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LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Anti-natal Care
ARI	Acute Respiratory Infections
ART	Antiretroviral Treatment
ARV	Antiretroviral
CBOs	Community Based Organizations
CBDs	Community Based Distributors
CHAL	Christian Health Association of Lesotho
CHWs	Community Health Workers
DCU	Disease Control Unit
DHMT	District Health Management Team
DHP	District/Essential Health Package
DHS	Demographic Health Survey
DOTs	Direct Observation Technique
DRA	Drug Regulatory Authority
EDF	European Development Fund
EPI	Expanded Program on Immunization
EMU	Estates Management Unit
FC	Financial Controller
FMC	Financial Management Committee
FMU	Financial Management Unit
FMIS	Financial Management Information System
FHD	Family Health Division
FP	Family Planning
H/C	Health Center
HCT	HIV/AIDS Counselling and Testing
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPSU	Health Planning and Statistics Unit
HRD	Human Resource Development
HSA	Health Service Area
IT	Information Technology
IEC	Information Education and Communication
IMCI	Integrated Management of Childhood Illnesses
LFDS	Lesotho Flying Doctors Services
HSRP	Lesotho Health Sector Reform Program

M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
MPS	Ministry of Public Service
MOU	Memorandum of Understanding
MTEF	Medium-term Expenditure Framework
MOFDP	Ministry of Finance & Development Planning
NHTC	National Health Training College
PAU	Project Accounting Unit
PD	Pharmacy Department
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PU	Procurement Unit
PS	Principal Secretary
RHSP	Rural Health Service Project
RSA	Republic of South Africa
STIs	Sexually Transmitted Infections
TB	Tuberculosis

EXECUTIVE SUMMARY

The process of developing an MTEF for the health sector started over three years ago. It has been a learning process for all the programmes of the Ministry including the management team as well as other partners in health and social welfare, particularly CHAL. Initial attempts had to involve extensive consultations with the MOFDP as a system was being developed that would accommodate the data needs at this level as well as data needs at the MOHSW level.

The guiding principles for developing the 2005/08 MTEF were the national policies and objectives as they are outlined in the PSRP and vision 2020 documents, which highlight poverty reduction and effective implementation of the PHC strategy. Development of this MTEF was also guided by the three-year operational plans which form the closest representation of the needs identified at the community level. Various assessment undertaken during the capacity building phase of the HSRP provided a much needed foundation for evidence based planning.

Although the health sector has a number of strengths the current challenges facing the sector far outweigh the strengths. Much of the MTEF objectives are geared towards improving health service delivery systems to the minimum acceptable level of quality. Areas of expansion are in the implementation of HIV/AIDS strategies which were being implemented in selected areas around the country. Here one is referring specifically to the ARV roll-out, expansion of PMTCT, VCT etc. Decentralisation also entails expansion of services.

The main objectives outlined for implementation during the MTEF period can be summarised as:

- Decentralisation/ service delivery
- Decentralised Management
    1. Human Resources
    2. Pharmaceuticals
    3. Monitoring and evaluation
    4. Contractual arrangements and outsourcing
    5. Forging Partnerships in health & social welfare
- Social Welfare
- Sector financing and financial management
- Infrastructure development and maintenance

The total budget requirement, available resources and resource gap for the 2005/08 MTEF are summarised in the table below.

	Recurrent	Development	Grand Total
Total Requirement	1,130,820,307	838,603,349	1,969,423,656
Available Resources	855,899,989	166,751,315	1,022,651,304
Resource Gap	274,920,318	671,852,034	946,772,352

The total budget for the MTEF is representative of what the sector perceives as the priorities for the next three years. However given the existing absorptive capacity and insufficient human resources at the operational level the MTEF plan may have to be scaled down so that it accommodates systematic weaknesses that can only be eradicated overtime

CHAPTER 1

INTRODUCTION

Background & justification

This document is a product of several initiatives undertaken within the health sector to facilitate a costed sector plan or medium term expenditure framework, which is linked to the overall Policy and strategic plan of the MOHSW. The need to develop a three-year plan as opposed to costing the strategic plan as it is, derives from the fact that the needs of the sector as articulated in the strategic plan far outweigh the resources that could be made available. Hence, developing the Health sector MTEF, involved a conscious effort on the part of the MOHSW and other health partners to focus on the key priority areas of focus for the next three years.

