health care was assessed. Generally, 56% of health facilities had data clerks available for compiling into the data tools. Interpretation of data collections tool is considered key in collecting reliable data and therefore enables accurate reporting for use. Around 52% of health facilities trained their data clerks on use of tools. The figures are significantly low nationally; hence, there is a need to strengthen recruitment of data clerks where unavailable, to provide routine and ad hoc supervision to ensure reliable and timely reporting therefore improvement on Health Management Information System (HMIS).

Roughly 63% of health facilities across the country have an organized record keeping or filling system. Quthing district has the highest percentage (88.9%) of facilities with organized record keeping or filling systems, while Mokhotlong has the lowest (40.0%). A defined patient referral system is available for few health facilities in the country. Generally, 31% of the facilities have the defined referral system with Botha Bothe, Mafeteng, Mokhotlong, and Quthing districts leading with percentages slightly above 40%. Results on the availability of record keeping or filing systems and on defined patient referral systems by district are presented in figures 3.47 and 3.48, respectively.

Figure 3.47. District Health Facilities with an Organized Record Keeping or Filing System

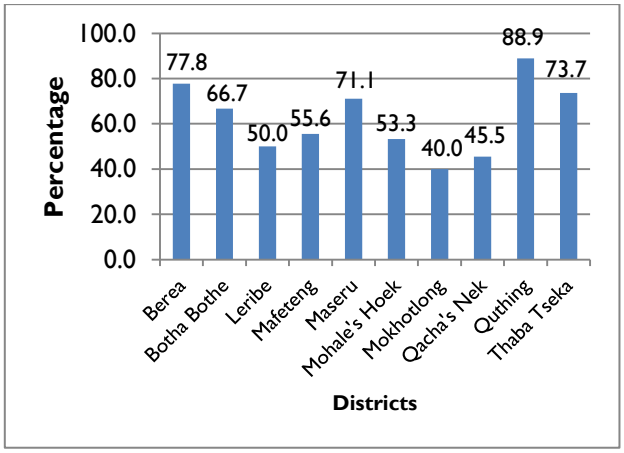
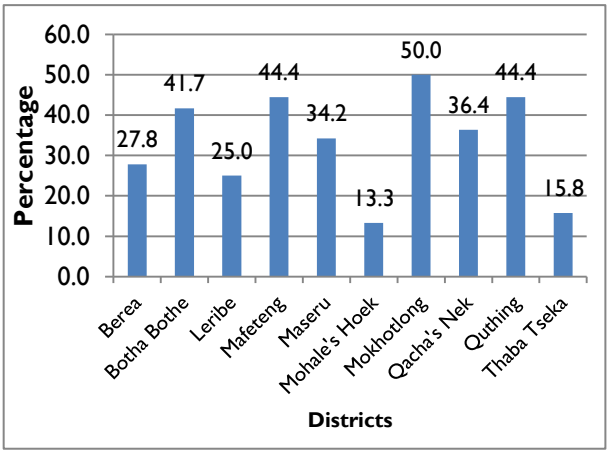
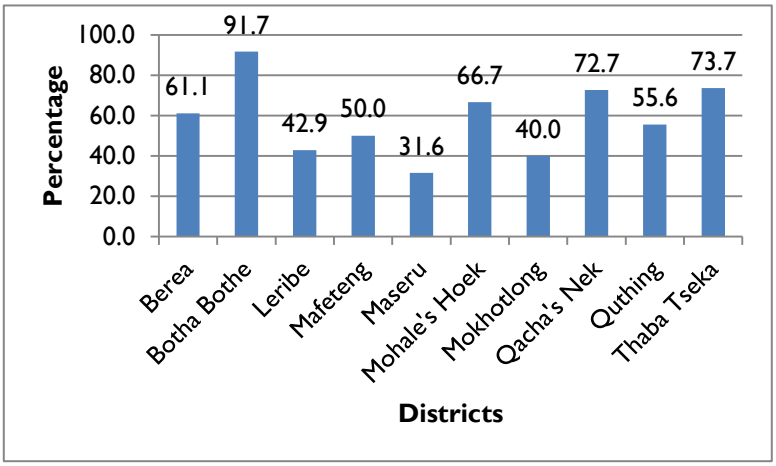


Figure 3.48. District Facilities with a Defined Patient Referral System



Overall, 53% of health facilities in the country have their registers correctly complete and up to date. Botha Bothe district has the highest percentage (91%) of facilities with complete and up to date registers, while Maseru has the lowest (31.6%). Results by district are presented in figure 3.49.

Figure 3.49. District Health Facilities with All Registers Correctly Completed and Kept up-to-date



Data interpretation is not adequately carried out in district health facilities. An average of 38% of facilities countrywide regularly analyses data and 46% use analysed data to learn and improve on the provision of all health care services. Data analysis occurs regularly in 60% or more of the facilities in only two districts: Berea and Maseru. Mohale's Hoek and Mokhotlong districts have the poorest performance with regards to regular data analysis, as illustrated in figure 3.50. Furthermore, figure 3.51 shows that in each district, less than 60% of facilities use data to learn and improve service provision, with the percentage being lowest in Mohale's Hoek, Leribe, and Mafeteng districts.

Figure 3.50. District Health Facilities Regularly Analyzing Data

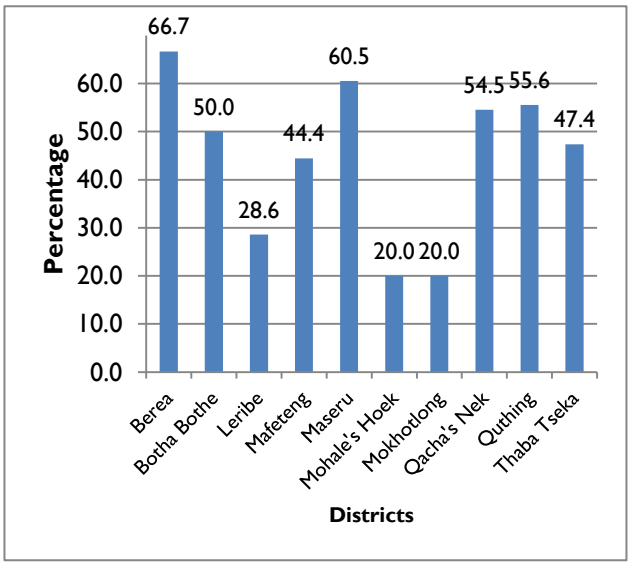
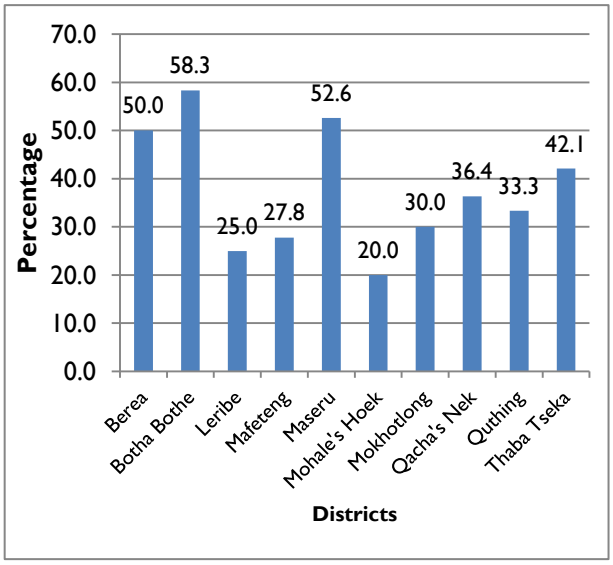


Figure 3.51. District Health Facilities Using Data to Learn and Improve on the Provision of all Health Care Services



These observations indicate that more needs to be done to strengthen reporting by the facilities. There is a need to recruit personnel with skill to compile and interpret the data for use on a daily basis to inform facility decisions regarding improvement of services. This can be achieved if robust supervision is also in place to ensure efficiency and effectiveness.

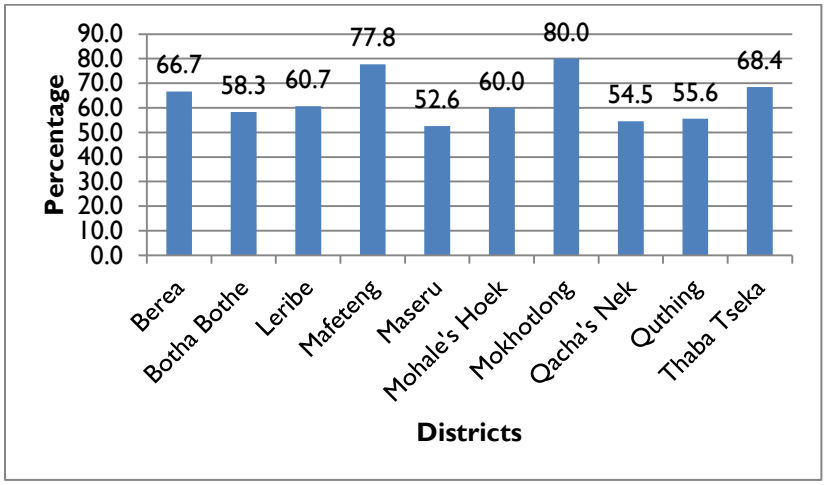
Logistics and Supply Chain

This section summarizes findings on the logistics and supply chain support systems at health facilities. Facilities were assessed on the following logistics and supply chain indicators: 1) Safe and orderly storage of medication; 2) Occurrence of stock outs in the last 3 months; 3) Development and timely submission of PMIS reports; and 4) Daily monitoring and recording of medicine storage temperatures.

In general, there are many problems with logistics and supply chains and very few indicators where most facilities are performing well. Severe to moderate problems exist regarding cleanliness, lack of storage space, safety of sensitive supplies, lack of pharmacy technicians and stock outs of drugs. Severe and moderate problems also exist regarding monitoring and recording information/data, labeling equipment, keeping equipment and drugs safe and orderly.

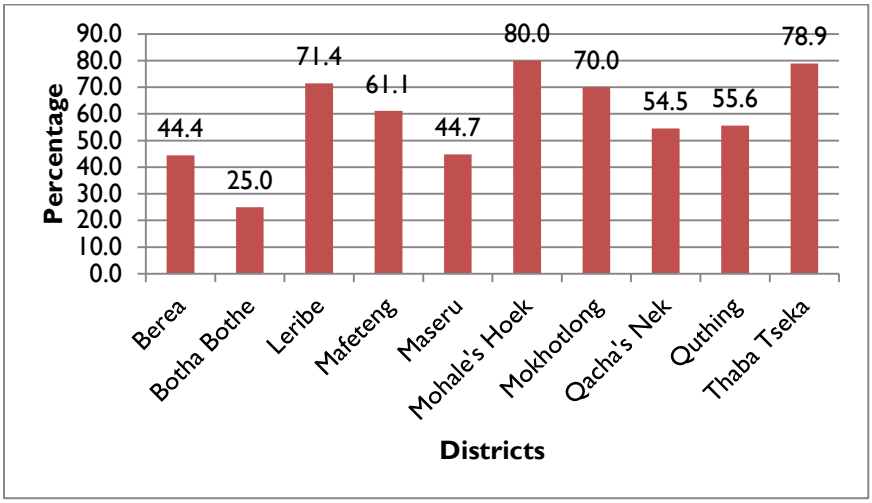
Districts performance with regards to safe and orderly storage of medication is relatively uniform. More than 50% of facilities in all districts store medication safely and in an orderly manner. Mafeteng (77.8%) and Mokhotlong (80.0%) are the highest performing districts, while Maseru (52.6%) is the lowest, as illustrated in figure 3.52.

