

CHAPTER 1: SITUATION ANALYSIS

1.1 Country profile

Lesotho has an estimated population of 2.2 million people. About seventy percent of the people live in rural areas. Annual population growth rates have declined slightly from 2.29% in 1966 to 2.10% to date (LBOS, 2000). The current growth rate indicates that Lesotho's population will double in 33 years. The population is youthful with 43% being under 15 years of age. Life expectancy is 45.1 years for male and 54.1 years for female. Male population proportion is 49.4%. Women in reproductive age (15 – 49 years) constitute 24% of the population. 52.1% of women attending antenatal clinics are below 19 years of age. Adult literacy rates favor women but are still low: for males the rate is 38% and for females 55% (GOL, 2003, National Population Policy). Dependency rate is 47%; that is all those who are under 15 years and over 65 years. Those over 65 years constitute 3.43% of the population (GOL/MCDI, 2000). The proportion of the elderly fell from 5% in 1970s to 3.7% in 1996, and is estimated to have gone up again (GOL/TWG, 2003). Total fertility rate (TFR) for Lesotho is currently 4.2.

The average household size is approximately five persons. The population is unevenly distributed with more than 70% residing in lowland region. This spatial distribution has resulted into high population densities. The population density in the arable lands more than trebled from 306 per square kilometre in 1976 to 988 per square kilometre in 1996. This has put a strain on the capacity of arable land, which is only 9% of total land mass.

Lesotho is prone to humanitarian crises such as drought, food shortage, insecurity, malnutrition, illness and unemployment. Limited employment opportunities in the country have compelled Basotho to migrate to look for employment. An estimated 32% of the male labour force has migrated to South Africa to work. This has resulted into 51.9% of all households being headed by women. Internal migration from rural to urban areas is common among females.

The mainstay of the economy had been remission of funds from Basotho migrants working in South Africa. This has changed as many migrants working in South Africa mines have been laid off. Now the South African Customs Union (SACU) is the major income earner for the country. Agriculture has been the traditional form of sustenance for

Lesotho. However, this is not yet developed enough to make a significant contribution to economic development. Efforts have been made to initiate small and medium-sized enterprises but these are in infancy. Other forms of economic activities being developed, also in their infancy, are tourism and mining. Other sources of livelihood are subsistence farming (22% of households), cash wages and salaries (17% of households), cash cropping and livestock sales (12% of households) (GOL/TWG, 2003).

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

1.2 The context of development

1.2.1 Previous development efforts

To address the problems brought about by an imbalance between population and economic growth, coupled with inequity, the Government took a number of measures to try and address the implications on the population. These measures include: Five year National Development Plans since 1970; the National Population Policy 1994 and 2003; Primary Health Care (PHC) policy adopted in 1979 with targets on maternal and child health; Poverty reduction strategy 2002; and Vision 2020.

1.2.2 Current poverty status

A medium term vision for Lesotho's development has been articulated in the Poverty Reduction Strategy Paper (PRSP) (GOL/TWG, 2003). Poverty has been defined by Basotho as "Powerlessness and exclusion, resulting in denial of access to basic human needs and lack of capacity to influence the direction of one's life".

The magnitude of poverty in Lesotho is big and is increasing. Poverty incidence is estimated to be 50%, poverty depth 21%, and poverty severity 15%. All poverty indices have taken a worsening trend (LBOS, 2002). Moreover, economic and social inequality in Lesotho is one of the highest in Africa. The Gini-coefficient (measurement of

inequality, where 0 is full equality and 1 full inequality) in Lesotho is 0.66 with district variations of 0.60 to 0.70. Inequities and poverty are more in rural areas.

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

The macroeconomic prospects are to be improved through the Poverty Reduction Strategy. The average economic growth of 8.2% experienced between 1997 and 2001 declined to 4.6% due to riots resulting from the elections held in 1998. Public debt stood at M6.8 billion in 2001. Lesotho has a high external debt/GDP ratio of 96.4%. 90% of Government revenue is used for debt servicing (GOL/BOS, 2001)

1.2.3 Poverty reduction strategy

The Government's economic plan is two pronged: first is to create a macroeconomic environment, which supports efficient production and attracts foreign and domestic investment. Second is to improve public sector performance by allocating resources to activities with the highest impact on poverty. The fiscal strategies include achieving budget balance (i.e. revenue to balance with expenditure), meet debt sustainability indicators, reduce public sector borrowing through additional concessional financing, improve the management of financial assets and liabilities, and ensure expenditure is targeted at national development objectives and priorities.

1.3 Health sector development

1.3.1 Health system development

Since 1966, successive Governments in Lesotho introduced various policies and programmes to improve the state of health of the people. The policies have had varying degrees of success. Some health indicators indeed significantly improved over time. These improvements have begun to be eroded over the recent 15 years due to AIDS, economic decline and unhealthy lifestyles.

The first attempt to undertake a systemic review and to revamp the health sector came with the adoption in 1979 of PHC as the strategy for health service provision. The cardinal feature of PHC was to bring services nearer to the people with their participation. A multi-sectoral approach to health service provision was also instituted in recognition of the fact that improvements in health status are not the sole responsibility of the health sector.

The introduction of Health Service Areas (HSA) concept was a major innovation intended to ease over-centralized administration and provision of health care. The country was divided into 18 HSAs based on catchment areas of existing hospitals. Community participation would be ensured through District Management Teams, HSA Management Teams and Health Centre Committees. A hospital in an HSA would form the highest level of referral. The hospital would then be responsible for the supervision of all health centres within its catchment boundaries.

The creation of a Nurse – Clinician cadre was another innovation to address the lack of doctors and of capacity in the nursing cadre. It was expected that this cadre would carry out medical functions of diagnosis, prescription of drugs and the usual nursing and midwifery functions.

The District Management Improvement (DMI) Project was introduced to improve the management capacity of the Ministry of Health and Social Welfare (MOHSW). It was directed particularly at the management of HSAs. The Community Health Worker Programme was introduced in 1980s to help communities access some of the basic health services. About 6,000 CHWs were trained. Physical infrastructure was rehabilitated through the Rural Health Services Project; Clinics Improvement Project; Population, Health and Nutrition (PHN) Project and Rural Health Maintenance Project. These projects targeted only Government facilities. The PHN Project also constructed Filter Clinics, which are intermediate hospitals.

Since 1979, cumulative progress has been made in the reduction of childhood mortality rate (CMR). The Expanded Programme on Immunization (EPI) and that of Control of Diarrhoeal Diseases (CDD) have been instrumental in reducing childhood mortality. EPI antigen-specific coverage ranges from 77% measles to 98% (BCG), while complete infant immunization coverage is 71%. CDD introduced widespread availability and use

of oral dehydration salt (ORS). Other achievements were made in nutrition and maternal health.

Programmes on TB control, Reproduction Health, Sexual Health and Family Planning, Mental Health, Environmental and Sanitation and Sexually Transmitted Diseases (STDs) made modest gains. However, sustainability of these gains remains a major challenge.

1.3.2 Trend of health status

1.28 All health gains in the past have begun to be eroded due to socio-economic difficulties and HIV/AIDS. The level of infant mortality (IMR) had fallen from 122 in 1976 to 74 in 1996. But IMR has gone up again to 81 with male children dying more at a rate of 88. Under-5 mortality rate (U5MR) has increased from 55 in 1986 to 113 in 2001. Maternal mortality rate has gone up from 205 to 419 per 100,000 live births. Life expectancy had reached 60.2 years in 1996, but is estimated to be 54 years (LBOS, 2001). Table 1 shows worsening trends of health indicators.