Since reform was a direct response to institutional inefficiencies in the Health Sector one of the key outcomes of this process is efficient use of scarce resources and more importantly responsiveness of health sector strategies to the needs identified at the community level. Hence, one of the key triggers for support and continuation of the reform initiative was the adoption of a system of budgeting that would facilitate linkages between Ministerial objectives and the budget. This link is not only in the formulation of plans and budgets but also in reporting financial progress against physical progress.

Objectives of the MTEF Process

The MTEF is a direct product of sector financing and financial management aspect of the reforms. Specifically, financial reforms were undertaken to improve allocative efficiency and equity, ensure sustainable financing for the sector and generate appropriate financial information for decision makers at all levels of the health and social welfare system. In itself the MTEF cannot guarantee achievement of all these objectives. It is however a significant stepping stone towards realising these objectives.

The sector medium term expenditure framework was developed to facilitate:-

- Effective resource mobilisation
- Rational allocation of resources between sector programmes
- Integration of the planning and budgeting functions
- Integration between the recurrent and capital budgets
- Continuous prioritisation of strategies undertaken by the MOHSW

The document thus aims to outline the key sectoral objectives and activities to be undertaken during the MTEF period, 2005/08 as well as to provide an analysis of the total resource requirements, available resources and the total resource gap for both the recurrent and development budgets.

Overview of Methodology

Development of a sector MTEF commenced in 1999, it has been a continuous learning process not only for the MOHSW but also for our health and development partners. The process was significantly stalled by the absence of a sector policy and strategic plan, which were finalised in 2003.

A planning cycle was developed as an attempt to integrate the planning and budgeting processes. As part of the effort to ensure that a complete, MTEF is available for appraisal by January 2005, meetings were arranged with management teams of programmes of the Ministry of Health and Social Welfare. All programmes were trained on the use of the budgeting system but none of the budgets were based on clear plans that integrated both capital and recurrent inputs. In 2004 a different approach was adopted where emphasis was placed on the responsibility of the programme Management Team for both the programme 3-year plan and budget. Moreover, the approach that was adopted was more hands-on where programmes, especially the districts were visited and actively assisted in developing their plans. This development of plans was paralleled with assistance in budget formulation.

The sector MTEF was consolidated based on submissions from the programmes as well as recommendations emanating from the various studies undertaken during the capacity building Phase of the HSRP. A process of consensus building on the MTEF objectives was undertaken in October 2004.

Some key limitations in developing the sector MTEF

- Lack of capacity for costing meant that most aspects of the plan had to be costed at the central level
- Though the needs of CHAL have been included in the MTEF, consultations with CHAL were highly limited
- Introduction of a new system of budgeting by the MOFDP meant that the budget had to be done twice and hence effort had to be divided between refining the sector MTEF and completing budgets as per requirement of the MOFDP
- Since there are no sectoral indicative capital/ development budget ceilings from the MOFDP for the three years, an assessment of the actual resource gap may be over or understated. Moreover, the budget for 2005/06 is yet to be approved thus the MOHSW is anticipating further cuts thus expanding the resource gap for this year
- The budget system used by the MOFDP is still very much item based such that success in liking budgets to objectives was impossible and assumptions had to be made in most cases
- The MOFDP system also limited the ability to integrate the recurrent and capital budgets such that it is evident what the total requirement for each programme is. Thus the recurrent and capital requirements have not been successfully integrated

Structure of the Document

The following chapters provide a description of the current situation in the health sector as well as an outline of the strategies to be implemented during the MTEF period. The activities and strategies are outlined in chapter three. Budgetary information is outlined in chapter four while chapter five summarises the key conclusions

CHAPTER 2

COUNTRY CONTEXT

Introduction

The following account provides a description of the national policy framework within which the MOHSW operates and therefore the context within which the MTEF was developed. The chapter outlines the national and health sector policy frameworks, as well as providing a brief analysis of national health financing systems.