Figure 3.52. District Health Facilities keeping Medication Safely and Orderly



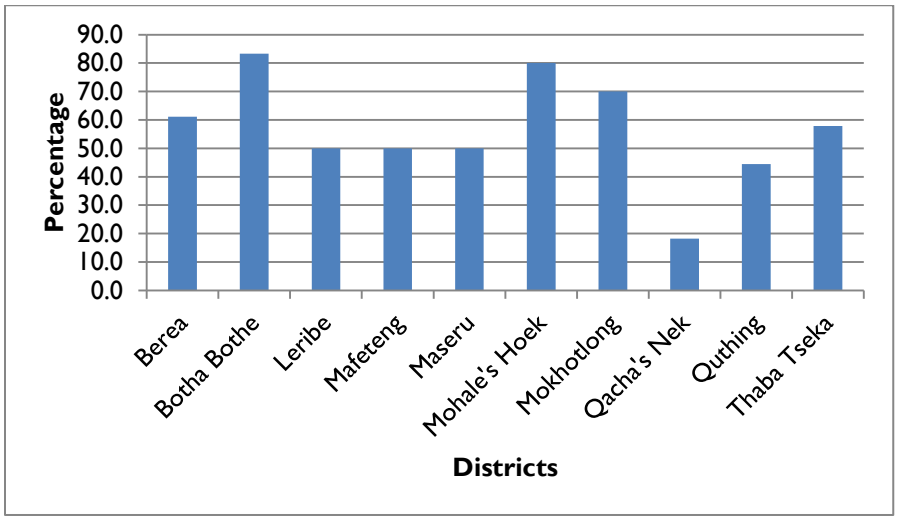
Stock-out occurrences experienced in the last 3 months were frequent. With the exception of Botha Bothe, over 40% of facilities in all other districts experienced stock-outs. In Mohale's Hoek and Thaba Tseka districts, stock outs occurred most frequently, in 80% and 78.9% of facilities, respectively, as illustrated in figure 3.53.

Figure 3.53. District Facilities that Experienced Any Drug Stock-outs in the Last 3 Months



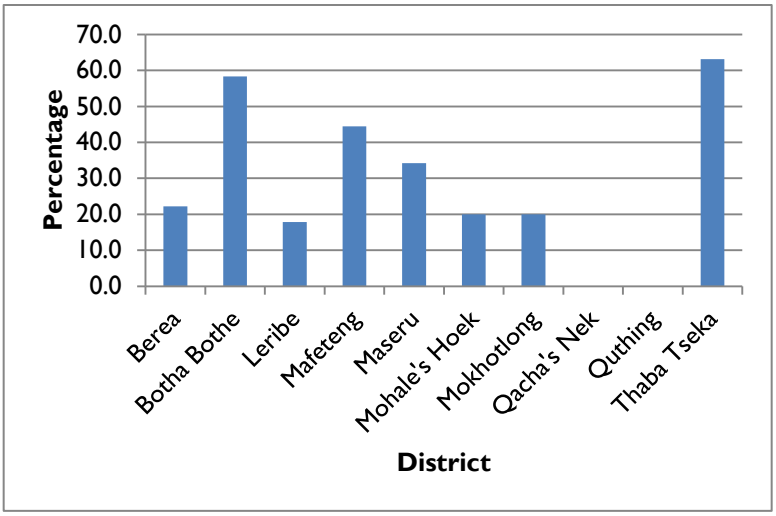
Timely preparation and submission of PMIS reports varies across districts. Performance is highest in Botha Bothe and Mohale's Hoek districts, where 80% or more of the facilities prepare such reports and submit them on time. Qacha's Nek is the poorest performing district, with less than 20% of facilities meeting the requirement. Results by district are presented in figure 3.54.

Figure 3.54. District Health Facilities with PMIS Reports Prepared and Submitted to Relevant Authorities in Timely Manner



With regards to monitoring and recording of storage temperatures, most districts perform rather poorly. In only two districts, Botha Bothe and Thaba Tseka, over 50% of the facilities monitor and record storage temperatures for hear sensitive medication. In all other districts, the percentage of facilities doing so is significantly lower, as low as 0% in the cases of Qacha's Nek and Quthing. Results are shown in figure 3.55 below.

Figure 3.55 District Health Facilities with a Fridge Temperature Monitor and Chart For Heat Sensitive Medicine



Additional findings on logistics and supply chain are provided in Appendix VI.

4. DISCUSSION AND RECOMMENDATIONS

A review of the assessment highlights some major health system challenges that are impacting service availability and readiness in the country as a whole. The assessment identified the main factors as - leadership and governance; human resources for health and quality service delivery. The report explores these issues in more detail in this section -with a goal of understanding how the interactions and relationships between these critical areas are influencing primary health care (PHC) services.

Leadership and governance for health is about providing strategic direction and governance in the health sector (AJR 2012). It is about enhancing the performance of the national health system; enforcing oversight, regulating health and ensuring transparency and accountability for the health sector.

The MOH like other organizations develops and implements strategic plans to provide direction and focus at all tiers of the health system (primary, secondary and tertiary). The MOH also adopts a strategic planning approach to point to specific results that are to be achieved and established and how they are going to be achieved. The MOH strategic plan communicates the vision and objectives of the MOH for purposes of aligning priorities and coordinating resources and managing the contributions of different development actors to the health sector.

4.1 Leadership and Governance

4.1.1 Leadership at the MOH

A recent study[9] by the MOH indicated that the health policy had been comprehensively updated in line with the PHC approach and other regional strategies. Notwithstanding this assertion, it is important to note that a large number of district health teams assessed did not have a copy of the MOH strategic plan or the health policy.

At the senior levels of the ministry, program and technical managers had awareness of key policy documents; however their day- to –day activities were not influenced by this policy mandate. In a related manner- the PHC revitalization strategic plan 2011-2015 -was not used to guide decision making for program design and implementation. Many respondents within the MOH attested to "knowing and understanding the PHC approach" but on further probing; could not articulate the key elements of the plan and its goals/ objectives in revitalizing primary health care.

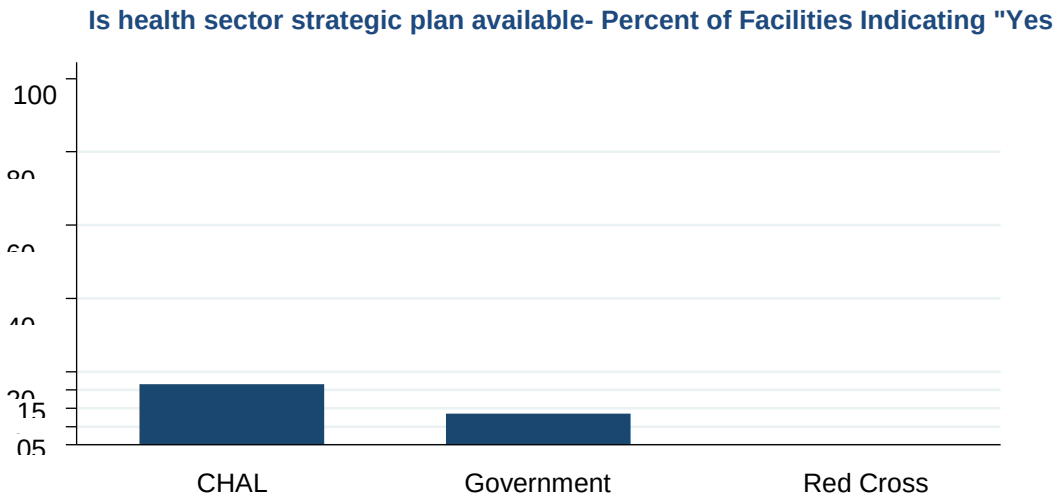
As part of this assessment, the study team also found that the national strategic plan and policies remain written documents which often do not shape , direct or provide context within which the MOH and its partners managed the health sector. Five partners selected and interviewed at random reported not having engaged with the MOH on the aforementioned strategic documents in the recent past. Almost all could not recall attending events, meetings convened by the MOH to coordinate partner activities/events.

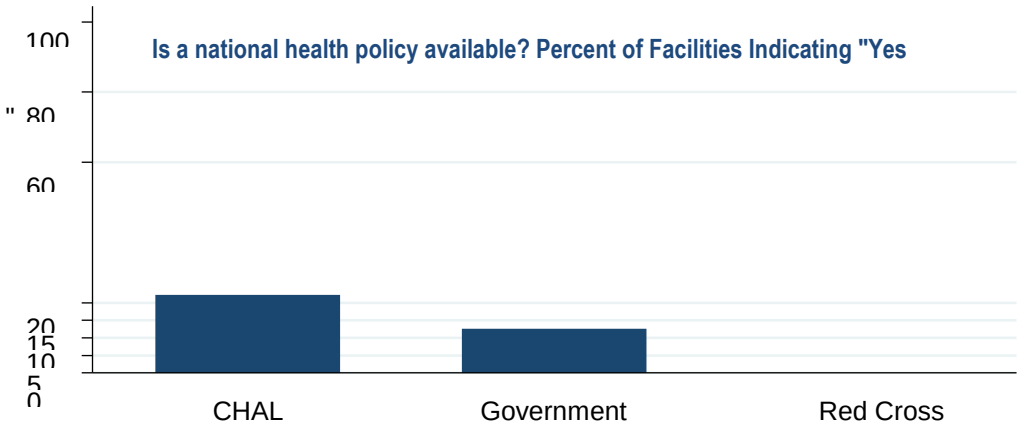
Furthermore, the study team analyzed the proceedings of senior management and heads -of -program meeting. The records revealed that the meetings focused primarily on process; rather than strategic and program technical matters to guide key actions within the health sector. Even when programmatic issues

[9] Report on policy maker's assessment for the 2013 annual joint health review

were discussed; important connections were not made between the ESP and the support functions as outlined in the district health package. The assessment team observed that the meetings were also held very sporadically and were inconsistent. As such the program teams are not using these critical processes to inform and support senior MoH leadership in effectively managing and addressing key challenges within the health sector.

As an example, the figures below summarize the responses of different health facilities (by type of management) on two questions on availability of both the health sector strategic plan and national health policy





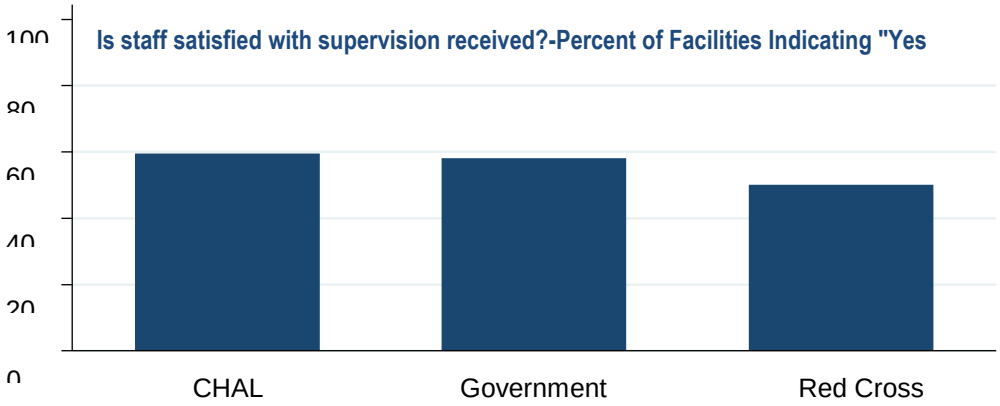
4.1.2 Leadership at district level

A decentralized health system brings provision and management of health and social services closer to the point of service delivery and therefore aims to improve efficiency of health service delivery at the community level. To achieve the mandate of health services decentralization and to ensure that services are delivered in the most efficient and integrated manner overall leadership, management and accountability of comprehensive district-based services rests with the District Health Management Team (DHMT). The DHMT is responsible for the implementation of the District Health Package *(Lesotho Supportive Supervision Manual System for DHMT: Guide to PHC supervision 2010).* According the same manual the specific functions of the DHMT are as follows;

- Leadership for district health service delivery
- Planning and resource mobilization
- Performance monitoring and evaluation
- Capacity building
- Human resource management and development
- Financial management
- Health regulation
- Operational research

At the district level (DHMT) the responsibility for supportive supervision falls within the scope and job requirements of the District Public Health Nurse (DPHN). The DPHN is the key officer responsible for planning, supervision, coordination, monitoring and promotion of public health services as outlined in the Essential Services Package. S/he is also responsible for supervision of staff based at health centers. In addition, the DPHN is also key to ensuring the co-ordination of home-based care activities and the supervision of community health workers (CHWs). It is acknowledged that for effective and sustained supportive supervision to be undertaken collaboration, co-ordination and support is vital and necessary. Whilst the core responsibility for supportive supervision, at district level, lies with the DPHN, s/he will need to engage with other members of the DHMT i.e. District Health Inspector, District Health Educator and District Social Worker and Program Managers / Coordinators in order to discuss service delivery problems and issues that arise at facility and community levels **(***MOH supportive supervision manual 2010***)**