Table 1: Trends of Health Indicators

Indicator	1970s	1980s	1990s	2000s
Life expectancy	40	54	59	54
IMR/1000 live births	122	84	74	80
Child mortality/1000	-	34	34	38
U5 mortality/1000	55	-	-	113
Total fertility	-	5.3	4.9	4.3
Maternal mortality/1000 live-births	-	282	282	419

Source: Bureau of Statistics- Demographic Survey 2001

Other indicators have either stagnated or have shown a corresponding decline as the general trend. The demographic survey shows that 73% of households had access to safe water, but currently only 49% of those in mountain areas have access to safe water. Only 49.8% of households have toilets. The under five nutritional status is a good pointer of food security. 12% of children are wasted, 22% are under weight and 45.4% are stunted. The trend shows worsening child welfare. Vitamin A deficiency rate is 13.4%, the prevalence of goiter is 43% among school children and 7% in women of child-bearing

age. HIV/AIDS has worsened health indicators through its social economic impact. UNICEF estimates that there are 93,000 AIDS orphans.

Apart from the impact of HIV/AIDS, the number of vulnerable people has increased as a result of retrenchments, increasing poverty, and other causes of death of breadwinners.

1.3.3 Outstanding challenges

Major challenges have been identified in human resource development, infrastructure, inefficient dual system of health services, pharmaceutical supply and management, health financing, decentralization and monitoring systems.

Concerning human resource, procedures for personnel selection and recruitment, and procedures for staff induction and performance assessment are not routinely used. Job descriptions, codes of conduct, procedures for disciplinary measures or for conflict resolution require to be revised or updated. There is also lack of capacity to implement the procedures. In addition, human resource management decisions are highly centralized and bureaucratic. Salaries are low, working conditions are poor and the reward system is not rational. Staff attrition is quite high, and there are no mechanisms for staff retention. The Human Resource Development Department at MOHSW has recently been established and is not yet capacitated to discharge its functions effectively.

The health infrastructure consists of five categories of health facilities as summarized in table 2.

Table 2: Lesotho Health Facilities

Type	GOL	CHAL	TOTAL
Tertiary Hospital	3	0	3
Hospitals	9	8	17
Urban filter clinics	3	0	3
Health centers	96	75	171
Health posts	1	16	17
Total	112	99	211

Source: Health Planning and Statistics Unit, 2003

The main challenge with the health infrastructure is that QEII hospital is in a state of disrepair, since this is the only tertiary hospital, there should be consideration to build a

completely new facility. Other government institutions have already received attention although many facilities are already suffering from maintenance problems. CHAL institutions on the other hand have not been renovated as yet. The renovation of facilities should go hand in hand with proper maintenance plan. Currently facilities are underutilized due to a combination of state of disrepair in which they are and poor management of service delivery. The improved service delivery and improved facilities will bring the patients back.

Regarding pharmaceuticals, the key issues are the absence of a drug policy, inadequate legislation and regulatory authority on pharmaceuticals, inadequate and inefficient drug supply system, and non-rational use of drugs.

On health financing, while overall total health expenditure in Lesotho is fairly high (US20 per capita) compared to 10 US average for sub-Saharan Africa, the funds are inefficiently used, and not appropriately allocated. Inefficiencies arise from underutilization of health facilities, under-spending of budget allocations and mal-allocation of resources. Expenditure is heavily biased towards hospitals and urban areas.

Partnership with the Christian Health Association of Lesotho (CHAL) is a necessary strategy. CHAL provides about 50% of health services in the country. But GOL and CHAL health systems are not harmonized integrated or fully taking advantage of each other. CHAL facilities are experiencing financing difficulties due to inadequate cost-recovery through user-fees, and limited financing from the Government and donors. Through the GOL-CHAL partnership, CHAL health facilities now get grants from the Government to cover 20% of their recurrent expenditure and all salaries of their professional staff.

While efforts have been made to transfer functions such as planning to lower levels of administration and communities, there are no effective methods for a genuine community participation in health service management. The challenge therefore is for the local authorities and Ministry of Health and Social Welfare to ensure that mechanisms for community participation in health service are developed.

Currently the generation of health service data is incomplete and unreliable. The Health Management Information Systems (HMIS) is being revitalized. Data bases are being

created through surveys, information management systems are being set up and the Health Planning and Statistics Unit (HPSU) is being restructured to meet its tasks.

1.3.4 Social Welfare

Social welfare sector aims to alleviate human suffering and facilitate social economic development. It enhances the potential of marginalized groups to improve their quality of life. Social welfare include child welfare, youth services, care for people with disabilities (PWDs), support for mentally sick persons, prevention and management of substance abuse and probation services.

Currently, social services and support to vulnerable people is stretched thin and has left out many people in desperate need of support. A limited range of services is currently provided to a limited number of orphans, the elderly, PWDS, those who are terminally ill, and children in need of rehabilitation and protection.

A small number of orphans do get scholarship from the Government. The Government encourages foster parenting with preference given to relatives of a child. A limited support is also given to foster parents by the Government and NGOs. But the Department of Social welfare (DSW) lacks the capacity to identify all orphans, place them in appropriate custody and monitor their condition.

The number of elderly persons has increased and yet many of them find themselves burdened with looking after their grandchildren orphaned by HIV/AIDS. The Government provides a small needs-based public allowance to a limited number of the elderly. They are also exempted from paying medical fees.

PWDs get limited support from the Government in the form of vocational training, small start-up loans of M 2,500 per person. However, PWDs are usually unable to generate meaningful income from these small businesses. Assistive devices are also given to a limited number of PWDs as the devices are expensive. The challenge is to get more support and increase the coverage of those who qualify for support.

Child exploitation, abuse, neglect and abandonment appear to be on the increase. While institutionalized childcare is not encouraged, it may be necessary to establish government transit reception centers for abandoned children and those who have run away from home. Such centers can be used to keep the children until suitable foster parents are

identified or their parents have been counseled to take them back. Currently some NGO's own a few centres which receive minimal support from government. These centres lack resources and proper care for these children. They are not regulated and do not have a system for placement of these children.

CHAPTER 2: NATIONAL DEVELOPMENT FRAMEWORK

2.1 Development vision

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

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

Vision 2020 of Lesotho: The vision of the country is that **by 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.**”

2.2 Goal and Mission

The goal of the health and social welfare sector, which contributes to the vision of the country’s development, is **to have a healthy population, living a quality and productive life by 2020.**

The mission of the health and social welfare sector is to facilitate the establishment of a system that will deliver quality health care efficiently and equitably, and that will guarantee social welfare to all.

2.3 Objectives

The health and welfare objectives are therefore:

- 1. To reduce morbidity, mortality, misery and human suffering among the Basotho.**
- 2. To reduce inequalities in health and social welfare, and in access to health and social welfare services.**

3. To improve the health status and social welfare of the population for socioeconomic development

2.4 Core values

The following are key core values articulated in the Constitution of Lesotho and in the Vision 2020. They will guide the health sector policies: a) Unity and solidarity with one another; b) The spirit of sharing benefits and responsibilities; c) Respect of self and for others; d) Humanity in development strategies; d) Family bond and primacy of family unit; e) Gender sensitivity and responsiveness, and special consideration of women due to their special reproduction role; f) Transparency in activities, actions and resource use; g) Accountability for resources and actions; and g) Participation and involvement of communities and stakeholders; and h) Partnership with NGOs, churches, labour organizations and the private sector.

2.5 Guiding principles

2.5.1 Political Commitment: The Government is committed to poverty reduction and social welfare. This commitment will provide the critical guidance in priority-setting and resource allocation. Commitment to this policy will be required at all levels of political, civil and cultural leaders.

2.5.2 PHC Approach: The adoption of this approach since 1979 will be maintained. Emphasis will continue to be put on community participation, inter-sectoral collaboration, appropriate technology, disease prevention, health promotion through change of behavior and equity.