The National Vision

The national vision is that by the year 2020 Lesotho shall be a stable democracy, united, prosperous nation at peace with itself and its neighbours. It shall have a healthy and well-developed human resource base. Its economy will be strong, its environment well managed and its technology well established.

National Policy Framework

Like other developing countries poverty in Lesotho remains a significant concern for the government, hence within the guiding national policy documents the broad strategies are geared towards poverty reduction. The strategies are designed such that the principles of equity, efficiency and sustainability are promoted. These broad objectives have been clearly articulated in the National PRSP and Vision 2020 documents. The national development objectives include improved and equitable access to essential services/goods such as food, health, education, water and sanitation, as well as scaling up the response to HIV/AIDS. Current policies are also aimed at increasing employment, developing infrastructure and the industrial base. The intention is also to improve resource mobilisation, management and use of resources, as well as budgeting systems.

One of the current initiatives being undertaken by government with a view to promote efficiency in the use of scarce resources is the civil service reform, which is geared towards optimising human resources development, management and use. This initiative is particularly relevant for the health sector because of the problems relating to failure to retain the crucial health service skills, particularly medical doctors and nurses as well as improving quality of care through effective performance appraisal systems.

Decentralisation is another significant initiative that the government intends to undertake with a view to promoting the timely responsiveness of public services and therefore efficiency.

Health Sector Policy Framework

The Goal

The goal of the Health & Social Welfare sector is to have a healthy population, living a quality and productive life by 2020 by facilitating the establishment of a system that will deliver quality health care efficiently and equitably and that will guarantee social welfare to all.

The health sector policy and strategic plan derive directly from the broad government objectives outlined in the Vision 2020 and PRSP. The MOHSW Policy outlines the major health and social welfare priorities and also indicates the policy measures required to achieve the objectives of these priorities. The policy is dynamic and will

be regularly reviewed as the health and social welfare system evolves to adjust to the prevailing environment

The strategic plan was the key guiding tool for developing the sector MTEF. The objectives of MOHSW as outlined in the policy and strategic plan are:-

- To make health care available, affordable, acceptable and responsive to the needs of Basotho particularly to the most vulnerable, and by so doing reduce the inequalities in health and social welfare.
- To provide an essential health service package that is affordable and will have the greatest impact on reduction of morbidity, mortality, misery and human suffering.
- To extend health coverage by constructing and upgrading health facilities and equipping them with the requisite equipment and human resources, and ensuring that resources are used efficiently and affectively.
- To form partnerships with multilateral and bilateral agencies, private for non-profit organisations, especially CHAL, and private for profit agencies, to improve the health status and social well being of the population for socio-economic development.

Health Sector Reform

The HSRP is one of the main initiatives undertaken as part of an effort to promote efficiency and has been on-going since 2001. The reform initiative cuts across all the programmes of the health sector as it is geared towards rationalizing existing management systems and implementing effective guidelines and protocols so that basic service delivery standards are met efficiently. Health sector reform incorporates restructuring of all the elements of the sector including those related to control and management of pharmaceuticals, human resources, infrastructure development and institutional management capacity for the health sector. Primary Health Care remains the cornerstone of service delivery therefore the Ministry has also undertaken to define the essential services package, which incorporates all the elements of PHC. Decentralization is another important initiative under the Health Sector Reform programme.

Health context

Increasing poverty, declining public health expenditure in real terms, and the AIDS pandemic are currently the greatest threats to health status in Lesotho. Infant and under five mortality rates have increased by 33 percent and 38 percent respectively to 80/1000 and 113/1000 live births over the past 5 years. Disease conditions such as tuberculosis, malnutrition, diarrhoea, acute respiratory infections, pregnancy related complications and AIDS, continue to contribute significantly to morbidity and mortality patterns Although vaccine preventable diseases such as measles, diphtheria, tetanus, peruses and polio have been contained due to sustained high immunization coverage of the early 1980s, there is a threat of these diseases re-emerging in epidemic proportions due to the declining coverage witnessed in the 1990s.