The Assessment team observed that the DHMT is clearly a critical arm of the MOH at the District level. However, as noted from the previous Health Systems Assessment (HSA 2010); the DHMT are still not supported to play this role effectively. The DHMT has been without a managerial leader since the MOH decided to adopt the structure as the backbone of the health system. Despite being recognized as the offices responsible for supportive supervision at district level, the DPHN does not have full control and cannot hold other members of the DHMT accountable for delivery or non-delivery of health services. At most the DPHN has more control and authority over health center nurses. Clearly this reflects a vacuum in the leadership at district level. The assessment revealed that there's an absence of a key individual directly responsible for the proper functioning of the DHMT. The Assessment revealed that most staff were dissatisfied with the level and frequency of supervision received from the DHMTS. The figure below summarizes responses from different health facilities by type of management (Christian Health Association of Lesotho- CHAL, Government and Red Cross facilities)

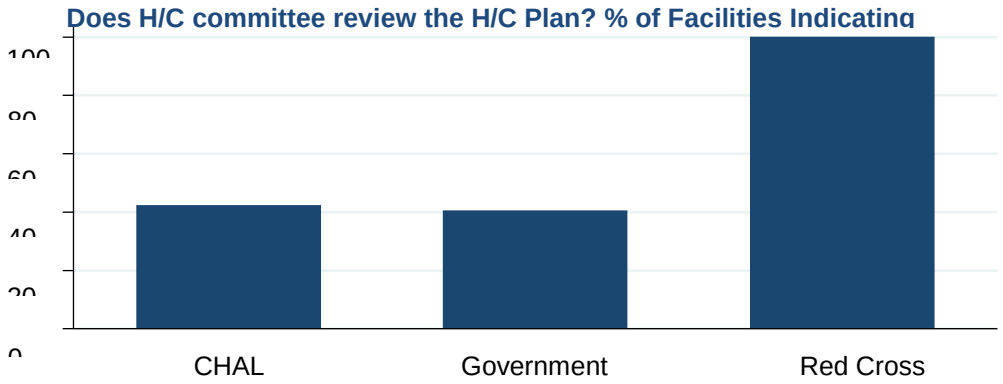


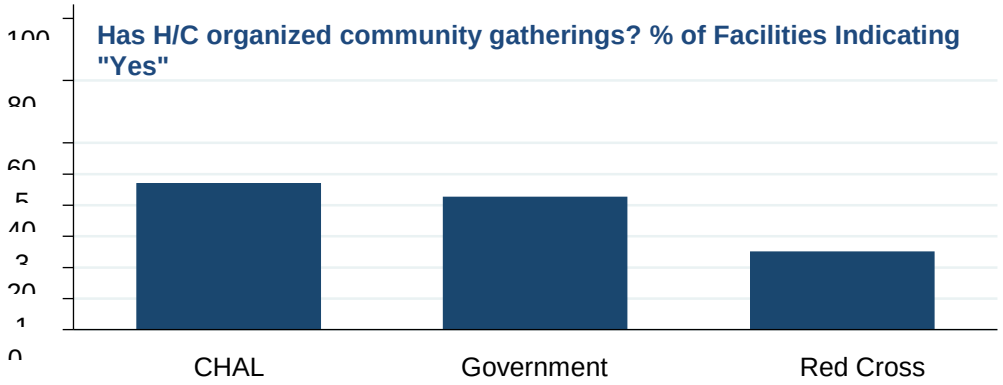
4.1.3 Leadership at community level

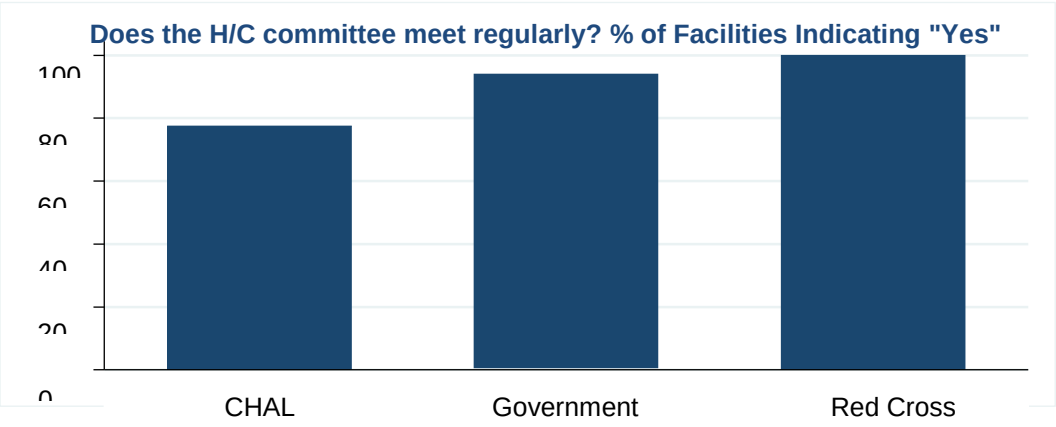
Primary health care (PHC) shifts the emphasis of health care to the people themselves and their needs, reinforcing and strengthening their own capacity to shape their lives. Hospitals and health centres then become only one aspect of the system in which health care is provided. As a philosophy, primary health care (PHC) is based on the *overlap of mutuality, social justice and equality*. As a strategy, it focuses on individual and community strengths (assets) and opportunities for change (needs); maximizes the involvement of the community; includes all relevant sectors but avoids duplication of services; and uses only health technologies that are *accessible, acceptable, affordable* and *appropriate.* Primary health care needs to be delivered close to the people; thus, should rely on maximum use of both lay and professional health care practitioners.

According to the MOH Decentralization Plan 2009, all health centres in Lesotho should have a health centre committee. The health centre committee should ideally comprise of comprising village health workers, representatives of chiefs, traders, teachers, churches, and traditional healers, extension workers of other ministries, local representatives of the HSA Advisory Board, other community representatives and health workers of the area. The health centre committee is expected to provide leadership and oversight vis-à-vis the proper functioning of the health centre.

In this regard this assessment observed that at large; most of the GOL, CHAL, and Red Cross facilities had health centre committees and the committees meet regularly as proposed in the decentralization strategic plan. Contrary to expectation, this assessment also observed that a high number of health centre committees were not discussing the health centre plan. This by implication undermines the ethos of the PHC approach. The study also observes that not many health facilities were organizing community gathering and conducting outreach programs. Representation in the health centre committees varied from health centre to health centre and that District Administrators and District Council Chairperson are not held accountable for a proper functioning of the health services governance. Their role in health is very limited to virtually being non-existent. The following figures summarize some of the observations of the study team as far as leadership at community level is concerned


Does H/C committee review the H/C Plan? % of Facilities Indicating
100
80
60
40
20
0
CHAL
Government
Red Cross


Has H/C organized community gatherings? % of Facilities Indicating "Yes"
100
80
60
40
20
0
CHAL
Government
Red Cross


Does the H/C committee meet regularly? % of Facilities Indicating "Yes"
100
80
60
40
20
0
CHAL
Government
Red Cross

4.1.4 Summary

The Assessment concludes that the MOH has produced a number of documents aimed at providing strategic direction but these documents are yet to achieve their objective of providing strategic direction for priorities within the sector. There's unclear understanding of the MoH strategy and approach at all levels of the health structure; including among partners and donor coordination. Whether inadvertently or not; partner activities are often separate and do not coherently support the vision and direction of the Ministry.

The Honourable Minister's and Principal Secretary's have shared a vision and policy mandate to revitalize primary health care as an approach for strengthen the provision of health services. However a lot more that needs to be done to achieve this goal. The different health departments and respective program teams will need to develop key actions in the design, implementation and management of programs to transform this vision into reality.

4.2 Recommendations: Leadership and Governance

4.2.1 Leadership at MOH Headquarters

The role of the Minister of Health and the Principal secretary is to support the MOH to develop a clear vision; articulate that vision and constantly communicate and oversee adherence to the vision. According to MOH 2013, the Director General Health Services(DGHS) office is conceptually the lead adviser on the direction for the core business of the Ministry. Within the current structure of the MOH, the responsibility to design, implement, supervise and evaluate health systems falls within the scope and mandate of the DGHS. The DGHS performs these responsibilities through a team of clinical and public health specialists and support programs (*Human Resources, Finances, Infrastructure, Health Management Information System, etc.*) It goes without saying that the DGHS's office is therefore charged with bringing into action- the vision set by the Hon Minister and the Principal Secreatry. This critical office has lacked substantive leadership for almost two years now. This situation has negatively affected decision making within the MOH as evident with lack of strategic direction at all health service levels observed during the study.

This assessment team recommends that the MOH considers the following actions at the macro level to strengthen leadership and governance;

- The Principal Secretary(PS) should immediately hold the Director Human Resources(DHR) accountable for delaying advice and subsequent filling of the position of the DGHS. The DHR is responsible for advising and supporting the PS to appoint and fill critical leadership positions within the MOH.
- The DHR should support the PS to immediately fill up the vacant position of the DGHS.
- The DGHS should sign a perfomance based contract with the Principal Secretary. The PS will then use the DGHS peformance contract to manage and asess the perfomacne of the DGHS
- The DHR and other senior managers should study the key findings and recommendations of this study and other recent studies notably; *Health Services Assessment 2010, Health Facility Survery November 2011, the AJR 2013/13* . Utilise the findings and recommendations of these studies to shape the performance contract of the DGHS.
- The Hon Minister can consider demanding the performance contract of the DGHS from the PS

4.2.2 Leadership and Governance at Districts-DHMT Level

Noting the visible leadership challenges at the district level and the potential of the reform programme the MOH is leading, the assessment team recommends the following:

- The reform agenda should be crafted as a major part of the DGHS perfomance contract. This will ensure that the office of the DGHS resumes distinct ownership of these reform efforts within the MOH.
- The DGHS should consider facilitating an open dialogue on criteria and merit for being a the roles and responsbilities of the DHMT leads through the position of District Manager.
- The DGHS should immediately facilitate a process where the central progrmmes of the MOH are brought to speed with regard to the ongoing reform programme
- DGHS to mobilise for greater involvement of DA's and District Council Chairperson, civil societ , MPs and Principal Chiefs in the management and oversight of health services at District level. The DGHS to develop a programme that will support DA's and Distrit Council Chairpersons, civil society, MPs and Principal Chiefs to understand their roles in health
- DGHS to draw up a programme to enable the Hon Minister and Principal to meet regurlary with DA's and Distrit Council Chairpersons, civil society, MPs and Principal Chiefs to discuss the perfomance of the health sector in their respective districts.

4.3 Human Resources Management and Quality Services Provision

4.3.1 Quality Assurance – ESP

Quality assurance is defined as a system of evaluating performance, as in the delivery of services or the quality of products provided to consumers, customers, or patients. In the context of health – quality in health implies the degree of excellence attained by health care providers in relation to the extent to which a health facility meets the client's needs and exceed their expectations.

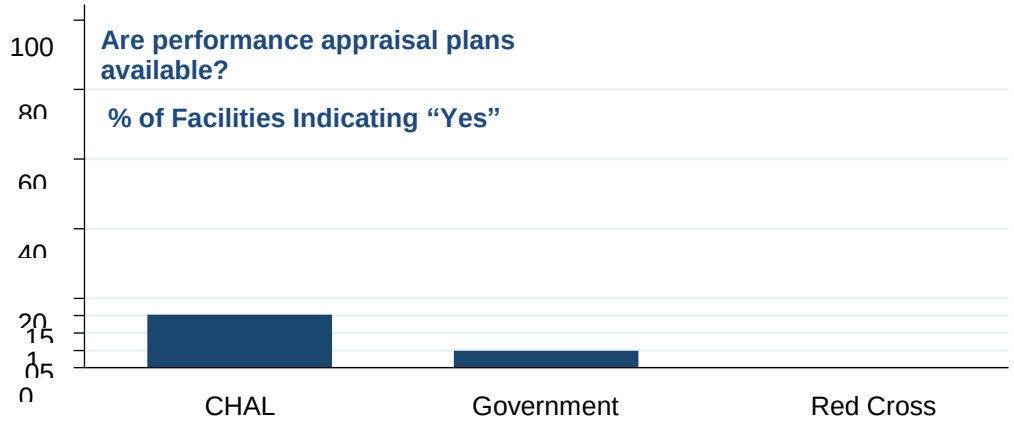
The assessment revealed that the provision of an essential services package (ESP) including availability of resources and infrastructure seemed reasonably satisfactory throughout all services. HIV/AIDS services are better resources and managed in comparison with other health services. Greater challenges were noted in maternal health where a greater percentage of the facilities were not providing quality obstetric care services. Some of the factors affecting this were the transport challenges- including lack of ambulances. Oral health services were inadequate overall- and this was primarily due to the absence of doctors/ dental assistants at the health centre. Other specific technical area issues are described earlier in the report.