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

2.5.4 Accessibility and availability: Services shall be progressively extended to reach all communities in Lesotho. Special attention shall be given to the disadvantaged

regions and underserved communities in the country. Services shall be community based taking into consideration special socio-cultural circumstances.

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

2.5.6 Community involvement: Communities shall not be mere consumers of services. They will be actively encouraged and supported to participate in decision-making and planning for health and social services. Through ownership of community projects, communities will be masters of sustainable primary health care programmes in their own areas.

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

2.5.8 Acceptability: Social interventions will only be successfully implemented if they are acceptable to the people. Therefore people's participation will be sought in the identification, design and implementation of social programmes.

2.5.9 Sustainability: The ability for a service to continue into the future when external support aid has stopped is referred to as sustainability. New programmes will be subjected to sustainability assessment before implementation.

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

2.5.11 Inter-sectoral collaboration and partnership: Government and non-Government sectors will be consulted and involved in implementation, monitoring and evaluation of health and social services.

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

2.5.13 **Gender balance:** Gender sensitivity and responsiveness shall be applied in health and social service planning and implementation. Special consideration shall be accorded to women due to their generally lower status in the society and their special role in reproduction. Where men have been disadvantaged by lack of education, special effort will be made to support them.

2.5.14 **Ethics and human rights:** Health and social welfare workers shall exhibit the highest level of integrity and trust in performing their work. They will be guided by ethical guidelines, which will be enforced by professional councils. Health and social welfare service consumers shall be protected by legislation. Likewise, health and social workers shall be protected by legislation specifying their rights and channels of appeal.

CHAPTER 3:HEALTH AND SOCIAL WELFARE PRIORITIES

3.0 Rationale for priority setting

The country's disease burden overwhelms the available resources. It follows that the available limited resources will be used as prudently as possible to have the largest possible impact on disease burden. There are two ways to achieve this. One will be to target health problems and diseases with the heaviest burden. Two, only health care and social interventions with proven cost effectiveness will be used.

3.1 The District Health Package

The District Health Package (DHP), based on the Essential Health Package (EHP) concept, will consist of selected health interventions that address priority health and health related problems that result in substantial health gains at a low cost. The package should be affordable and funded by the Government and should cover the whole country. Lesotho's DHP will consist of the following interventions:

3.1.1 Essential Public Health Interventions:

3.1.1.1 Health Education and Promotion: The Government will run a campaign to change people's risky and unhealthy lifestyles. The behaviour change will be in respect of HIV/AIDS; consumption of animal fat, sugar and alcohol; tobacco and cigarette smoking; physical exercise; road safety; domestic violence; screening for common cancers; nutrition; child development and protection; adolescent health; family planning; maternal health and support to vulnerable groups.

3.1.1.2 Immunization will target TB, diphtheria, pertussis, poliomyelitis, tetanus, measles, hepatitis, and hemophilus influenza type B. Other diseases will be added as and when vaccines become available and affordable.

3.1.1.3 Nutrition programmes will target nutrition and diet behaviour and in-house food distribution; food support to the vulnerable; Vitamin A, Iodine and Iron supplementation; promotion of vegetable growing; hygienic food preparation; food security; school feeding programmes; and nutrition support for people living with AIDS.

3.1.1.4 Integrated Management of Childhood Illnesses: The Government will adopt a comprehensive approach to child health, taking advantage of every contact with a child. The priority will be to target common causes of illness and death such as pneumonia, diarrhoea and dehydration, and anaemia. Parents will be taught to recognize symptoms of child illness, what first aid or basic treatment to give and when to take a sick child to a health facility.

3.1.1.5 Environmental health: Government will promote environmental health by ensuring safe water and sanitation, vector control, occupational health and safety, waste disposal, food hygiene and port health.

3.1.2 Communicable Disease Control

3.1.2.1 HIV/AIDS: The Government has adopted a multi-sectoral approach to HIV/AIDS management. In the health and social welfare sector, the Government will promote voluntary HIV testing; facilitate care and support of people infected and affected by AIDS; de-campaign discrimination, fear and prejudice against PLWAs; promote and facilitate safe blood transfusion; facilitate counseling to all individuals and families; make parents play a key role in HIV prevention among children and the youth; promote human rights of PLWAs; change risky attitudes and behaviour of men and women; and promote the prevention of mother-to-child transmission of HIV.

3.1.2.2 Sexually Transmitted Infections: The Government will sensitize and educate communities on STIs; condoms will be distributed widely and their use promoted; safe sex will be promoted and health facilities will be equipped and staffed to diagnose and treat STIs.

3.1.2.3 Tuberculosis: The Government is aware of the resurgence of TB in the country and will intensify diagnosis, treatment, contact-tracing and follow-up of patients in combination with WHO's directly observed treatment short course (DOTS). Communities will be helped to notify and report suspected cases of TB, and community agents will be supported to supervise DOTS. Facilities will be equipped and staffed to diagnose and treat TB.

3.1.3 Sexual and Reproductive Health and Rights.

3.1.3.1 Reproductive health: The Government will respect people's choice to reproduce but facilitate safe, effective, affordable and acceptable methods of family planning, and access to appropriate care for pregnant women and infants.

3.1.3.2 **Safe motherhood:** The Government will promote safe motherhood by making reproductive services, including education and counseling available. Particular emphasis will be placed on preventing teenage pregnancy and post-abortion care.

3.1.3.3 **Maternal and infant nutrition:** Nutritional support and micronutrient supplementation will be provided to mothers and infants at home and in facilities. The Government and its partners will design and implement a programme on nutrition and nutritional support to vulnerable people.

3.1.3.4 **Adolescent Health:** The Government recognizes the problems of the youth, which include unemployment, substance abuse, school dropouts, mental illness and HIV/AIDS. The Government intends to mainstream youth services in the overall socioeconomic development. In the health and social sector this will be by reorienting services to target the youth; ensuring political and community appreciation and support for adolescent services; influence cultural and religious support for adolescent health and welfare; and management of HIV/ AIDS, STDs, substance abuse, school dropouts and mental illness among the youth.

3.1.3.5 **PMTCT and ART:** It is now possible to prevent mother to child transmission of HIV and for PLWAs to live near normal lives by taking antiretroviral drugs (ARVs). The Government will endeavor to make ARVs increasingly available. A specific plan for nationwide expansion of Anti Retroviral Therapy (ART) will be implemented as soon as possible. The Global Fund for HIV/AIDS and TB will be explored for the ART expansion program.

3.1.3.6 **Sexual and Reproductive Rights:** The Government will protect the rights for Family Planning decisions, for Information, Services, Sexual Security, Freedom from Sexual Violence, and for Sexual Privacy. This will be achieved through a combination of strategic communication for behaviour change, regulation and legislation.

3.1.4 Essential Clinical Services.

3.1.4.1 **Services for common illnesses:** The Government will identify and quantify the most common diseases and conditions through epidemiological profiling. The range of diseases will be considered for public funding. The intention is that as many as possible of all diseases in the country can be managed and afforded by individuals, the Government and its partners.

3.1.4.2 **Basic Dental Care:** The Government will promote primary prevention and treatment of common dental diseases. Efforts will be put to ensure that fluoridation of water supply is carried out. School dental health services as part of a wider school health programme will be developed and implemented. The size of the free or highly subsidized

curative dental service package will be determined by what the Government and its partners can afford.

3.1.4.3 Mental Health Services: The Government will decentralize and integrate mental health services through the orientation and training of Medical Officers; Intensify the training of psychiatric nurses; Promote community participation in the management of mental illnesses through client group formation, associations and networking; and Explore ways and means of reviving interest in the mental health professions.

3.2 Social Welfare Priorities

The priority of social welfare services will target the most vulnerable groups in society. These are children, youth, women, PWDs, elderly and adults living in difficult circumstances.