The sector is also plagued with run down infrastructure, insufficient health personnel, particularly nurses and doctors. Financial resources are limited and are diminishing in real terms, this situation is aggravated by inefficient use and management of key health inputs such as drugs and other medical supplies. Table 2.1 below provides a

summary of the key indicators.

Table 2.1 Key health and demographic indicators for Lesotho Formatted

Indicator	Value	Source
Population	2,333,846	Population data sheet: 2002
Infant mortality rate	81/1000	LDS, 2001:Vol 1
Maternal mortality rate	419/100,000	LDS, 2001:Vol 1
Crude birth rate	30/1000	1996 Census
Life expectancy	Females 56.3 Males 48.7	LDS, 2001:Vol 1
Access to health	Urban: 35% Rural: 11%	CWIQ 2002

Financing Health Care

The total health budget ranges between 7% and 7.5% of total government expenditure. On average, 82% of the total Health & Social Welfare budget comes from the government while the other 18% is from external sources. The average per capita government expenditure on health is USD 26.50 while as a percentage of GDP total health expenditure is on average 6.11%. In 2003 total health expenditures represent 6.4% of the GDP of the country. Of these health expenditures, 57% was from the Government of Lesotho (GOL), with the remainder from partners, and households.

Government tax funding plays a significant part in the financing of service delivery. Patient user fees are the most prominent form of health financing but this revenue is reverted to the Central Treasury at the Ministry of Finance & Development Planning and thus does not add direct value to the Health Sector. Non-for-profit health providers are an exception to this procedure. Although a patient user fee exemption system is in place, the systems for this are still underdeveloped. Official exemptions are granted on the basis of socio-economic status, type of illness as well as patient demographic details.

Future Prospects for Health Care Financing

One of the key government priorities in the next three years is to reduce the debt burden, which currently rests at 3%. This focus limits the potential for allocating additional funds to the social sector including health. The expectation is that over the period 2005/08, public expenditure will be targeted at high priority activities as identified in the Poverty Reduction Strategy Paper (PRSP) and enhancing operational efficiency. The implication is that to ensure sustainable provision of health and social welfare services great effort has to go into ensuring efficient use of scarce resources by adopting the most cost effective strategies and the health sector will need to undertake aggressive resource mobilisation strategies.

Budgetary process and financial management

The GOL budget cycle runs from April to March of the following year. In 2003/04 the MOHSW budget outturn was 101% (MOFDP data for 2003/04) for the recurrent budget and 70% for the capital budget. This disparity between approved budget and actual expenditure is mainly due to inefficient financial management systems where financial reporting is not adequately linked to physical progress reports. Moreover disbursement mechanisms tend to be very long and tedious such that at a particular point in time it is difficult to say exactly how much has been spent or committed. The end result of this is that by end of year the MOHSW still has some outstanding debts,

which have to be financed through the new budget, because of the cash accounting approach used by government. These factors impact greatly on resources actually available for use in a given year and on how these resources are used.

The capital budget is prone to under-spending. Much of what is termed capital budget is in fact recurrent in nature but is called capital because it is donor funded. The main reason for under-expenditure of the capital budget is the lack of absorptive capacity, which can be attributed partly to the vertical administrative planning for PHC programmes. In this vertical system, planning and budgeting for all programmes takes place at the central level for the district level. The lack of capacity to coordinate and manage planning processes and implementation of these plans and budgets means that even when resources are available, more often than not they do not reach the intended beneficiaries at the district level. In fact, budgets often get as far as the central programme and have to be returned at the end of the financial year, as they have not been spent. The current initiatives towards decentralisation and rationalisation of role and responsibilities between the central and district level should go a long way to improving this situation.

CHAPTER 3

MEDIUM TERM EXPENDITURE FRAMEWORK 2005/08

Introduction

As indicated in chapter one the process of developing the sector MTEF involved extensive consultations with all the programmes of the Ministry. The focus in this chapter is to provide a snap shot of the prevailing situation in the health sector, focusing on the key challenges and strengths as identified by the programmes. A description of the way forward in terms of the broad strategies to be implemented during the MTEF period is also provided.