However, an in-depth analysis of the key findings on service delivery also demonstrates a pattern of inconsistency and unpredictability in the delivery of the ESP. When a similar questionnaire was administered within a period of three weeks at two respective facilities (under same conditions in terms of resources, materials and supplies etc.), the data showed significant deterioration in performance of essential services. The implication is that whereas supplies, resources, infrastructure, and support systems are necessary for the provision of essential services, it is also evident that even where such resources are in abundance, chances are that service delivery can still remain poor. This study attributes this to lack of supervision and the fact that health professionals are generally not appraised to determine

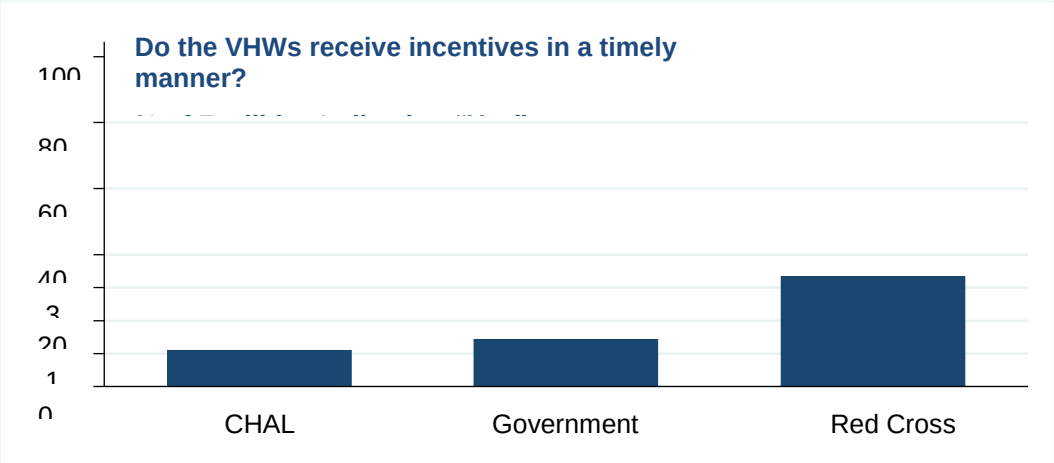
whether they perform effectively or not. The issues are infact more related to leadership and human resources.

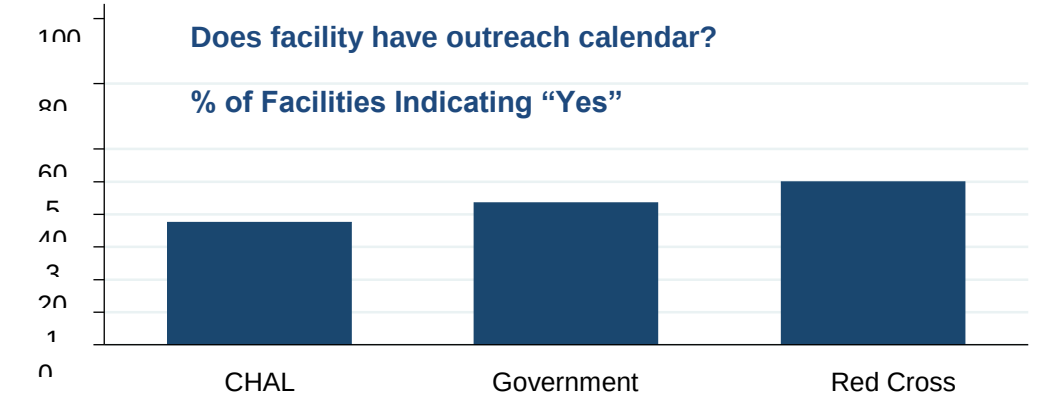
4.3.2 Human Resources

According to the MOH 2013, human resources for health (HRH) or the health workforce, refer to all persons primarily engaged in actions intended to enhance health. Health service providers are the core of every health system and are central to advancing health. Furthermore their numbers, quality and distribution correlate with positive outcomes of health service delivery. The goal of the MOH is therefore to ensure that the required health workforce is available and functional (effectively planned for, managed and utilized) to deliver health services (MOH 2013). Whereas there still noticeable challenges and gaps in terms of getting the right number of HRH, the study also observes that even the limited number of HRH that is available is not utilized optimally.



Given the existing shortages of professional health workers in the country as a whole, the MOH could address some of these challenges by dedicating increased resources towards a viable community health worker (CHW) program. However, the assessment observed that the CHW program remains uncoordinated and very fragmented. A reasonable number of health centres observed did not have job descriptions for VHW/CHW; they also did not have the CHW manual or the CHW policy developed in 2012. Only a small number of facilities scheduled visits to the VHW/CHW and the majority of health facilities studied were not conducting outreach programs. Transport challenges were often raised as a major issue. On the other hand, at the HQ level- the study team found that on average a program director at the MOH had three vehicles at their disposal- raising issues of inefficient resource allocation which is contrary to the ethos of the PHC approach. It was also observed that a large proportion of health facilities reported untimely receipt of CHW incentives – which left of the workers disgruntled and unhappy. Obviously this pattern will negatively affect service delivery.





The study observes that collection of routine data remains a challenge. Data collected at facility level is rarely used to inform decision making. It was observed that DHMT still does not give feedback to facilities on data collected and the MOH headquarters suffers from a similar challenge- in turn the MOH does not provide feedback on data to the DHMT. The poor feedback on HMIS information from the MOH to health facilities is a perennial problem in the region and a key reason why routine data is so often of poor quality. Staff at the facilities resent having to spend considerable time compiling routine data for the district office, without receiving substantial feedback on their performance and achievements.

4.4 Recommendations: Human Resources and Quality Service Provision

This study recommends the following to address these systemic challenges:

- The office of DGHS will develop and sign performance based contracts with all program staff and support functions including HR, Finance, and Legal etc.
- The office of the DGHS must be held accountable for developing a strong HMIS system that prioritizes data collection, analysis and use of data for decision making. This will involve engagement with department of planning (i.e. the DGHS should take control of the functioning of the department of planning.
- Restructure and redefine agenda for Senior Management and Heads of Programmers – ensure that "function follows form". The MOH needs to plan for structured and effective collaboration between the DGHS and Principal Secretary. A results –oriented management approach is required (*for example focused program meetings that define objectives; develop monitoring plans on key deliverables, and assessing performances against benchmarks etc..*)
- Rationalize use of resources- including vehicles at MOH and headquarters level by redistribution resources to lower level health centers.
- Adopt a PHC oriented health financing model - the department of finance should assume management oversight to ensure full accountability on the use of the budget resources. The DGHS should be empowered to work directly with the Director of Finance.
- The DGHS should take responsibility to develop a framework to guide community health worker program.
- The Director of Human Resources should be held accountable for implementing an effective performance appraisal system within the MOH.

4.5 Conclusion

This Assessment reviewed the key elements that constitutes the PHC approach as defined by the MoH policy guidelines- and recommends that the MOH should prioritize factors related with internal management and institutional reorganization. The study concludes that of all the PHC elements assessed – Leadership for strategic planning and direction, human resource management, quality assurance and community participation are critical elements that should be addressed immediately. The MOH should move beyond adopting PHC in principle and focus on supporting the operationalization of a PHC approach that informs key decisions on well-defined program priorities, resource allocation, and quality delivery of the essential services package.

The appointment of a DGHS should also be a top priority and should be done immediately. At the same time, the MOH should allocate more resources towards strengthening the ailing community health worker program. The assessment revealed clearly that the MoH has the necessary technical capacity to delivery health services both efficiently and effectively. The greatest challenge facing the MOH is poor HRH management. The Director Health Resources should receive support from senior management to rethink the role of HR department of the MOH. It is recommended that the HR department should focus on introducing a culture of reporting and performance appraisal within the MOH. The human resources department/unit should address HR management issues more broadly, rather than narrowly focusing on staff recruitment. Issues of performance management and workforce planning and development should receive increased priority and attention.

It's recognized that some of these institutional reforms will require direct support and involvement of senior leaders within the Ministry- including the Hon Minister, the Principal Secretary and the office of DGHS. To some extent this may be supported by the Right Honorable Prime Minister signing a PHC revitalization service compact with the Hon Minister; and similar contracts signed between the Hon Minister with the Principal Secretary (PS) and onwards to the PS and the DGHS.

The is not able to conclude that the reason the MOH is not performing is due to lack of resources because even with the limited resources be it finances, Human resources, infrastructure, supplies and others, the MOH is still not getting value for the level of investment.

APPENDIX I: GENDER CONSIDERATIONS RELATED TO HEALTH AND HIV/AIDS IN LESOTHO

Lesotho performs very well in terms of gender equality overall, ranking 9th out of 135 countries in the Gender Gap Index in 2011[10], representing a dramatic improvement over its rank of 43rd out of 115 countries in 2006[10]. Furthermore, in 2011 Lesotho ranked 2nd in the Gender Gap Index in terms of economic participation, and 1st in terms of both educational attainment and health and survival. Women are significantly represented in the labor market, with a female to male labor participation rate of 0.92, and they earn similar salaries as men for similar work. Women also perform better than men in terms of educational attainment, with a literacy rate of 95% compared to men at 83%10. Although healthy life expectancy is very low, no significant gender gap is observed. The Government of Lesotho has policies in place to address gender inequality.

Despite these impressive results, however, gender continues to affect human development outcomes in Lesotho. Lesotho recognizes both civil and customary law, an approach which negatively affects women; under customary law, women are considered to be legal minors and dependent on men throughout their lifetimes[11]. Furthermore, females are at an economic disadvantage compared to males. For instance, land ownership is biased in favor or males, as the male is considered to be the head of the family and therefore the owner of all property belonging to the family.[12]

Significant gender differences can be observed in the burden of HIV among males and females in Lesotho. Female HIV prevalence (28.20%) is significantly higher than male HIV prevalence (18.50%)[10]. This difference is greatest in the 20-24 age group, "where prevalence is 24% in women and only 6% in men"13. **Maseru, Leribe a**nd **Mohale's Hoek** are the districts with the highest HIV prevalence among women.[13]

Females also have a higher risk of becoming infected with HIV than men, with gender-based violence and inequality being important determinants of this risk. Beliefs about male dominance, which can lead to violence against females, are common not only among men, but also about women. One study found that "twenty-three percent [of married women] agreed that a beating was justified if a wife refused to have sex with her husband."[14] Cultural beliefs about women's status and sexual obligations impact women's ability to negotiate protected sex. "Payment of a bride price (bohali) gives men the impression that they 'own' their wives. Furthermore, the fear of violence or abandonment by partners is one other factor that contributes to the spread of the disease."[12]

---

[10] Hausmann, Ricardo, Laura Tyson, and Saadia Zahidi. 2011. The Global Gender Gap Report 2011: Rankings and Scores. Geneva: World Economic Forum. Accessed 3 Jun 2014. Available at http://www3.weforum.org/docs/GGGR11/GGGR11_Rankings-Scores.pdf

[11] OECD. 2010. "Lesotho", in Atlas of Gender and Development: How Social Norms Affect Gender Equality in non-OECD Countries. OECD Publishing. Accessed 3 Jun 2014. Available at http://dc.doi.org/10.1787/9789264077478-114-en

[12] Hlalele, Dipane, and Puleng Relebohile Letsie. 2011. Gender Inequality and HIV/AIDS in Lesotho: A Human Disease Ecological Perspective. J Hum Ecol, 36(3): 159-165.

[13] Coburn, Brian, Justin Okano, and Sally Blower. 2013. Current drivers and geographic patterns of HIV in Lesotho: implications for treatment and prevention in Sub-Saharan Africa. BMC Medicine, 11: 224.