3.2.1 Child welfare: Under child welfare the Government will implement the following interventions: a) Child survival strategies include immunization, basic health services and IMCI; b) Child development includes proper growth, physical and mental development, nutrition and education; c) Child protection against sexual and physical abuse, sexual and labour exploitation, and against neglect and abandonment; d) Respect for the views of the child and promotion of child participation in national development; e) Care for orphans and other vulnerable children.

3.2.2 Youth Services: The Government will mainstream the youth in socio economic development by: a) Advocating for the promotion and encouragement of vocational education for the youth; b) Controlling and managing HIV/AIDS among the youth; c) Establishing adolescent health services; d) Preventing and managing substance /drug abuse; e) Preventing and managing crime and adolescent delinquency; f) Promoting and creating employment for the youth; g) Establishing places for safety and crisis management.

3.2.3 Services for Women: The Government recognizes the centrality of women in the economy and welfare of the society. The Government with the support of partners will: a) Provide economic, social and political opportunities to women and protect their rights; b) Prevent domestic violence and support and manage victims of violence. This will include sexual and gender based violence. Strategies for prevention of violence will include strategic communication through sensitization, media campaigns and legislation; c) Establish centers and systems for crisis (post-violence) management.

3.2.4 Services for adults in difficult circumstances: The Government recognizes a growing number of people are living in extremely difficult conditions. The Government will with the support of its partners endeavor to: a) Strengthen family welfare services; b) Provide support to homeless persons; c) Provide support to those in *Bakoao* (living rough); and d) Prevent and manage domestic violence.

3.2.5 Services for PWDs: The Government will provide support to PWDs in the following aspects: a) Vocational training; b) Provision of assistive devices; c) Provision of start-up loans; and d) Political and social empowerment.

3.2.6 Services for the Elderly: The Government will implement the following interventions in respect of the elderly: a) Provision of public assistance allowance; b) Support to elderly people looking after orphans; c) Support to associations of the elderly; c) Support to the terminally ill; and d) Probationary visits and support to households where there are elderly people.

CHAPTER 4: HEALTH SERVICES

4.1 Sexual and Reproductive Health and Rights

Reproductive health rights refer to people's freedom and ability to reproduce and to decide when and how often to do so. Both women and men should access safe, effective, affordable and acceptable methods of family planning. Women should access appropriate care that will enable them go through pregnancy and childbirth safely and ensure a healthy infant. Sexual health refers to the enhancement of life and personal relations whereby among others, counseling and care related to reproduction, are provided.

Policy objective: To make reproduction safe for parents and infants, and reproductive health services acceptable to individuals and the Basotho society.

Policy measures: a) Promotion of family planning and child development; c) Enhancement of safe motherhood through pregnancy monitoring, antenatal care, safe delivery and post delivery care; d) Promote adolescent health by addressing issues related to transmission of HIV/AIDS and STI's; e) Prevention of parent to child transmission of HIV/AIDS and STI; f) Implementation of legislation related to sensitization and education in respect of sexual and reproductive rights.

4.2 Child Survival and Development

Many children still die before their fifth birthday due to preventable diseases. More and more children are being orphaned. There are increasing cases of child abuse, exploitation and abandonment. Inappropriate early childhood management and poor parenting lead to poor physical and mental development of the child.

Policy objective: To ensure the survival, development and protection of all children and ensure children's views are sought and respected.

Policy measures: a) Integrated management of childhood illness shall be adopted as a strategy to tackle multiple causes and management of childhood mortality and morbidity conditions; b) Immunization will be strengthened to achieve at least 80% protection of all children under five years; c) Early childhood development strategy shall be used to give children the best chance for development and growth including guardian education and counseling; d) Protection and care of children who have undergone all forms of abuse; e) Promotion of child participation in social, political and economic development, f) Encourage and provide support to vulnerable children; g) Strengthen probation and welfare services at the community and household levels by establishing and recruiting

Auxiliary Social Workers (ASWs) and facilitating them to visit households to follow up cases of child abuse and ill children..

4.3 Nutrition

Malnutrition and micronutrient deficiencies among the general population have increased over the past decade. Protein Energy Malnutrition (PEM) is a major problem in children under five years. There are also serious deficiencies of micronutrients such as vitamins and minerals. Malnutrition leads to early death, frequent illnesses, poor cognitive capacity, and generally limits socio-economic development.

Policy objective: To improve the nutrition status of the population for socio-economic development. The specific objectives are to: a) eliminate childhood and maternal malnutrition; b) reduce micronutrient deficiencies.

Policy measures: a) Promote diet diversification and balance food distribution in the house, especially to children and mothers; b) Community and institutional ante-natal nutritional support; c) Facility based nutritional care and support to vulnerable children and mothers; d) Integrate nutrition counseling with PMTCT; e) Promote small-scale production of vegetables and poultry farming in households in collaboration with the Ministry of Agriculture; f) Work with the private sector to fortify foods with iodine, Vitamin A and iron; g) Develop a long term strategy for sustainable food security; h) Establish school feeding programmes in high-risks areas and communities in collaboration with the Ministry of Education and other relevant partners; i) Provision of food and nutrition support to households with severely malnourished children; and k) Integration of nutritional support for PLWAs in health, education and agricultural services.

4.4 Environmental Health

Environmental health services aim to address all potential and actual threats to human health and welfare. Environmental health is determined by physical, chemical, biological, social and psychological factors.

Policy objective: To influence environmental conditions that will enhance health and social welfare.

Policy measures: a) Equitable access to resources and the satisfaction of people's basic needs are fundamental to the concept of sustainable development; b) Environmental health interventions will involve education, promotion, advisory functions, inspection, monitoring and setting of standards; c) A multidisciplinary approach will be promoted to secure collaboration between different sectors; d) Review of different areas of legislation that impact on environmental health.

4.5 Emergency and Humanitarian Action

The country is prone to natural and manmade disasters, which predispose into humanitarian emergencies. The emergencies require a multi-sectoral response.

Policy objective: The objective of Emergency and Humanitarian action is to prevent and prepare for disasters, mitigate health and social consequences and to strengthen coordination and response to emergencies in collaboration with the Disaster Management Authority.

Policy measures: a) Ensure community and national level preparedness to manage and prevent disasters and mitigate their consequences; b) Training emergency humanitarian team, community members, and health and social welfare personnel in rescue work and emergency care; and c) Mobilization of local community, district, national and international support to accelerate rehabilitation of disaster victims.

4.6 Occupational Health

The protection of workers' health and welfare at the place work is an essential aspect of health policy.

Policy objective: To prevent the occurrence of occupational hazards and accidents, and to rehabilitate those who are injured or impaired by occupational hazards.

Policy measures: a) Establish a comprehensive, multidisciplinary and participatory approach to occupational health prevention and hazard management; b) Occupational health services will be comprehensive to include promotive, preventive, curative and rehabilitative care; c) Monitoring and enforcement of existing legislation on occupational health and safety; d) Ensure provision of protective environment for all employees; and e) Enforcement of the Compensation Act 1977.

4.7 Health Education and Promotion

Diseases can be prevented and health promoted if people adopt healthy lifestyles. This requires people to be informed and persuaded to change their lifestyle.

Policy objective: To advance health education and strategic communication on risky lifestyles in order to promote behavioural change.

Policy measures:

a) Strengthen and enforce the communication strategy and mechanisms at individual, community and national levels for health education and promotion; b) Changing people's behaviour and lifestyle in respect of the following priority aspects, diseases or risky lifestyles: HIV/AIDS through casual sex and drug injections; Excessive consumption of animal fat, sugar and alcohol; Tobacco smoking; Lack of physical exercise; Inconsiderate and risky driving and road use; Domestic and gender based violence; Diabetes, Hypertension and Heart disease; Breast, cervical and prostrate cancers; Family planning;

Maternal health; Child health and development; Environmental health; Adolescent health; and Nutrition education and promotion.