The current situation

Review of the HSRP in November 2003 revealed that all the priorities identified at the beginning of the reform programme are as relevant today as they were four years ago. It was also evident that implementation of the reform programme was somewhat fragmented and in most instances quite remote from the regular activities of the Ministry, especially at the operational level. One of the key challenges in for the MTEF period, is ensuring that the approach is more integrated and comprehensive such that the value generated through the HSRP actually impacts on the operational level of the sector. Though the focus in the next three years will be on testing systems and protocols developed during Phase I, this will not preclude implementation of some good practices in the non-pilot areas. Generation of the areas of focus for was geared towards developing an approach that is more integrated.

The need to strengthen the referral system means that facilities in the district and mountainous areas require various forms of resource injections, more so now than was necessary five years ago. Problems of insufficient human resources, coupled with inadequate resources for the provision of equipment and other vital inputs for effective service delivery are some of the factors that have limited the ability of the Ministry to construct additional clinics in those areas that are historically underserved.

Maintenance of equipment has been one of the key shortcomings in the ministry, to an extent that almost all the health facilities are functioning at dismal capacity, especially the national referral hospital QEII. This problem has been aggravated by continuous budget cuts in the past coupled with freezes on special expenditure in the past two years. These factors have contributed to the deterioration in the quality of services provided by health facilities around the country.

Specific details on the strengths and challenges faced by the Health Sector are outlined in table 3.1 below.

Table 3.1 Strengths and weaknesses in the Health Sector

Area	Strengths	Challenges
Policy and Planning	▪ Sector policy and strategic plan have been developed ▪ M&E policy and strategic plan developed ▪ ICT policy and strategic plan developed ▪ Data collection, analysis manual and curriculum developed ▪ Statistical tables produced for 2003 ▪ MOU between GOL and CHAL drafted	▪ To provide an effective framework for strategic policy review, formulation and planning ▪ To determine appropriate performance indicators ▪ To strengthen HMIS and use data for effective planning, management and service delivery ▪ To strengthen disease surveillance ▪ To provide effective supervision and guidance to the district level ▪ Coordinated implementation of priority strategies with NGO's
Service delivery	▪ Availability of well defined programmes (DHP) ▪ Progress in forging a formal partnership with CHAL ▪ Restructuring of the HMIS	▪ Linking poverty and HIV with service delivery requirements ▪ Develop and implementation integrated PHC strategy ▪ Implementing an integrated approach to sector priorities ▪ Costing the DHP to facilitate rational allocation of resources ▪ Inadequate infrastructure for service delivery in general and HIV/AIDS services in particular ▪ Strengthening the referral system ▪ Institutionalising effective exemption systems ▪ Effective treatment and follow-up of TB patients ▪ Strengthen health education with a particular focus on school health ▪ Fragmented management of and planning for pharmaceuticals, financing, decentralisation and M&E systems ▪ Services from CHAL not fully integrated ▪ Drug shortages due to unpaid bills ▪ Improve dispensing practices in all health facilities ▪ Mountain areas are acutely under-served ▪ Under-utilisation of facilities due to inefficiencies ▪ Improve capacity of district health facilities to prevent unnecessary referrals to QE II ▪ Capacity for routine pap smears for cervical cancer is not utilised ▪ Revitalise specialist visits to district hospitals by psychiatrist, gynaecologist and surgeon ▪ Finalise definition of catchment areas ▪ Develop an efficient transport system to allow for efficient PHC delivery at the district level ▪ Improve dental services at the district level ▪ Improve radiography services in district hospitals
Decentralisation	▪ Availability of a decentralisation strategic plan ▪ Three learning districts have been identified ▪ Members of the DHMT have been deployed to the 3 districts	▪ Clarify role and responsibilities between the central and district levels ▪ Build capacity for both levels to carry out their mandates ▪ Optimise community participation in planning processes ▪ Analyse and utilise facility data at the point of collection ▪ Creation of the relevant posts to support decentralisation ▪ Secure sufficient funding for implementing the decentralisation strategic plan ▪ Facilitate effective coordination and collaboration between the MOHSW and local government structures