[14] Fustos, Kata. 2011. Gender-Based Violence Increases Risk of HIV/AIDS for Women in Sub-Saharan Africa. Population Reference Bureau. Accessed 7 Jul 2014. Available at http://www.prb.org/Publications/Articles/2011/gender-based-violence-hiv.aspx

Additionally, due to women have an important role as primary caregivers to children and sick relatives, largely due to labour migration and the absence of men from their homes.[15] As a result of this role, the higher burden on HIV on females negatively impacts the livelihoods and health outcomes of other vulnerable populations such as children and the sick.[12] At the same time, HIV/AIDS affects women disproportionally by making them more economically vulnerable due to the fact that they have the primary responsibility for caring for relatives who are infected with HIV.[15]

Implications for Lesotho Assessment Action Steps:

While it was not the focus of this Assessment, an analytical approach that examines relevant gender considerations could include focus on the following areas:

1. **Geographical Areas of focus:**

   As the MoH concludes the Health Services Assessment; it' s important to review in greater detail the availability and quality of health services in the districts of Maseru, Leribe and Mohale's Hoek Districts- where women are disproportionately affected by HIV.

2. **Access to Services- priority interventions**

   The following Indicators that primarily explore how women's access and use if HIV services should receive greater priority for the MoH health Assessment Team as they develop key recommendations and plans of action. The indicators linked to Maternal Child Health, RH and HIV services are:

   - Facility provides educational sessions to pregnant women
   - CoTrim and INH prophylaxis provided as pre- ART care to ANC clients that are HIV positive
   - All HIV positive women are initiated on ART (OPTION B+) during the first visit
   - All women testing HIV+ during B/feeding are initiated on ART
   - Facility retests all HIV negative women at 36 wks. gestation as stipulated in national guidelines
   - Availability of consulting and counseling rooms that have adequate privacy
   - Availability of guidelines for family planning information and counseling
   - Do the facility provider screening for cervical cancer?

3. **Division of Labour: Human Resources Management**

   While the assessment did not explore in detail the distribution of labor by gender, there are a couple of indicators listed below and related actions that can help the Assessment team support a more gender- responsive program

   Action: Explore the distribution of male and female health workers at the respective facilities that have received updated training in the last 3 months. The appropriate indicators are listed below; with a greater opportunity to influence the community health program.

   - Providers receive short term training (in service training)- any differences by gender?

[15] Harrison, Abigail, Susan Short, Maletela Tuoane-Nkhasi. 2013. Re-focusing the Gender Lens: Caregiving Women, Family Roles and HIV/AIDS Vulnerability in Lesotho. AIDS Behav, 18:595–604.

- Community Health Workers:

  Action: explore the gender disaggregation within the following indicators at the district level, so that the DHMTs can develop stronger and more representative Community Health Worker programs

  - Facility have copies of the JD outlining roles and responsibilities of CHWs(Any differences by gender?)
  - Availability of Data reporting tool for CHWs(are there any variations among female and male CHWs)
  - CHWs receive incentives in a timely manner((are there any variations among female and male CHWs)

APPENDIX II: HEALTH FACILITY LIST

Berea MCH	Government	Berea
Bethany	CHAL	Berea
GOOD SHEPHERD	CHAL	Berea
HOLY FAMILY	CHAL	Berea
IMMACULATE conception	CHAL	Berea
KHUBETSOANA	MCC	Berea
KOALI H/C	Government	Berea
Kolojane	Red Cross	Berea
MABOTE	Private	Berea
MAHLATSA	Government	Berea
MALUTI MCH	CHAL	Berea
MAPHELENG	CHAL	Berea
Pilot	Government	Berea
Sebedia	CHAL	Berea
SION	CHAL	Berea
ST DAVID	CHAL	Berea
ST MAGDALENA	CHAL	Berea
ST THERESA Bela-Bela	CHAL	Berea
Boiketsiso	Government	Botha Bothe
Botha Bothe	Government	Botha Bothe
Linakeng	Government	Botha Bothe
Makhunoane	Government	Botha Bothe
MOTETE	Government	Botha Bothe
Muela	Government	Botha Bothe
Ngoajane	Government	Botha Bothe
Rampai HC	Government	Botha Bothe
Seboche MCH	CHAL	Botha Bothe
St. Peters	CHAL	Botha Bothe
ST.PAUL	CHAL	Botha Bothe
Tsime	Government	Botha Bothe
Bobete	Government	Thaba Tseka
Kuebunyane Health Centre	Government	Mohale's Hoek
Lebakeng	Government	Qacha's Nek
Manamaneng	Government	Thaba Tseka
Methalaneng Health Center	Government	Thaba Tseka
SEMENANYANE H/C	Government	Thaba Tseka
EMMANUEL	CHAL	Leribe
HOLY TRINITY	CHAL	Leribe
KHABO	Government	Leribe

LEJONE	Government	Leribe
LI0TSING	Government	Leribe
LITTLE FLOWER	CHAL	Leribe
LOUIS GERALD	CHAL	Leribe
MAHOBONG	Government	Leribe
MAMOHAU MCH	CHAL	Leribe
MAPUTSOE FILTER	Government	Leribe
MAPUTSOE SDA	CHAL	Leribe
MARYLAND	CHAL	Leribe
MATLAMENG	Government	Leribe
MOTEBANG MCH	Government	Leribe
OUR LADY OF LOURDES	CHAL	Leribe
Palama	Government	Leribe
PEKA	Government	Leribe
PONTMAIN	CHAL	Leribe
SEETSA	Government	Leribe
SEETSA	Government	Leribe
Seshote	Government	Leribe
ST Ann	CHAL	Leribe
St Denis	CHAL	Leribe
ST MARGARET	CHAL	Leribe
ST MONICAS	CHAL	Leribe
ST ROSE	CHAL	Leribe
THABA-PHATSOA	Government	Leribe
FOBANE	CHAL	Leribe
Auray	CHAL	Thaba Tseka
Dilli Dilli	Government	Quthing
Health Division	Government	Thaba Tseka
HERMITAGE	CHAL	Qacha's Nek
Katse	Government	Thaba Tseka
KHOHLO-NTSO	Government	Thaba Tseka
LEPHOI	CHAL	Thaba Tseka
Libibing	Government	Mokhotlong
Linakaneng	Government	Mokhotlong
Linakeng	Government	Thaba Tseka
MACHABENG MCH	Government	Qacha's Nek
Mafa health post	CHAL	Thaba Tseka
MAKOAE	Government	Quthing
Malefiloane	Government	Mokhotlong
Mapholaneng	Red Cross	Mokhotlong
MAQOKHO	Government	Quthing
MELIKANE	Government	Qacha's Nek
Moeketsane	Government	Mokhotlong
Mohlanapeng	CHAL	Thaba Tseka

MOHLAPISO	Government	Qacha's Nek
Mokhotlong Hospital (MCH)	Government	Mokhotlong
MOKOTO HEALTH CENTRE	Government	Thaba Tseka
Molikaliko	Government	Mokhotlong
MONT MATRE	CHAL	Thaba Tseka
MPHAKI	Government	Quthing
PARAY MCH	CHAL	Thaba Tseka
Popa Health Centre	CHAL	Thaba Tseka
Quthing MCH	Government	Quthing
Rankakala	Government	Qacha's Nek
Sacred heart	CHAL	Qacha's Nek
SEHLABA-THEBE	Government	Qacha's Nek
SEHONG-HONG	Government	Thaba Tseka
SEKAKE H/C	CHAL	Qacha's Nek
ST FRANCIS	CHAL	Qacha's Nek
ST GABRIELE	CHAL	Quthing
St James health centre	CHAL	Mokhotlong
ST JAMES MCH	CHAL	Thaba Tseka
St Martins	CHAL	Mokhotlong
ST MATHEWS	CHAL	Quthing
St Theresa- MASHAI	CHAL	Thaba Tseka
TEBELLONG MCH	CHAL	Qacha's Nek
Tlhanyaku	Government	Mokhotlong
TSATSANE	Government	Quthing
VILLA MARIA	CHAL	Quthing
EMMAUS	CHAL	Mafeteng
KOLO HC	CHAL	Mafeteng
LECOOP	Government	Mafeteng
Litsoeneng HC	Government	Mafeteng
MALEALEA	Government	Mafeteng
Masemouse	CHAL	Mafeteng
MATELILE	CHAL	Mafeteng
Mafeteng MCH	Government	Mafeteng
MOTSEKUOA	CHAL	Mafeteng
MT OLIVET	CHAL	Mafeteng
MT TABOR	CHAL	Mafeteng
RIBANENG	CHAL	Mafeteng
SAMARIA	CHAL	Mafeteng
Sekameng	Government	Mafeteng
ST ANDREWS	CHAL	Mafeteng
TH MORENA	Government	Mafeteng
THABA-TSOEU	Government	Mafeteng
Tsakholo	Government	Mafeteng
Botsabelo Health Centre	Government	Maseru

Domicilliary	Government	Maseru
FATIMA HEALTH CENTRE	CHAL	Maseru
HA SENG	Government	Maseru
KENA H/C	REDCROSS	Maseru
Korokoro Health Centre - ST JOSEPHS KOROKORO	Government	Maseru
LDF	Government	Maseru
Lesotho College of Education Health Centre	Government	Maseru
LESOTHO CORRECTIONAL SERVICE	Government	Maseru
Likalaneng	Government	Maseru
Likotsi	Government	Maseru
Loretto	CHAL	Maseru
Makoanyane MCH	Government	Maseru
Marakabei Health Centre	CHAL	Maseru
Maseru SDA	CHAL	Maseru
Matsieng Health Centre	Government	Maseru
MOFOKA	CHAL	Maseru
Mofoka Health Centre	Government	Maseru
Mohale health Centre	Government	Maseru
Nazareth Health Centre	CHAL	Maseru
NUL HEALTH CENTRE	Private	Maseru
Paki Health Centre	CHAL	Maseru
Pshatlella	Government	Maseru
QMM MCH	Government	Maseru
Queen II MCH	Government	Maseru
ST JOSEPH MCH	Government	Maseru
SCOTT MCH	Government	Maseru
Semokong Health Centre	Government	Maseru
ST BERNARD HEALTH CENTRE	CHAL	Maseru
St Leonard	CHAL	Maseru
St. Benedict	CHAL	Maseru
St. Leo	CHAL	Maseru
St. Rodrique	CHAL	Maseru
St.Barnabas	CHAL	Maseru
St.Peter Claver Health Centre	CHAL	Maseru
Thababosiu	Government	Maseru
THAMAE	Private	Maseru
Tlali	Government	Maseru
Bethel	CHAL	Mohale's Hoek
Holy Cross	CHAL	Mohale's Hoek
Liphiring	Government	Mohale's Hoek
Lithipeng	Government	Mohale's Hoek
Mofumahali Oa Rosari	CHAL	Mohale's Hoek
Mohalinyane	Government	Mohale's Hoek

Mootsinyane	Government	Mohale's Hoek
Morifi	Government	Mohale's Hoek
MPHARANE	Government	Mohale's Hoek
Nkau	Government	Mohale's Hoek
Nohana	Government	Mohale's Hoek
Nt'sekhe MCH	Government	Mohale's Hoek
Phamong	Government	Mohale's Hoek
Ts'epo	CHAL	Mohale's Hoek

APPENDIX III: SUMMARY OF KEY CHALLENGES IDENTIFIED IN THE HEALTH SECTOR AND RECOMMENDATIONS[16]