4.8 Pharmaceutical services

Medicine financing is not equitable. Procurement of medicines is relatively expensive as Lesotho public sector market is small. Uncertainty about the quantities medicines demand of the country creates speculation and leads to increase in medicines prices. Medicines supply management at health facilities is extremely variable. Medicine use is not rational.

Policy objective: To ensure that essential, efficacious and affordable medicines are available at all times in health facilities and are accessible to all.

Policy measures: a) Rational use of medicines will be promoted, with emphasis on better diagnosis, prescribing, dispensing and patient-compliance ; b) A Medicines Act will be promulgated to establish a Medicine Regulatory Authority, and to control who may import, manufacture, store, sell, distribute, prescribe and dispense medicines; c) A Pharmacy Board Act will be promulgated to strengthen the control of professionals involved in handling medicines; d) Pharmaceutical human resource policy and plan will be prepared to: designate training institutions for pharmaceutical services; determine the cadres and quantity of student load; project human resource requirements for short, medium and long term; determine the organogram for pharmaceutical staff; train, upgrade and support pharmacy technicians where pharmacists may not be adequate; train and supervise other cadres who handle pharmaceuticals; the Pharmaceutical Services Unit at the MOHSW will be strengthened; f) A National Medicine Policy Steering Committee will be established to strengthen the coordination of stakeholders; g) Indigenous Sesotho knowledge of traditional medicine will be promoted and preserved, and the Government will ensure safe use of complimentary medicines; h) Government will promote regional collaboration with SADC on medicine regulation and bulk purchasing ; and i) Local production of medicines shall be encouraged whereby the manufacturing plant will be equipped and improved to meet the standards of Good Manufacturing Practices, and Lesotho Pharmaceutical Company will be given technical support and substantial capital investment to ensure sustainable availability of medicines in the country.

4.9 Communicable and Non-communicable Disease Control

Lesotho is experiencing a double disease burden as a result of an incomplete epidemiological transition. While the burden of communicable (infectious) diseases is still high, there has been an accelerated increase in non-communicable diseases. These include hypertension, diabetes, smoking, alcoholism and obesity.

Policy objective: to reduce the mortality, morbidity and disability due to diseases through preventive, promotive, curative and rehabilitative health care.

Policy Measures: a) Promotion of change of behaviour that leads to the acquisition of disease; b) Maintaining healthy environment, which includes safe food and water, personal hygiene, adequate sanitation, shelter and ventilation; c) Regular surveillance and interventions against vector borne and zoonotic diseases; d) Strengthening immunization against communicable diseases for vulnerable groups such as infants, mothers and travellers; f) Conduct epidemiological investigation of disease outbreaks; g) Protect susceptible community members by immunization, education and other appropriate interventions; h) Integrate physical, mental and social rehabilitation activities in the epidemic control measures; i) Review and update public health legislation and ensure its effective enforcement; j) Carry out research on diseases to improve on their management; k) Screen populations at risk for diseases; and l) Institute early treatment and prevention of complications such as blindness, stroke, retinopathy, and heart disease.

4.10 Oral Health Services

The prevalence of oral disease is high. For example, dental caries are present in up to 98% of dental out patients and 19% of school children. 27% of children have gum disease and 10% have fluorosis (GOL, draft Oral Health Policy, 2002).

Policy Objective: To reduce oral diseases through comprehensive oral care and adoption of healthy life styles.

Policy strategy: a) Integrate oral health into PHC; b) Develop appropriate curriculum for Dental Assistants at the National Health Training College; c) Increased output of Dental Assistants for deployment to health facilities; d) Implement advocacy social mobilization, and IEC programmes on oral health; and e) improve oral health service capacity by acquiring equipment and supplies, human resources, and building a delivery system.

4.11 Mental Health Services

The Government recognizes that mental illnesses are on the increase. These include drug/substance abuse, HIV/ AIDS related psychoses in addition to anxiety, depression, schizophrenia and organic psychoses. The Government is also aware that mental health services are not easily accessible by patients due to stigma and prejudice. In addition, the Government is concerned that mental health services and professions are gradually declining due to lack of motivation and support.

Policy Objective: To build capacity to provide sustainable mental health services to all those in need.

Policy Measures: a) Strengthen public mental health services by integration into overall health services and strengthening community level services; b) Reconstruct, equip and staff all mental health facilities; c) Strengthen specialist mental health services by recruiting Psychiatrists Mental Health Nurses and other relevant professionals, and by their sustainable training and by holding them in their profession; d) Strengthen management capacity of communities and community systems to manage mental illness at family and community levels, which will entail deploying social welfare workers and establishing client groups, associations and networks; e) Explore ways of creating

incentives and professional pathways in mental health care; f) Explore ways of attracting candidates for training, and of retaining mental health professionals; and g) Mental health services will be free of charge.

4.12 Clinical services and internal referral

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

Policy Objective: To provide effective and efficient clinical services for prevention and treatment of disease, and for rehabilitation of disability for all those in need of the services.

Policy measures: a) Government shall ensure that all health facilities are functional by providing the necessary staff, supplies, equipment and operational funds; b) Government has reclassified health facilities according to service packages and level of technological sophistication; c) a referral system will be developed whereby, through an a fee for jumping levels of care, people will be encouraged to seek for health care first at the primary level, before going for higher level of care by medical referral; d) Government will provide funding to accredited non Government health facilities based on agreed service packages and workload; e) People will be encouraged to seek for clinical services from private providers where they can afford. Otherwise, clinical services will be provided in Government and accredited NGO facilities for free or at highly subsidised rates. But when a user-fee policy is operational, a mechanism must be put in place to ensure that no one is turned away for inability to pay; and f) People will be encouraged to go to the nearest health facility even if this means going across a district border. A mechanism will be developed for districts to share resources, and for cross-border services and responsibilities.

4.13 Referral Services Abroad

Health care capacity within the country is not adequate to handle all disease conditions. However, only a limited number of patients can benefit from referral services abroad because of limited financial resources.

Policy Objective: To capacitate our tertiary referral hospital with specialized medical care, specialized nursing and specialized equipment, to the extent that the majority of patients requiring specialist care will be managed within the country. Only highly specialized services not available at our capacitated tertiary hospital will be considered as the last resort for referral abroad in accordance with procedures which will be set up.

Policy Measures: a) Individuals who are able to pay will be encouraged to seek referral services on their own; b) As the bulk of referrals abroad are late cancer patients,

they will be sensitised on the risky factors, the importance of early detection and treatment before the disease gets out of hand; c) While flexibility will be given to Clinical Consultants to advise on which patients to refer, a National Medical Board will be established to review regularly the patients referred, the level of funds involved and whether more funds needs to be mobilized; and d) The National Medical Board will consist of: the Director General of Health Services, Medical Superintendent of Queen Elizabeth II Hospital, Director responsible for clinical services in the MOHSW, Director Planning in the MOHSW, two representative of a patients/ consumers' association, and the Chief Financial Controller.

4.14 Traditional Health Services

Traditional practitioners are indispensable among the Basotho. They provide health care, carry out ceremonies for marriages and births and for initiation into adulthood. They perform worships, cleansing, ceremonial rites, cultural dances, and indigenous art. It is a well known fact that most Basotho consult with the traditional healers before presenting to health facilities and that the traditional healers are popular for some diseases. MOHSW has established some integration with some traditional healers on aspects of mental illness, TB and HIV/AIDS and condom distribution.

Policy Objective: To streamline the practice of traditional healers and develop partnership with them.