Area	Strengths	Challenges
Human Resources	▪ Assessment of sector HR needs has been completed ▪ Sector HR strategic plan has been completed ▪ A directorate has been established for the department	▪ Develop staffing standards for facilities to facilitate appropriates skills mix for different levels of the health system ▪ Improve working conditions, particularly in the most remote area of the country ▪ Develop effective incentive systems (including for CHW) and career ladder to reduce attrition of health workers ▪ Improve management of medical doctors employed on contract basis ▪ Decentralise processes of filling vacancies, disciplinary action, promotions and transfers to the districts ▪ Review existing establishment lists and address the vacancy factor ▪ Develop sustainable systems for securing housing for health workers placed at the district level
Social Welfare	▪ Availability of trained personnel ▪ Social workers deployed in all ten districts ▪ Provide services to orphans, disable and destitute	▪ Inadequate resources to accommodate the rapidly growing demand for social welfare services ▪ Expand and refine the range of services provided to orphans, PLWD, vulnerable children and other clients ▪ Inadequate staff to meet the current demand for services ▪ Develop legislation for management of cases of abuse
Health Financing & Financial Management	▪ Process of linking sector objectives to the budget has been initiated ▪ All programmes have been sensitised to the need to prepare monthly expenditure and revenue reports ▪ Programme managers are more conscious of the need to manage their budgets ▪ Budgeting procedure standardised and user manual for working papers and data consolidation developed and implemented ▪ Some degree of budget management has been realised	▪ Develop effective resource mobilisation strategies ▪ Develop effective resource allocation strategies ▪ Strengthen financial management systems at the central and district level ▪ Improve budget formulation and management for programmes ▪ Improve capacity of the Finance department of the Ministry by filling vacant positions with qualified staff ▪ Financial Controller ▪ Develop a financing formula for CHAL ▪ Develop linkages between the FMIS and HMIS ▪ Review the established MOHSW budgeting system so that is in line with the latest requirements from the MOFDP ▪ Build capacity of the of the FMU to coordinate the budget formulation and management processes ▪ Revitalise the Financial management committee of the MOHSW
Infrastructure	▪ Availability of a sector infrastructure plan ▪ Rich literature with recommendations for efficient implementation of infrastructure and maintenance reforms ▪ Standard equipment list has been developed ▪ Hospital typology has been developed EMU strengthened through merger with RHSP staff	▪ Facilitate availability of basic equipment in the district hospitals and health centres ▪ Address structural defects in health facilities ▪ Address structural and equipment problems at QE II ▪ Strengthen maintenance systems throughout the sector ▪ Institutionalise service contracts for hospital equipment ▪ Arrange alternative accommodation for the national laboratory and provide essential equipment to meet diagnostic demands ▪ CD4 count machines to be strategically placed (regionally) to address demands made by VCT and ART programmes ▪ Improve communication systems, particularly communication at health centre level which requires two-way radios ▪ Construct adolescent health corners in hospitals ▪ Improve staff accommodation ▪ Procure ambulances for districts to serve referral between district hospital and Health Centres

Area	Strengths	Challenges
Pharmaceuticals	▪ Availability of skilled personnel at the central level ▪ Pharmacy technicians deployed at the district level ▪ Draft medicine policy is available ▪ Free drugs are provided for priority diseases	▪ Improve drug procurement and management systems to avoid shortages and stock outs ▪ Establish a drug regulatory authority ▪ Establish a drug fund at the community level ▪ Monitor consumption patterns- develop an electronic drug management system ▪ Institutionalise evidence based drug procurement to ensure responsiveness to established need ▪ Inappropriate drug storage facilities

Further details on the current situation in terms of strengths, weaknesses and way forward are outlined in the AJR document of November 2003 as well as AJR Report of January 2004. Given the institutional weaknesses within the health sector and the growing demand for health and social welfare services, the biggest challenge facing the MOHSW is to implement the various strategic plans and guidelines, protocols etc that were developed during the first phase of the HSRP.