Area Assessed	Key Challenges Identified	Recommendations Of Hsa 2010
Finances	• At the central level, no clear resource allocation criteria exist for the districts or any cost center, therefore, issues of equity in financial resource allocation cannot be effectively addressed[23]. • Delays by the MOFDP in transferring funds to the MOHSW and with the MOHSW transferring funds to the districts and other cost centers outside the MOHSW headquarters. This occurs frequently during the first and second quarter of each financial year, thus disrupting service delivery at the concerned cost centers. • The second major weakness in this arrangement is inadequate capacity at the district level to process payments, in particular for drugs and medical supplies. As a result, the districts have significant unpaid bills owed the National Drug Services Organization (NDSO) for their procured drugs and medical supplies rendering NDSO almost insolvent • There is no clear methodology for allocating the MOHSW budget to the districts. As such, persistent inequities in resource allocation exist between districts. For example, if we use population per capita as the principal determinant of health care needs and adjust it for poverty levels, which is also one of the main factors affecting demand for health care, per capita MOHSW recurrent budgets would differ by a factor of 2.2 between Maseru district and Quthing district, whereas, in reality, Quthing district has a slightly higher proportion of poor compared to Maseru (MOHSW 2008). Also at issue is how to obtain the best value for money ("best buys") with the available resources. Within the past 5 to 10 years, trends in health indicators have been deteriorating (World Bank 2009), while budget allocations have been consistently rising, as previously noted. This inverse relationship between the budget allocated and health outcomes is indicative of systematic failures and inefficiencies at the different levels of the public sector. It is also a	• Improve public finance management systems and technical capacity at all levels so as to improve the flow of funds between various levels of the system and increase funding for HIV/AIDS services and goods. • Split the district health budget in two: one budget for the health centers, prevention, and public health programs and one budget for the district hospital, as indicated in the decentralization strategy. • Consider recentralizing the payment system for drugs and medical supplies; the MOHSW should pay for drugs at NDSO on behalf of the districts until capacity for processing payments is developed at the district level. • Develop and implement a rational resource allocation methodology that includes indicators of health needs. • Develop a fully fledged health SWAp, with common planning, funding, and M&E procedures. • Expand risk pooling mechanisms, in particular medical aid schemes, and develop a social health insurance scheme so as to reduce out-of-pocket spending. Also undertake an evaluation of the impact of abolition of user fees in GOL and CHAL health centers. • Undertake National Health Accounts so as to fully understand the total amount of health care resources in

[16] Source: HSA 2010

Area Assessed	Key Challenges Identified	Recommendations Of Hsa 2010
	reflection of resource allocation mechanisms that are not responsive to the health needs of the population • Consistent under expenditures across the board, worse at district cost centers. • Weak links between planning, implementation, and M&E of programs and budgets. • Sustainability of health financing	Lesotho and their distribution between different uses, and assess the bottlenecks in the flow of funds within the health system.
Human Resources	• Challenges that have affected the growth of the community-based program include inadequate funding, increased burden of diseases, acute shortage of health professional to supervise, and inadequate incentives—all of which have led to low morale and motivation of this workforce • Until 2008, CHWs received no remuneration, and their only benefit was free medical care for themselves and their immediate family. This benefit lost its significance with the adoption of the free PHC policy. In 2008, the government began paying CHWs a monthly salary of M300, thereby institutionalizing the community-based health service. • the last decade there has been a steady decrease in focus on the functions for which the CHWs were established, and they are not included in policy and planning discussions. The level of GOL financial support is also inadequate (World Bank 2009). • Support supervision for the community system is inadequate, as is financial assistance for the CHWs' operations, such as transport allowances when carrying out their duties • 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 MOHSW does not have a sector-specific performance management system. It relies entirely on the PSC's performance management system. Key informants suggested that this system is used essentially for administrative purposes (mandatory process required by the PSC), as opposed to active performance management of employees. supervision system as a "routine" function that does not provide an adequate platform for appropriate supervision of health workers • Community-based facilities and workers are also faced with frequent stock-outs of drug kits and other commodities, which greatly affects their ability to serve the community and, as a result, impedes the level of trust the community has in their ability to deliver services. • Inadequate funding, among other challenges, has dramatically decreased the level of GOL-led training since the 1990s and has resulted in a poorly coordinated and less efficient system. The training that does	• Establish a system for monitoring the implementation of the various strategic plans aimed at strengthening HRH (emergency hiring plan, continuing education plan, etc.). Indicators on uptake of cadres (i.e., percentage of newly trained workers/cadre absorbed into the civil service) would be useful to measure improvements in this area. • Take urgent measures to reinvigorate the CHW system through updating and large- scale training (particularly for skilled birth attendants and providers of home-based care kits), revamping CHW supervision mechanisms (through DHMTs), and using CHWs to collect community health data to strengthen HMIS at all levels. • With SAHCD assistance, operationalize the HRIS system (i-HRIS) at the central and district levels, as well as within the nursing council, before the end of 2010. • Engage with the GOL Cabinet and Parliament and propose the establishment of a health service commission to streamline recruitment of health sector personnel. • Establish twinning arrangements with NHTC and NUL, and explore the possibility of establishing formal cooperation mechanisms between these training institutions and PEPFAR (cooperative agreements) to ramp up production of health workers. • Rapidly identify blockages causing poor absorption of health workers and propose solutions

Area Assessed	Key Challenges Identified	Recommendations Of Hsa 2010
	• , CHWs are not catered for within the context of broader health sector operations and the implementation of activities. • Non replacement of the original 'stock' of CHWs trained during the 1980s and 1990s, whose current average age is 54 years (Kimane 2008), suggests that the majority are now near retirement. The country is thus faced with the urgent need to replace thousands of sector personnel to avoid the certain losses that will occur in less than 10 years.	
Pharmaceuticals	• Lack of national quantification data for pharmaceutical commodities • Weak procurement systems nationally • Weak regulatory frameworks for pharmaceutical commodities and professionals • Inadequate supportive supervision for facilities • Weak central pharmacy administration	• The MOHSW should expedite the process of reviewing the national essential medicines list (EML). Availability of a current EML, which clearly identifies items as vital, essential, or nonessential (VEN analysis), would assist the NDSO to review its own product catalogue, in line with the national EML, thus enabling NDSO to improve its procurement and storage efficiency by managing only a limited number of line items. • A clear system for quantification of pharmaceutical commodity needs to be adopted across all levels of the pharmaceutical system, using both the morbidity-based and consumption-based methods for quantification of essential medicine needs throughout the country across all levels. • A national quantification exercise involving all the critical clinical programs and vertical programs should be facilitated by a task team led by NDSO, with the pharmaceuticals directorate assuming the role of secretariat. • Urgent attention also needs to be placed on the facilities' timely payment to NDSO, as this has the biggest impact on the ability of NDSO to run efficiently. Key informant interviews at NDSO indicated that late disbursement of funds from district sub accountancies resulted in NDSO failing to honor debts from its own suppliers. • The government's efficient absorption of graduates from NHTC and NUL pharmacy training programs would improve the pharmacy personnel density throughout the country. The priority areas under this intervention should

Area Assessed	Key Challenges Identified	Recommendations Of Hsa 2010
		be the following: • Rationalization of the pharmacy training curricula toward national needs. This should involve assessment of curriculum relevance at the two training
Services Delivery[17]	• • No facilities passing the accreditation exercise • Slow progress of implementation of the decentralizations and health sector reforms processes. • Lack of clarity within existing statutory instruments, regarding the position of the health sector, within the decentralization framework • Unresolved issues concerning the GOL/CH AL Memorandum of Understanding • Greatly increased demand for HIV/AIDS services, particularly at district level, well in excess of capacity to deliver o • High level of community focus on HIV/AIDS(vertical) programming, to the exclusion of other community priorities • Increasing level of non communicable diseases • Low morale throughout the health sector • High level of dependence on external HR capacity • Poor access to services in the highlands • Continued existence of the primary level health posts outside of the formal health system • Poor maternal care services • Weak referral system • Non prioritization of recommended interventions • Poor planning, coordination, and monitoring mechanisms • Non-use of data for planning and decision making • Private sector facilities not included in planning for service delivery Policy Framework: • No policy framework formalizing the roles, responsibilities, and status of voluntary/community health workers • No national Quality Assurance Policy	• Define and formalize the roles and responsibilities of the structures created by the health sector reform and decentralization processes. • Strengthen the interministerial dialogue process. • Strengthen the health sector policy framework through the following: • Community Heath Workers • Equipment procurement and maintenance. • Formalize the roles of the health posts within the health system. • Strengthen the leadership and management capacity of the health sector. • Use the prioritization process in developing intervention strategies and operational planning. • Develop/strengthen internal performance assessment mechanisms. • Develop/strengthen outreach programs in remote and hard-to-reach areas. • Maintain an up-to-date national health facility inventory.

[17]service access, coverage, utilization and quality

Area Assessed	Key Challenges Identified	Recommendations Of Hsa 2010
	• Weak policy framework regarding equipment Human Resources for Health:	
Governance[18]	• The capacity of advocacy organizations working in the health sector is similarly weak, and these organizations are mainly focused on vertical programs. • Councils and community groups have very limited capacity to participate in national-level health planning. One of the major reasons for strengthening the decentralized structures is to better enable community and district-level groups to participate in planning processes through the DHMTs • few health-related NGOs exist in Lesotho, and those that do exist are not primarily focused on health • Evidence also suggests that NGOs and CSOs are not involved in the health planning and policy processes at the MOHSW • There is no documented participation of an NGO in the annual joint review of the MOHSW and no CSO is listed as a key stakeholder in the MCC health sector project documentation (MOHSW 2009, MCC 2007). • The lack of engagement between CSOs and government may mean that important ideas from the constituents that civil society represents go unheard due to (1) the CSOs' inability to raise the issues in a productive, engaging manner and (2) public officials' inability to provide the opportunities for civil society to engage, based on past experiences. • No evidence of service providers advocating for policy, program, or procedural changes • Weak CSOs and NGOs for client advocacy and health system strengthening • . NGOs and stakeholders have also reported that they do not have the opportunity to provide input into health legislation until the bill reaches Parliament. • Very few health-focused CSOs at the national level • to date, there are no official mechanisms in place to ensure active engagement of the community in the management of the health system and the delivery of services • The ability, therefore, of the health sector to elicit the population's priorities, clients' perceptions of the quality of service delivery, and the barriers clients face in seeking care is limited • This lack of formal policies, guidelines, and central coordination has resulted in a number of crucial and unresolved challenges, which have led to the country's current inability to harness what is potentially one of the most significant resources available	• Implement a results-based strategic planning process for the health sector, which includes the participation of representatives from the lowest levels of the health system, vulnerable groups, NGOs, CSOs, and donors active in health service delivery. This strategy should be linked to country priorities identified through a criteria-based participatory process, a sound situational and response analysis, and realistic cost estimation. This strategy should then feed into a rational budget allocation and donor coordination process. • Enhance civic engagement by strengthening the capacity of chiefs, CSOs, NGOs, and community councilmen to advocate on behalf of their constituents, members, and clients. Although this is happening somewhat through the Global Fund activities, a round 10 Global Fund health system strengthening proposal could request funds for health sector CSO/NGO strengthening to compliment existing disease-specific CSO/NGO strengthening already occurring in earlier Global Fund rounds. • Strengthen the functions at the decentralized levels to communicate with community-level stakeholders about health issues/topics, as identified through community councils in the decentralization plans. Enhancing this information flow will not only enrich the discussions of client needs but will also enable the MOHSW to respond more quickly to service delivery challenges. • Encourage stakeholder input into the planning and policymaking processes at the national and decentralized levels. More formalized health planning forums is one way to encourage stakeholder participation at the district level. Another would be to establish bylaws that include representatives from stakeholder groups to participate in

[18]including public and civil society engagement

Area Assessed	Key Challenges Identified	Recommendations Of Hsa 2010
		interministerial committees and reviews, such as the annual joint review. • Conduct budget allocation to the districts based on a set criteria, taking into account population dynamics and needs as well as district health priorities. The DHMT structure needs to be strengthened to take on these planning and budgeting functions. Lesotho would benefit from allocating resources through a strategic planning process that takes into account the geographic distribution of the health system's needs. • Empower and capacitate districts to take on their technical oversight role by providing them with staff, communication, and transportation resources to reach facilities on a regular basis. • Pilot the provision of incentives for providers to improve service delivery in the areas in which HIS is stronger and the MOHSW and DHMTs are able to monitor health indicators. • Increase information flow out of the ministry by making ministry policies, plans, and reports publicly available.
HMIS	• Insufficient human resources for HIS, particularly at lower levels • Poor data use culture • Lack of a broad vision/strategy for HIS • Low budget execution rate	• Develop standard operating procedures/guidelines on health information management for facility- and district-level staff. • Develop standardized training materials on management of health information to enable districts to provide step-down training to facility-based staff. • Develop national standards for electronic health information systems to ensure interoperability, data exchange, and national ownership. Information systems should be adaptable and extensible, and preferably should be an open source, easy to maintain in country, and capable of exchanging data with district- and national-level databases. • Develop a national health information architecture or vision in collaboration with implementing partners.