Policy Measures: a) Develop a policy for the partnership between traditional and western medicine in the context of Basotho culture b) Develop legal framework to operationalize the partnership c) to regulate the practice of traditional medicine through a Parliamentary Act.

CHAPTER 5: SOCIAL WELFARE SERVICES

5.0 Objectives

The overall objective of social welfare is to alleviate human suffering and improve the quality of life of disadvantaged people to enable them participate meaningfully in socio-economic development. The specific objectives are to: a) strengthen legislation to guarantee social welfare to all; b) improve the coverage and quality of social welfare services; c) register, regulate and monitor social welfare organizations; d) advocate and provide social services to disadvantaged people; e) build the capacity to provide social services; f) mobilize resources for social welfare.

5.1 Child Protection and Development

The Government undertakes to protect children and to ensure they grow and develop into healthy and responsible adults. The Government has ratified the Convention for the Rights of Children which reaffirms the four pillars of child welfare: survival, protection, development and participation. The document also emphasizes the best interest of the child, non-discrimination, and respect of the views of the child.

Policy Objective: to ensure the survival, protection and development of children, and their participation in socio-economic development.

Policy Measures: Therefore the Government will: a) Develop and implement regulations and systems for monitoring and evaluation of child welfare; b) Identify and provide social support to children in difficult circumstances or in need of special protection; c) ensure that services to children with disabilities are comprehensive, individualized and cover their special needs; d) Provide separate facilities of custody for child offenders; e) Develop and implement statutory measures for child protection; f) Develop tax incentives and other packages of support for persons caring for children other than their own; g) Strengthen the legal protection of children by providing child friendly courts; h) Provide compulsory and free primary education; i) Prevent violence on children by sensitising communities and through legislation; j) Give sufficient attention to emerging issues concerning children, which include HIV/AIDS; child labour; sexual exploitation; child abuse, neglect and abandonment; and orphans and street children.

5.2 Youth

The youth are agents of development and have the potential to engage in productive ventures. Special issues relating to the youth include education and employment opportunities, HIV/AIDS, lack of youth centres, crime and drug abuse.

Policy Objective: To guide, facilitate and support the youth to develop their full potential for their individual and wider socio-economic development.

Policy Measures: a) Advocacy for the creation and expansion of educational opportunities for the youth, which opportunities include formal education, non-formal

and distance learning, skills enhancement programmes and skills training that require innovation, and career guidance; b) Sensitise the youth about the dangers of HIV/AIDS; c) Develop a programme to de-campaign teenage pregnancy and help girls who have become pregnant cope with the problem and to resume education; d) Legislation will be instituted and enforced to curb rape, physical and sexual abuse; e) Establish youth friendly centres where they can be counselled and helped, and where STDs can be diagnosed and treated; f) Encourage the youth to be involved in productive activities such as employment, education, recreation, and peer support, so they do not turn to crime; and g) Implement IEC programmes to change their sexual behaviour so as to reduce HIV transmission and to curb crime and criminal tendencies.

5.3 Adults in difficult circumstances

The numbers and categories of people living in difficult conditions have greatly increased as a result of unemployment, growing poverty and HIV/AIDS. All of them require some public support and facilitation to cope and to be lifted out of their situation.

Policy Objective: To support people living in difficult circumstances to cope, and to come out of those circumstances so they can live quality life and contribute to socio-economic development.

Policy Measures: a) A programme to give women legal, political, economic and social empowerment; b) Promote family welfare, integrity and self-reliance, and minimize divorce, broken relationships, family violence and suicides; c) Mobilization of the Government, civil society and communities to provide housing or shelter for homeless people and assisting them to acquire skills to enable them fend for themselves; d) Establishment of crises centres which will also be centres of temporary safe haven for people who have to leave home for various reasons, including domestic violence; e) Participatory development of strategies to empower unemployed / under employed persons, including support for entrepreneurship; f) Provision of public assistance to destitute; the definition of a destitute will be agreed upon and they will be identified through the social welfare system; g) Institutionalisation of coordinated disaster management through civil defence units, Social Welfare Department, Disaster Management Authority and agencies such as Lesotho Red Cross Society; and h) Develop a program to de-stigmatise substance abusers and to link with the relevant institutions to prevent and manage substance abuse.

5.4 People with Disabilities

PWDs, without special support cannot develop their potential to live independent and productive life. In addition they continue to suffer discrimination due to the prejudice of the society.

Policy Objective: To support PWDs to be self-reliant and to enable them live quality and dignified lives.

Policy Measures: a) As much as possible integration of PWDs into their community, including family, schools, and social events; b) Development and implementation of community-based rehabilitation and service provision; c) Legislation to ensure that the

physical environment, public buildings and transport will be made accessible to PWDs; d) Provision by the Government and Partners of assistive devices to PWDs; e) Making public information accessible and available to all persons including persons with hearing and visual impairment; f) Recognition, popularisation and use of the sign language as a means of communication for people with hearing or speech impairment; g) Exemption of PWDs from payment for health care; and h) Provision of sheltered workshops by the Government and NGOs for PWDs who can and want a place to work or to carry out their trade.

5.5 Prisoners

Prisoners are confined and often lead miserable and unproductive lives. It need not be so. Prisoners are punished through incarceration but that does not remove their right to social services. In addition they can be used for economic production.

Policy objective: To work with the Prison Rehabilitation Services to ensure prisoners' rights and social needs are met and prisoners are rehabilitated to enable them make a useful contribution to socio-economic development.

Policy Measures: a) Provision of rehabilitation services, counselling, and psychological support; b) Skills focussed training for prisoners aimed at contributing to the overall poverty reduction; c) Provide health and social health services to prisoners; d) Strengthen open prison policy integrated with community based justice system built on restitutive justice; f) Design and implement alternative options to imprisonment for expectant mothers and mothers with young children; g) Provision of separate housing for and care for pregnant women and mothers with young children; and h) Children over the age of two will not be housed in prison with their mothers.

5.6 The Elderly

The number of the elderly has increased but many live miserable lives due to lack of safety nets, loss through HIV/AIDS of their children who would otherwise give them assistance, their adult offspring who are alive are not employed and are themselves in need of assistance, and the elderly are burdened with looking after orphaned children.

Objectives: To enable elderly people live decent and quality lives as part of their families and communities.

Policy Measures: a) Strengthening community-based support to the elderly people; b) Integration of elderly people within their own families and communities; c) Revival and promotion of useful roles of the elderly in their communities; d) Integrated and coordinated partnership with NGOs support to the elderly; e) Where institutional care for the elderly has been found necessary, implementation of minimum standards, monitoring and evaluation of the services given to them; f) Promotion and support of respite care, whereby elderly people, those chronically ill and PWDs are cared for by people other than their relatives;

CHAPTER 6: SUPPORT SERVICES

6.1 Human Resource Development (HRD)

Human resource is the determining factor for satisfactory delivery of health and social services. The entire public sector is faced with inadequate personnel, and many are not appropriately trained, motivated, rewarded, deployed or supervised. Personnel trained abroad are not subjected to quality assessment and could be performing below professional standards.

Policy Objective: To get and maintain the right numbers of appropriately trained, motivated and deployed health and social welfare personnel.

Policy Measures:

a) Ensure appropriate human resource supply for health and social welfare; b) Ensure that personnel are appointed, paid their dues, are subject to effective management and appropriately advised/assisted in career development; c) Ensure that personnel are properly trained to provide the services that meet people's needs, and to ensure effective career development and employment continuity; d) Strengthen and expand the training capacity in the country e) Set up a professional body to assess and vet personnel trained abroad before employment, and to subject them to periodic assessment during employment; f) Facilitate good employer/employee relations and conduct; g) Provide accurate and timely information required for proper HR management; and h) Liaise with CHAL regarding HRD.