Specific areas for implementation are summarise below:

i. Decentralisation/ Service delivery
   - Implement the DHP and decentralization in the three learning districts
   - Develop health legislation in line with the DHP and decentralization
   - Strengthen the national referral system
   - Implementation of treatment guidelines including guidelines for referrals to RSA
   - Streamline mandate of QEII management vis-à-vis MOHSW management

ii. Sector Financing & financial management
   - Improved budget formulation, management and execution
   - Strengthen billing, collection and exemption systems
   - Develop a comprehensive sector financing strategy
   - Rationalise resource allocation mechanisms
   - Facilitate evolution of a National Health Accounts for the sector

iii. Social Welfare
   - Develop and implement sustainable strategies for care of vulnerable groups (elderly, orphans, destitute and disabled)
   - Strengthen community based social welfare structures and initiatives
   - Develop clear monitoring and evaluation strategies for community based programmes

iv. Human resources planning, management & development
   - Produce and implement the MOHSW strategic plan
   - Improve HR management and development systems (organogram and clear job descriptions
   - Develop and implement strategies for speedy response (training and recruitment) to sector human resources needs

v. Pharmaceuticals supply & management
   - Strengthen drug management, regulation and quality assurance mechanisms
   - Development of legislation and implementation of the drug policy
   - Strengthen drug procurement and distribution mechanisms

vi. Infrastructure development & maintenance
   - Definition and institutionalisation of national equipment standards in accordance with the DHP
   - Strengthen facility management and preventive maintenance systems at the district level

- Strengthen the referral system as per recommendations of the *QEII Economic Analysis* and the *Health Study*

vii. Partnership & Donor Coordination
- Operationalise the Memorandum of Understanding and operating agreements between CHAL and GOL
- Establish working relations with selected NGO's working in health and social welfare
- Improve and sustain collaboration with sector development partners

viii. Monitoring & evaluation
- Integration of financial and health information systems
- Strengthen data collection, management and institutionalisation at all levels of the health system
- Improve communication networks at the HSA level

Annexure 1B (ii) provides the details of activities to be undertaken during the MTEF period as well as the indicators and budget for the development budget.

CHAPTER 4

MTEF BUDGET ANALYSIS

Introduction

The previous chapters have attempted to provide a description of the context within which the MTEF was developed, focusing on current financing patterns, the key problems currently faced by the Health Sector as well as the strategies to be implemented during the MTEF period. The following account provides an analysis of the resource requirement for realising the objectives outlined for the MTEF period. Specifically one looks at the requirement for the recurrent budget and the requirements for the development budgets as well as the resources gap.
Funding profile

Total budget requirements for the MTEF period

The total health sector requirement for the three year MTEF period is estimated at M1,969,423,656. Table 4.1 illustrates a breakdown of this total by recurrent and development budget and outlines resources available and the funding gap. The total resources available is the sum of total recurrent budget ceilings as provided by the MOFDP and total budget from projects that are currently on going.

Table 4.1

	Required	Available	Funding Gap
Recurrent	1,130,820,307	855,899,989	274,920,318
Development	838,603,349	166,751,315	671,852,034
TOTAL	**1,969,423,656**	**1,022,651,304**	**946,772,352**

Analysis of recurrent budget requirements

The requirements for the recurrent expenditure to support the three-year operational plans have been put together by all programmes and reviewed and revised by the MOHSW. The total recurrent budget requirement for the three-year MTEF period is estimated at 1,130,820,307. The 2005/06 recurrent budget bid is M352,000,000 compared with the approved budget for 2004/05, which was M260,933,550. Comparison of the revised expenditure requirements wit the notified ceilings shows a shortfall of recurrent funding of M82 million in 2005/06, increasing by M10 million to 92 million in 2006/07 and a further M8 million in 2007/08.