Area Assessed	Key Challenges Identified	Recommendations Of Hsa 2010
		• Leverage the expansion of IT infrastructure (district networked to national backbone) and mobile phone networks to deploy a mobile phone-based reporting system. • Strengthen the routine HIS system at the district level and systematically use routine health data for quarterly and annual monitoring activities (versus engaging in parallel data collection efforts).
Quality Assurance	• Application of QA methods and standards is not harmonized throughout the country. The GOL and CHAL still use different quality assurance tools and management systems, despite the MOU signed in 2007. Interventions NGOs involved in service delivery have implemented also use their own tools and standards for quality assurance and M&E, an example being ICAP's69 use of tools developed by Columbia University. In many cases, the utilization of separate tools is due to the lack of MOHSW-developed tools and its current inability to do so. That notwithstanding, it is felt that the current situation perpetuates a lack of harmonization within systems, the creation of silos, and effective fragmentation of critical data that are necessary to monitor and evaluate performance and ensure the centrally coordinated quality of service delivery. • The results of the two assessments reflect the low quality of service delivery in the country. Of the eight GOL hospitals, eight CHAL hospitals, and 147 health centers assessed, none passed the accreditation standards. It should be noted that the QA unit considers the 2006 national standards used during the assessment to be inadequate, as the standards assess only 11 domains rather than the 38 elements considered necessary to adequately capture quality performance and assurance.	• Build a quality assurance framework aligned to Lesotho decentralisation process as outlined in the Local Government Act and other policy documents for Local Government.

APPENDIX IV: MAIN AREAS COVERED BY THE PROVIDER INTERVIEW QUESTIONNAIRE

Essential services

- Provision or availability of service
- Adherence to Sops/Guidelines/protocols
- Availability of Support systems and structures

The essential services captured in the study are as follows

- HTC Services
- Maternal and Newborn and PMTCT services
- Child Health and Nutrition services
- Family Planning Services
- Point of Care testing (below hospital level)
- Oral Health
- Immunization and Surveillance
- Health promotion
- Mental Health

Human Resources

- Established positions
- Filled positions
- Vacant position
- Staff appraisals
- Job satisfaction

Protocol/Guidelines/SOP

- Availability of guidelines/protocols/sops
- Usage of the guidelines and protocols

Records and Information Management

- Availability of key personnel
- Collection and usage

Logistics and Supply Chain Management

- Support structures (store rooms etc)
- Adherence to guidelines (FEFO)
- Availability and incidence of stock outs
- PMIS and usage/adherence

Administration and Planning

- Availability of infrastructure

Community Health Worker Programme

- Job description
- Support from the health centre
- Incentives

Finance and accounting

- knowledge, control and understanding of budget

APPENDIX V: CODING

Binary Questions

Yes	1
No	0
N/A	2
Missing	99

Adherence Rate

Poor	1
Fair	2
Good	3

District

Berea	1
Botha –Bothe	2
Leribe	3
Mafeteng	4
Maseru	5
Mohale'shoek	6
Mokhotlong	7
Qhacha's Nek	8
Quthing	9
Thaba-Tseka	10

Proprietor

CHAL	1
Red Cross	3
Government	2

APPENDIX VI: ADDITIONAL FINDINGS

Health Promotion

Figure VI.1. District Health Facilities Ascertaining Providing Education on Correct Use of Medication

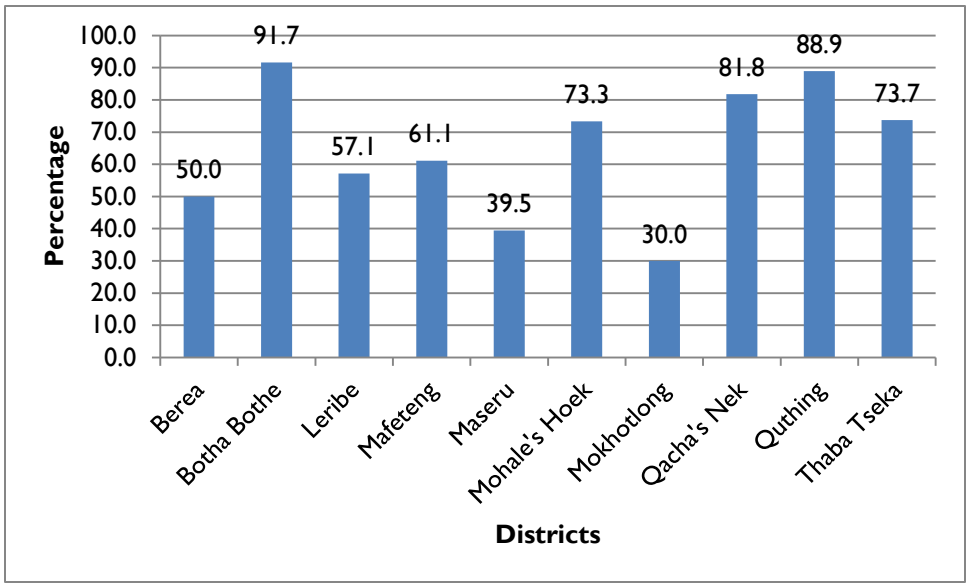


Figure VI.2. District Health Facilities Ascertaining Providing Education on Education on Healthy Lifestyle

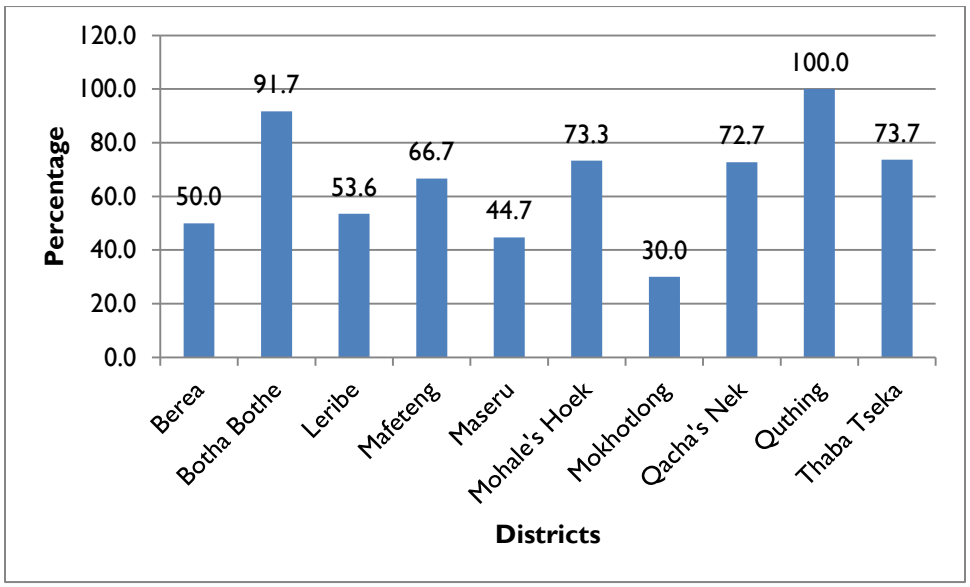


Figure VI.3. District Health Facilities with Emergency Treatment Available

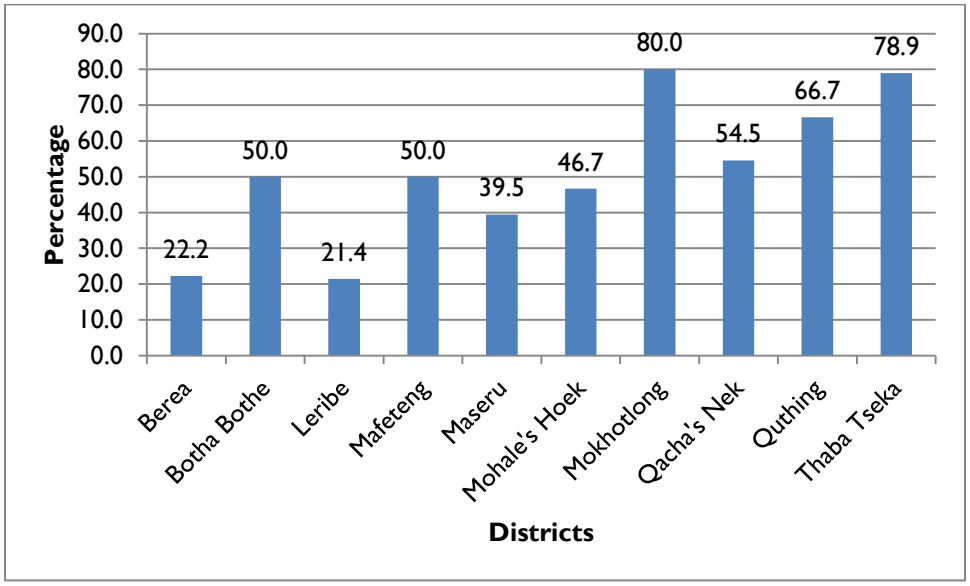
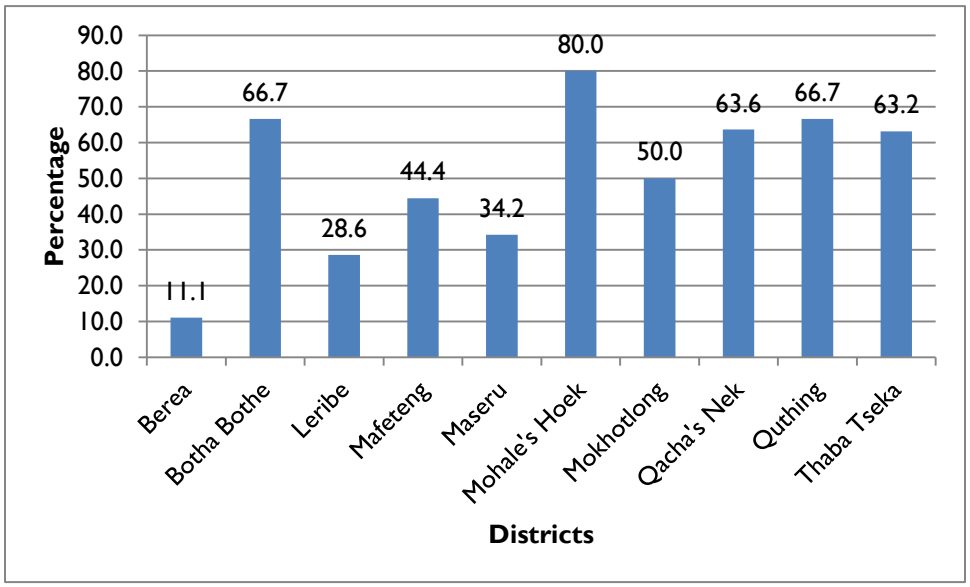


Figure VI.4. District Health Facilities with Individual or Family Couseling Available



Community Health Workers

Figure VI.5. District Health Facilities with an Acceptable Method of Incentive Disbursement to CHWs

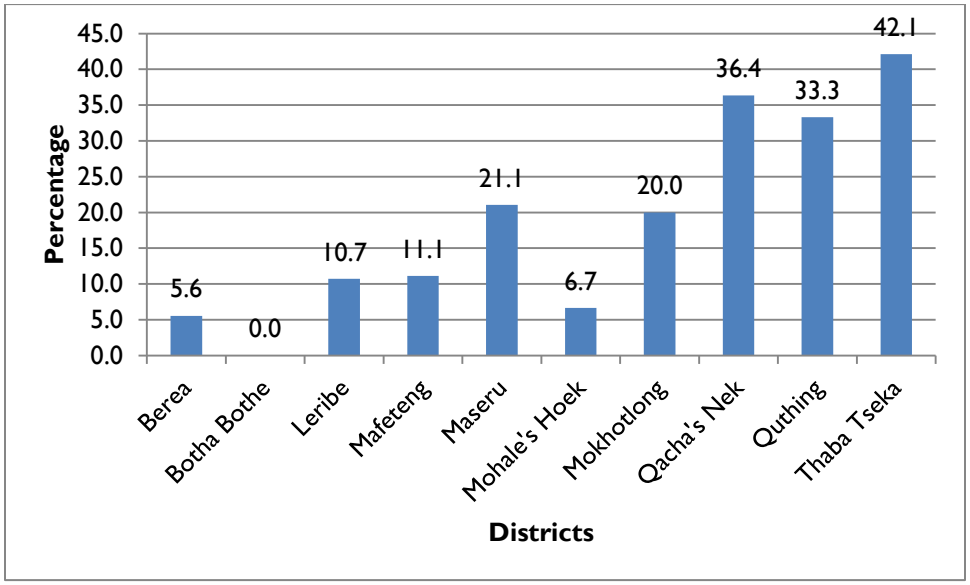


Figure VI.6. District Health Centers with Personnel who Provide Regular Support to CHW