6.1.1 Capacity building for social services

Social welfare department and services have a long history having moved from one ministry to another. As a result the department has not been able to acquire a sense of belonging to any sector, and to develop linkages and institutions for capacity building. It has thus remained relatively undeveloped, un-integrated and under-resourced.

Policy Objective: To build the capacity of the social welfare system to provide quality services and to enable all those in need of these services to access them.

Policy Measures: a) Training and recruitment of appropriate numbers of social workers at the Social Welfare Department and at district and community levels; b) Teaching of basic and specialized social work at higher institutes of learning such as national University of Lesotho, Lesotho Institute for Public Administration, Institute of Development Management, National Health Training Centre; c) Professional Social Workers will be registered with the Council of Social Workers; d) Establishment, recruitment and deployment of Social Work Auxiliaries as Para-professionals; e) The formation and operation of Welfare NGOs will be encouraged and will be registered by the Department of Social Welfare; f) An Act of Parliament governing the establishment, registration and supervision of welfare organizations shall be put in place; and g) Registration and monitoring by the Department of Social Welfare of all children's welfare institutions, which shall meet the minimum set standards and guidelines.

6.2 Health financing

Currently, the processes for budgeting capital and recurrent health expenditures are separated. The Health Planning and Statistics Unit of the MOHSW has responsibility for donor and capital funds while the Financial Controller prepares annual recurrent budgets. The user-fee policy requires to be evaluated and a sustainable financing system needs to be established.

Policy Objective: To generate and mobilize funds for health and social welfare without affecting the service utilization and ensuring that funds are allocated according to agreed priorities.

Policy Measures:

- a) The MOHSW shall therefore: 1) Bring together the process of capital and recurrent budgeting to produce a comprehensive integrated budget, which will capture all sources of financing and identify all health expenditure, including that of CHAL and other health providers such as Red Cross and Blue Cross societies; 2) Produce a three-year rolling expenditure plan – the Medium Term Expenditure Framework (MTEF) - to provide a long-term view of Government and externally sourced financial expenditure for the health sector.
- b) A sector-wide approach of expenditure shall be adopted where expenditures in other ministries which may be direct (such as on AIDS and health education), or indirect (such as pensions of health staff) will be included in the health budget.
- c) The Government and its partners shall continue to finance the bulk of health services. The Government will aim to finance the EHP from national revenue, external aid and from subsidized user-fees.
- d) Private funding through cost recovery user-fees, health insurance and community based financing will be encouraged.
- e) The user-fee policy will be reviewed after a household survey to assess how much user-fee is affordable by the average person in Lesotho. New user-fee structures will then be worked out.
- f) A study will also be carried out to determine the administrative cost of collecting user-fees and to assess whether, when compared with the amount of fees collected, it is still economically sensible to operate a user-fee policy.
- g) Criteria for exemption from user-fees will be worked out based on the ability to pay, and on diseases such as TB and mental illnesses where user-fee payment is not feasible or could reduce access to treatment and escalate further spread of infectious diseases.
- h) User-fees will be equal between GOL and CHAL facilities and the shortfall in Revenue of CHAL facilities as a result of user-fee equalization policy will be compensated by the Government. This will improve equity in access to services.
- i) Resource allocation procedures and mechanisms will be worked out. Resource allocation will be based on priorities and maximum benefit potential, size of the population, workload of health facilities, disease burden in different communities, and remoteness of a district or a facility.

- j) In line with decentralization and empowerment of communities, user-fees collected at health facilities will be retained and used at the point of collection. Financial regulations will be worked out to guide user-fee management at the community level.
- k) National Health Accounts shall be determined from time to time to assess how much funding is in the sector, who contributes how much, and how the funds are allocated to different sections of the sector.

6.3 Health Infrastructure

Health facility requirements are changing due to demand and supply factors. These include: 1) demographic changes including internal migration, emigration, changes in fertility, and changes in mortality, 2) major epidemiological shifts such as AIDS and TB, 3) the pricing of health care, 4) improvements in clinical case management and referral services, 5) improvement in preventive and promotive health services, and 6) mental health service capacity development.

Policy Objective: To ensure that health and social welfare physical infrastructure and equipment are properly procured, installed and maintained.

Policy Measures:

a) Health facilities will be reclassified, restructured and standardized as follows:

Type I Hospital: Tertiary care referral facilities, which includes all specialist services in a type II A plus an Intensive Care Unit, and Trauma Unit, full laboratory and advanced imaging.

Type II A Hospital: secondary care, District referral hospital with specialized services in pediatrics, obstetrics and gynaecology, internal medicine, ophthalmology, surgery, full laboratory, x-ray and ultra sound imaging.

Type II B Hospital: Secondary care, district referral hospital with generalist medical services plus pediatric, obstetrics and gynaecology specialists, laboratory, x-ray and ultra sound imaging.

Type III Hospital: Filter clinics with 20 beds capacity primarily for deliveries, but also for short stay inpatient visits including basic laboratory, portable x-ray and ultra sound facilities.

Health centre: will have 10-15 beds for deliveries and observation of patients. The health center will provide ORT facilities, initiate intravenous treatment, treatment of childhood illness according to IMCI guidelines, provide health education on common illness, refer severely ill patients. Limited laboratory services will be available at the health center.

Health Post: will have a structure, facilities and staff to assess a sick child's temperature, chest signs, hydration status and nutritional status. At the Health Post, oral rehydration treatment will be carried out. But severely ill patients will be referred to the health center or hospital. At the Health Post recognition of common symptoms and signs of main illnesses will be made, and advice including referral will be provided.

b) The MOHSW will strengthen the Estate Management Department and staff it with appropriate personnel to plan, procure, inspect and maintain infrastructure.

c) CHAL institutions will be planned for, rehabilitated and maintained just as GOL facilities through the Estate Management Department

d) Standards for social welfare physical infrastructure and institutions will be worked out and enforced by the Estate Management Department.

f) A Maintenance Team will be employed at the district level to inspect, maintain infrastructure and supervise construction work. The team will include an Electrician, a Plumber, a Builder, Carpenter and Bio-medical technician.

6.4 Quality assurance and Supervision

Quality assurance is about quality improvement. Quality is doing the right thing, the right way, the right time, first time. It is the extent to which services satisfy technical standards and people's expectations.

Policy Objective: To attain and maintain an acceptable level of service quality.

Policy Measures:

- a) Quality planning shall be included in health plans at all levels. A Quality assurance plan shall include quality assurance objectives, quality targets, activities and budgets.
- b) Quality assurance activities will be financed and implemented like other health care activities.
- c) Quality assurance will include supervision and technical support of health workers by supervisors based at MOHSW and districts headquarters. Quality standards, protocols and indicators will be developed and distributed; Health staff personnel will be trained on the standards and protocols for quality assurance.
- d) Indicators will be used to assess progress towards the desired quality targets.
- e) Quality improvement will require setting quality targets and expectations and bridging quality gaps. Bridging quality gaps shall require strategic approach and implementing specified activities. These will require resources, which will be allocated for the purpose of quality management.
- f) Strategic communication on quality assurance shall be part of quality assurance plan. It will target health service providers and users. A Quality Assurance Unit needs to be established to coordinate work on quality management.
- g) Recording good quality: A method shall be established to record quality of services work. Best performing individuals, units/departments, health units and districts will be rewarded.
- h) Through quality assurance targets and standards, the government will accredit both GOL and CHAL facilities for specified services. Accreditation shall be carried on annual basis to ensure health facilities do not backslide on quality.

6.5 Research

Research on health and welfare that is not given direction cannot contribute to a given goal. The need for research is often determined without due consideration of its usefulness to policy objectives.

Policy Objective: To ensure research contributes to and supports policy objectives and poverty reduction.