A summary of the ceilings and expenditure requirements is given on annex 1A Provides analyses of the recurrent ceilings and expenditure by Programme, Item and Sub- programme. Approximately three quarters of the shortfall can be attributed to two programmes, QE II and HIV/AIDS. Subjectively, drugs and dressings amounting to M38,000,000 make up nearly 50% of the shortfall. Other expenditure relating to the operation of health services accounts for a further M20,000,000.

Analysis of Development budget requirements

The total development budget requirement is estimated at M838,603,,349, available resource amount to M166,751,315 hence the resource gap is M671,852,034. The

available budget estimation is based on ongoing support from the GOL, ADB Health VI project, support from UNICEF, WHO, DCI, Global fund, World Bank, German government, Norwegian government.

The bulk of the development budget goes towards infrastructure rehabilitation and purchase of equipment for the health facilities. This is in-line with the intention of the MOHSW to strengthen the referral system and to assist CHAL in meeting accreditation standards. Moreover, Capacity building from Phase I of the reform programme resulted in expansion of existing departments and new responsibilities for health personnel hence training forms a significant part of the development budget. Two major projects have been included in the MTEF, namely construction of a new referral hospital as well as headquarters building for the MOHSW these two projects make up approximately a third of the total development budget. Table 4.2 provides a summary of the development allocation by the key areas.

Table 4.2 Development budget requirement and gap analysis 2005/08

Development Area	Requirement 2005/06	Requirement 2006/07	Requirement 2007/08	Total required	Total available	Total funding gap
Infrastructure development	18,520,000	76,170,000	158,500,000	253,190,000	57,800,000	195,390,000
Maintenance systems	52,725,000	75,510,083	39,544,000	167,779,083	32,290,000	135,489,083
Fiancial Management	560,000	858,000	415,000	1,833,000	0	1,833,000
Sector Financing	1,100,000	860,000	470,000	2,430,000	310,000	2,120,000
Partnerships	16,378,072	14,915,508	10,860,416	42,153,996	5,300,000	36,853,996
Contractual arrangements	110,000	80,000	80,000	270,000	0	270,000
Monitoring & Evaluation	17,371,000	1,837,000	521,000	19,729,000	10,490,000	9,239,000
Human Resources	6,660,000	9,390,000	7,800,000	23,850,000	16,840,000	7,010,000
Pharmaceuticals	1,543,000	3,499,000	1,374,000	6,416,000	1,278,000	5,138,000
Service delivery	63,103,960	98,574,057	123,201,867	284,879,884	24,678,221	260,201,663
Social Welfare	12,078,954	9,098,000	14,895,432	36,072,386	17,765,094	18,307,292
Total	190,149,986	290,791,648	357,661,715	838,603,349	166,751,315	671,852,034

Annex 1B provides further details on specific activities to be funded under the development budget.

CHAPTER 5

CONCLUSIONS

Given the systematic problems within the health sector, the fact that a three-year operational plan has been successfully developed by all the programmes within the sector, is an encouraging sign that all the stakeholders in the sector are committed to improving the environment in which operations take place.

The budget requirement is a reflection of the actual need of the Ministry, however in appraising the proposed sector MTEF one needs also to consider existing capacity to implement the strategies that have been outlined. Given the prevailing absorptive capacity and existing financial management systems one may find that the MTEF will require further refinement to take into consideration systematic inefficiencies that hinder efficient implementation, hence some of the strategies may have to be deferred until appropriate systems have been put in place. For example with decentralisation one would expect that budget management, including the donor budget will be controlled at the cost centre level, currently however the systems are still under developed. Capacity building will therefor continue to be an important aspect. The challenge is to retain trained staff and ensure that whatever systems are put in place are sustainable and are periodically evaluated to ensure responsiveness.

One opportunity that the MOHSW can take advantage of is that the MOFDP has just embarked on a process of implementing a public sector MTEF in all the Ministries. It is anticipated that this move will facilitate more effective guidance in terms of ceilings and therefore more focused planning processes. Moreover, this move may provide the necessary support from the MOFDP, in terms of efficient financial management systems and appropriate reporting and budgeting formats