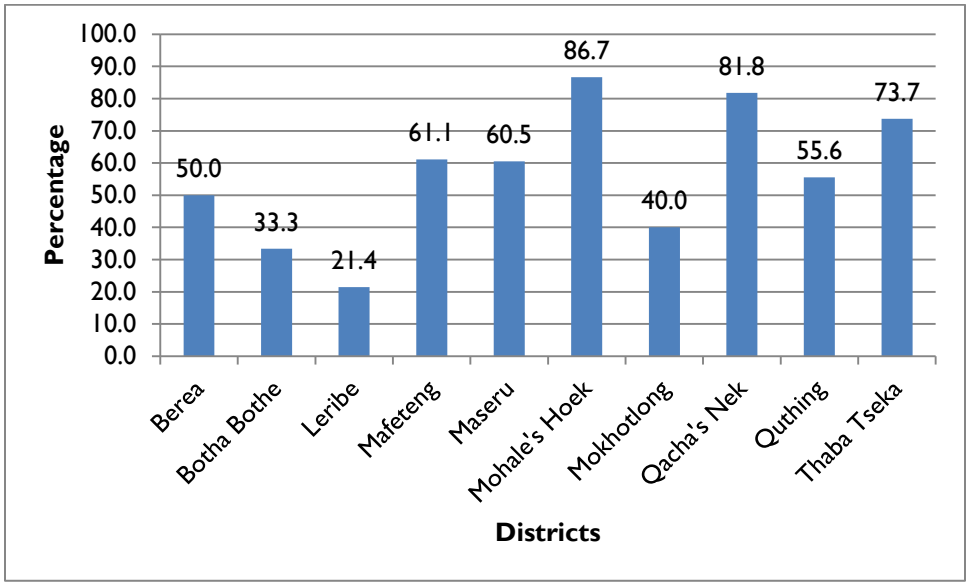


Figure VI.7 District Health Facilities with the Pharmacy Managed by a Pharmacy Tech

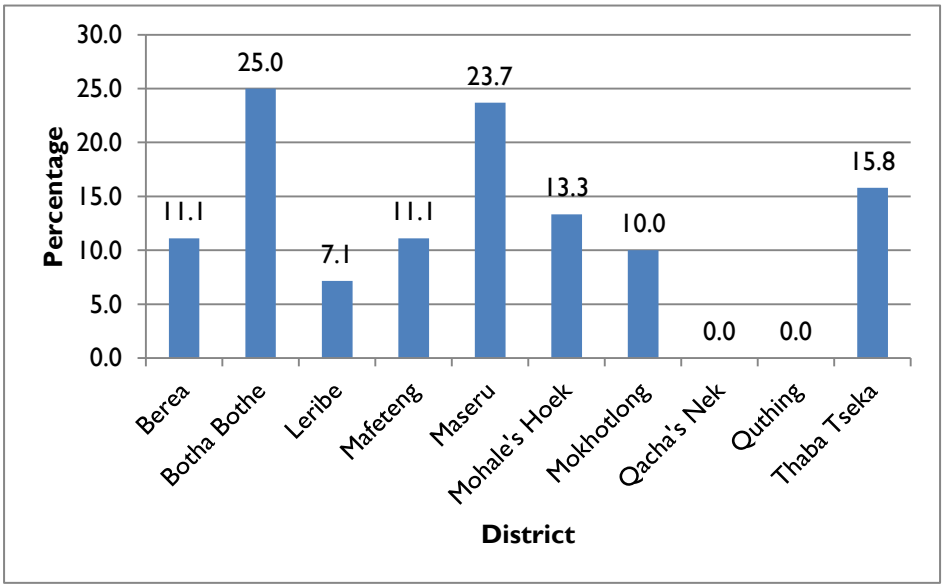


Figure VI.8 District Facilities with Medication Storage Room Inaccessible to Unauthorized People

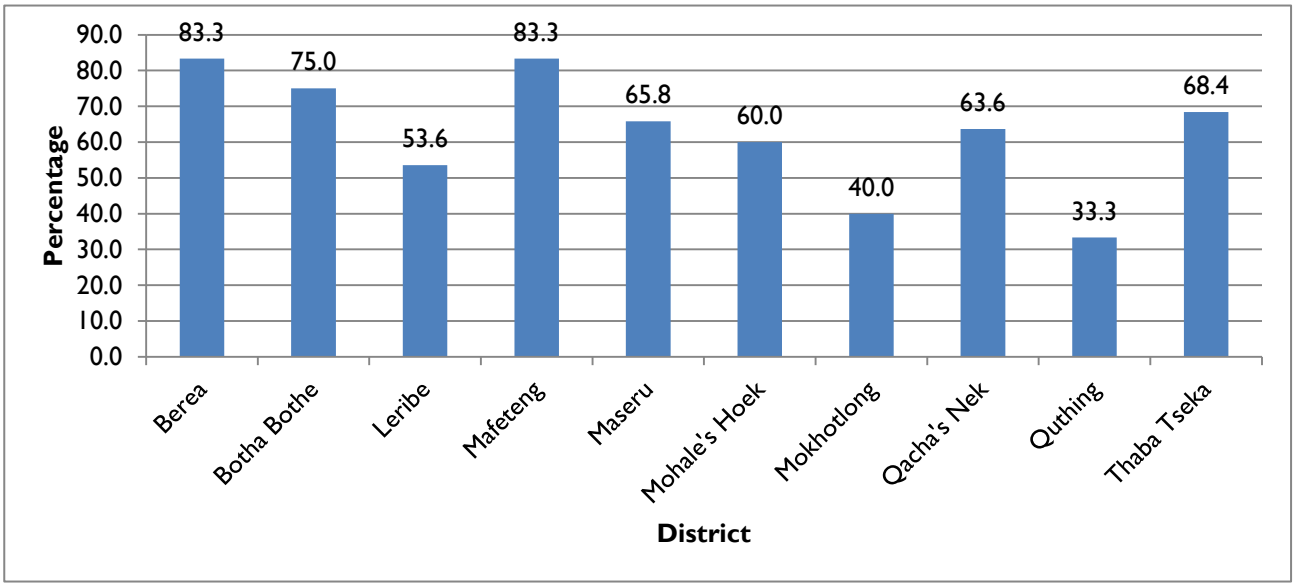


Figure VI.9 District Health Facilities with Medication Storage Roomed Locked at All Times

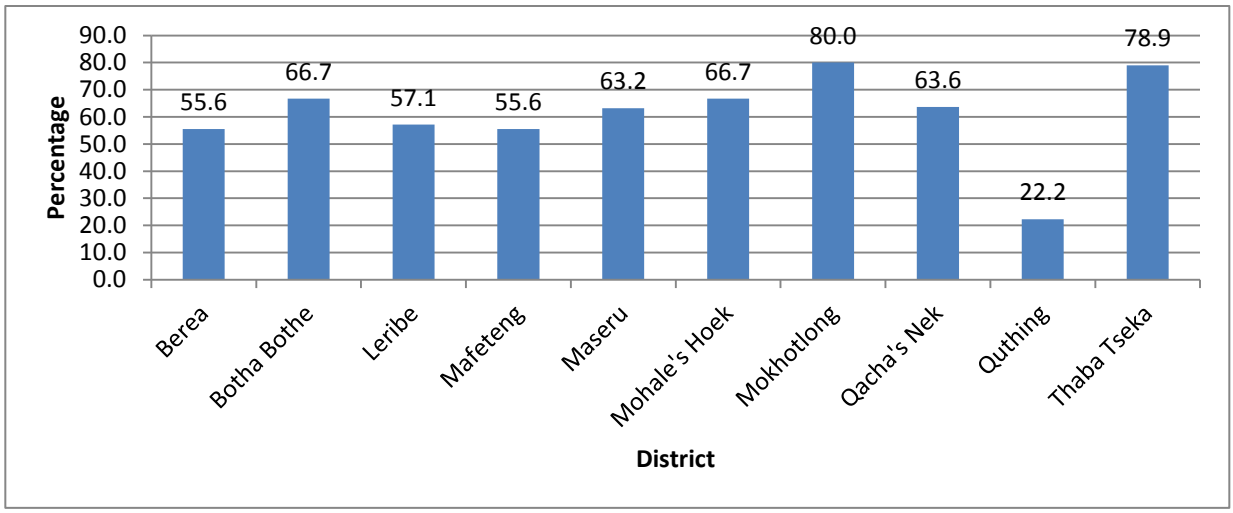


Figure VI.10 District Health Facilities with the Storage that Has a Separate Area to Keep Expired Items

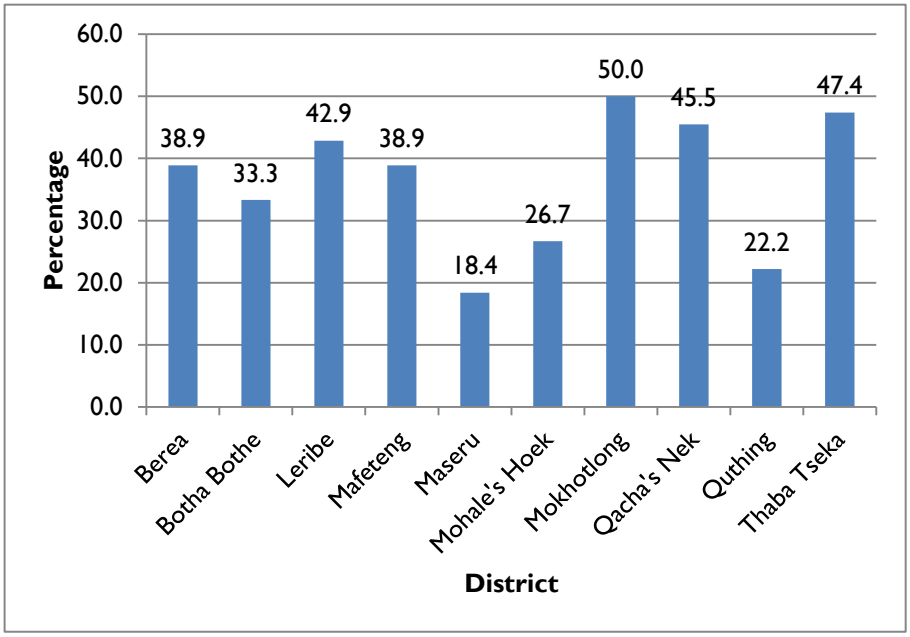


Figure VI.11 District Health Facilities with Bins Up-to-date

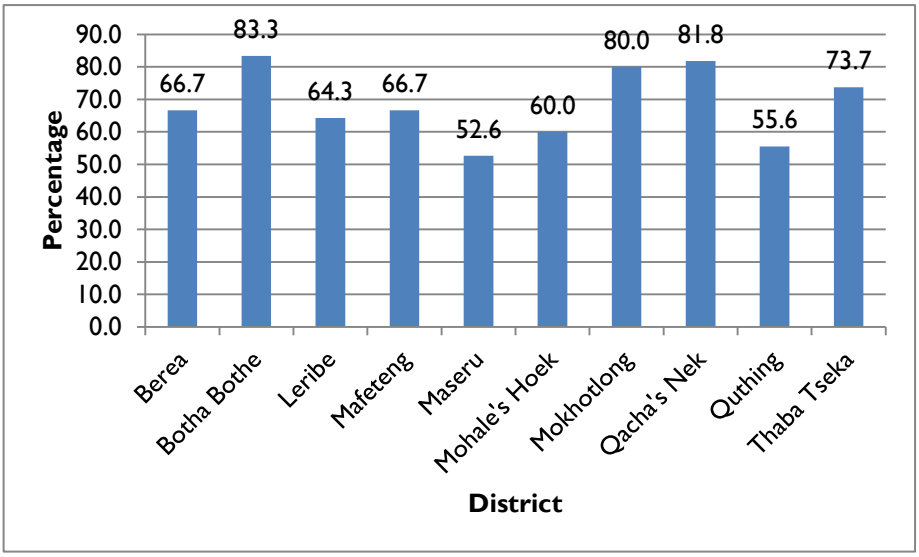


Figure VI.12 District Health Facilities with Bins Correctly Filled for All Items