Policy Measures:

- a) A Research Coordination Unit shall be established to coordinate, set national research objectives, disseminate research findings, mobilize resources for research, commission health research, and advocate for research use in health policy planning and management;

b) It will be headed by a Chief Research Scientist, who will be assisted by a researcher and a policy analyst. It will be supported by a coordination committee, whose members will be drawn from MOHSW, other government sectors, CHAL, the Academia (universities) and the private sector. The membership will not exceed 15. The unit will be operated by a Secretariat consisting 2 senior Researchers, a Policy Analyst and 2 support staff; c) The Committee will constitute an ethical committee to approve proposals and provide ethical clearance; d) The Research Coordination Unit and the Committee will formulate a research policy and strategic plans.

6.6 Legislation

Currently health laws are being updated and new laws enacted. There is need to provide guidance on what issues require law, what process is to be followed in law development, and how to ensure that laws and regulations are implemented.

Policy Objective: To develop legislation and regulation governing health and social welfare services, and to ensure their enforcement.

Policy Measures: a) Current health and welfare laws shall be reviewed for updating/amendment; b) New issues requiring legislation shall be reviewed and new laws developed; c) New non-health and non –welfare laws affecting health and welfare shall be assessed for their impact; d) Legal impact assessment will be carried out to ensure that laws have the desired impact on people and do not obstruct the smooth delivery of services; e) Consultation on any new law shall be extensive to exhaust all aspects on the subject of the proposed law before the law is fully developed; and f) The effectiveness of law enforcement will be assessed to determine better ways of law enforcement or to propose options to legislation.

6.7 Management Information System

Currently, health and social welfare information is unreliable and incomplete. A new system is being developed and a new structure established for health management information system. But social welfare information and system are almost non-existent.

Policy Objective: To provide timely, relevant, accurate and complete health and social welfare information on a sustainable and integrated basis.

Policy Measures: a) The Government will develop a simple information system for health and social welfare services and management; b) The focus of the system is to transform collected data into usable information; c) All recorded health and social welfare data will be reported in line with existing regulations; d) District Health Teams will collect, store, analyze and submit health and social welfare information to the MOHSW; e) MOHSW will publish guidelines with templates for quarterly and annual data analysis at all levels for evaluation, monitoring and planning; f) A system will be put in place to ensure that each individual uses only his or her medical forms when seeking for health care; this will require a system where every individual has a unique registration/ identification number in the country; g) The MOHSW will aggregate and analyze national health and social welfare data annually for service monitoring,

evaluation, planning and dissemination; h) Health and social welfare information will be shared by all stakeholders in Lesotho; and i) Only the Director General of Health Services or other authorized persons will give permission for health and welfare information about Lesotho to be published or used outside the country.

CHAPTER 7: HEALTH CARE AND SOCIAL WELFARE DELIVERY SYSTEM

7.1 Decentralization Policy The 1996 Local Government Act makes provisions for the following structures: rural, municipal and urban councils, community councils and District Development Coordinating Committee (DDCC), which brings together urban and rural councils.

The councils shall begin to operate fully at the end of 2003 when Local Government elections are held. Decentralization will strengthen technical and organizational capacities of Local Councils and community structures in development planning, budgeting and management of funds. It will enable community empowerment through popular and democratic participation in all matters of development.

7.1.1 Role of MOHSW

The MOHSW will have the following roles: a) provide overall guidance and advice on health and health services; formulate policies and strategic plans; b) provide health service standards; c) develop and manage national health programmes; d) monitor and evaluate health and social welfare status and services in the country; e) ensure quality of services through supervision and quality assurance activities; f) develop and enforce of health care and welfare standards; g) develop and enforce of technical guidelines; supervise and implement quality assurance; h) mobilize resources for services; i) plan and implement human resource development; and f) develop health and social welfare infrastructure.

The MOHSW will be restructured to respond to decentralization and the functions above. In particular, projects and programmes will be harmonized with the ministry's macro-organogram, and will follow the ministry's established reporting and management channels.

7.1.2 Central level activities

Because of the multi-sectoral nature of health and social welfare, and the need for multi-sectoral and sector wide consultations, the following institutions shall be established:

Annual Health Review Conference shall become a formal institution. It will be headed by the MOHSW and attended by representatives from all health sector partners, all sectors of the Government, all the HSAs, all Rural Councils, urban councils and DDCCs. District Administration will be invited to attend the Annual Health Review.

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

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

7.1.3 Local Level Functions

The health services for which the local governments are responsible and related functions will be agreed between the Ministry of Local Government and MOHSW.

Under the DDCC a District Health Team (DHT) shall be constituted. The DHT shall consist of: a) A District Health Officer (DHO) who may be a medical officer trained in public health or any senior health professional trained in public health; b) A District Public Health Nurse; c) A District Health Inspector; d) A Social welfare officer; and e) A District Health Information Officer.

The functions of the DHT shall be to: Supervise hospitals and health centers; Plan for health delivery in districts; Plan equitable allocation of resources between districts and Hospitals; Mobilize resources for district health service delivery; and Integrate health services into district development.

7.2 Social Welfare System

The major assurance of social welfare is the integrity and strength of the family. A stable family with means of sustenance and based on good social values is the best chance for

children and other vulnerable persons in the community. Beyond the household, Chiefs as community leaders are the next level to hold the responsibility for social welfare of the community.

The Chief's role in respect of social welfare are to: a) to identify and keep a record of all persons who desperately need social support and assistance, b) to mobilize local resources to provide social support to those in need; and c) refer people in need of social support where the support cannot be provided locally.

Chiefs will be helped by Auxiliary Social Workers who will be based in the community. An ASW will be responsible one or more villages.

7.3 National Council for Health and Social Welfare

The Minister for Health Social Welfare shall be advised by a National Council for Health and Welfare on broad issues of health development, intersectoral coordination and community participation. Its composition will emanate from the multi disciplines sections of the society. This Council shall consist of members appointed by the Minister.

7.4 Management of health facilities

7.4.1 Hospitals/Filter Clinics: Hospitals and filter clinics will be the responsibility of the central Government. The DDCC and the DHT will plan and budget for districts. Other local councils will plan and budget for health and social services with technical advise from the DHT.

The DHT will provide policy for the hospital, approve plans and budgets, and solve problems arising in the hospital including taking disciplinary actions.

7.4.2 Health centres/Village Health Posts: Each health centre shall be managed by a management team that will work closely with the DHT. It will consist of head of the facility and three other senior staff.

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

7.5 Public-Private Partnership

7.5.1 Partnership with CHAL facilities:

a) GOL recognizes the longstanding contribution of church facilities to the welfare of Basotho. The financial position of these institutions has deteriorated considerably in recent years and their viability and sustainability remain questionable.

b) **Policy Objective:** The GOL and CHAL shall forge a sustainable partnership based on mutual trust and respect for equitable and efficient health service delivery.

c) **Policy Measures:** 1) The GOL and the institutions shall agree on the necessary conditions for a viable and sustainable partnership, and public-private partnership policy and strategic plan shall be developed. The legal framework of the partnership and a Memorandum of Understanding shall be developed; 2) The financial arrangement, the organizational and coordination framework, annual plans and budgets to implement the partnership shall be developed; 3) The current GOL grant to CHAL of 20% operational support and payment of salaries of all professional staff will eventually be replaced by a long-term arrangement where grants will be based on service packages and size of the population served; and 4) In the long-term partnership, only CHAL accredited facilities will be funded for a specified package of services. Financial support will be provided for the central level CHAL for management and supervision.

7.5.2 **GOL's partnership with other private sector bodies.** Similar partnership shall be forged between GOL and other private sector organizations such as Red Cross and Blue Cross Societies.

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

7.6 Implementation arrangement

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

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

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