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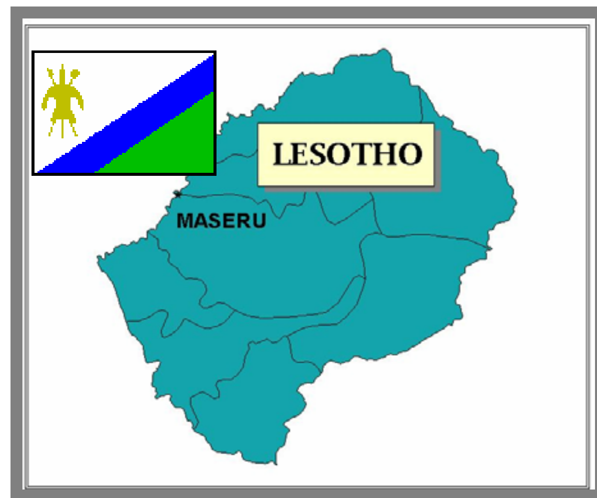
Performance Review of the Supplementary Emergency Financing Facility (SEFF)



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List of Acronyms

AGM	Annual General Meeting
CHAL	Christian Health Association of Lesotho
DCI	Development Cooperation Ireland
DG	Director General
DHMT	District Health Management Team
EPI	Expanded Programme on Immunization
ESP	Essential Health Package
FM	Financial Manager
FMIS	Financial Management Information System
FMU	Finance Management Unit
FY	Financial/Fiscal Year
GOL	Government of Lesotho
GOLFIS	Government of Lesotho Financial Information System
GS	Government Secretary
HC	Health Centre
HMIS	Health Management Information System
HR	Human Resources
ICD	International Classification of Diseases
JCC	Joint Commission of Corporation
JTF	Joint Task Force
LI	Letter of Intent
MCDI	Medical Care Development International
M&E	Monitoring and Evaluation
MPS	Ministry of Public Service
MOET	Ministry of Education and Training
MOF&DP	Ministry of Finance and Development Planning
MOHSW	Ministry of Health and Social Welfare
MOLG	Ministry of Local Government
MOU	Memorandum of Understanding
MTEF	Medium Term Expenditure Framework
N/A	Nursing Assistant
NDSO	National Drug Supply Organization
NGO	Non Governmental Organization
NMDS	National Manpower Development Secretariat
N/S	Nursing Sister
PHC	Primary Health Care
PS	Principal Secretary
QAP	Quality Assurance Programme
SEFF	Supplementary Emergency Financing Facility
SEP	Senior Economic Planner
TB	Tuberculosis
WSSP	Water Supply and Sanitation Project

Executive Summary

This report summarizes the findings of the SEFF Performance Review conducted between July and September 2004. It presents recommendations and an implementation plan for finalization of the MOU between the GOL and CHAL that have been reviewed by the stakeholders in the partnership process at a SEFF Performance Review workshop held in Maseru under the chairmanship of His Excellency the Government Secretary on September 15, 2004.

The Partnership Process. The Review determined that considerable progress has been achieved since the new partnership process was initiated in 2000. Significant milestones have included: (i) the reconstitution of the GOL/CHAL Joint Task Force under the chairmanship of the Government Secretary; (ii) the preparation and signing of an interim MOU and SEFF; (iii) a financial audit of all CHAL institutions as the basis for calculating the SEFF; (iv) strengthening of the CHAL Secretariat through the appointment of a Financial Manager and Senior Economic Planner; (v) a revision of the CHAL Constitution to assure adequate institutional and GOL representation on the CHAL Board; (vi) establishment of the GOL/CHAL Coordinating Unit within the MOHSW and appointment of a GOL/CHAL Coordinator to facilitate the further development of the partnership process; (vii) establishment of JTF Sub-Committees and specification of their terms of reference; (viii) the preparation of an investment strategy under the Lesotho Health Study for strengthening CHAL institutions and the Secretariat to position them to meet the new accreditation standards required under the MOU; (ix) drafting of a new MOU document with input from GOL legal advisers and the Task Force; (x) development of a new draft Health and Social Welfare Policy; (xi) initiating work on the articulation of a Quality Assurance Programme for the health sector; (xii) drafting of an Essential Service Package for health and social welfare services; (xiii) drafting of new Standard Treatment Guidelines and Essential Drug List; (xiv) further definition of the framework for decentralization; (xv) production of a Standard Equipment List for hospitals and health centers; (xvi) definition of minimum staffing standards for hospitals and health centers; (xvii) drafting of a Policies and Strategic Plan for the health management information system of the MOHSW; (xviii) completion of an initial Proprietor's Funding Study that provided some insight into the contribution being made by church proprietors to the financing of health services; (xix) completion of a Health Center Rationalization Study which identified health centers that are candidates for decommissioning due to overlapping coverage, quality deficiencies and inefficiency; and (xx) completion of a User Fee Study which provided initial guidance on the restructuring of user fees within the health sector.

The SEFF disbursements began in FY 2003/04 based on the original budget estimates for CHAL derived from the FY 1999/2000 audit statements. No attempt was made to revise the basis for the FY 2003/04 SEFF calculation (i.e., based on more recent audited financial data) since it was felt that this would only lead to further delays.

The first SEFF disbursement was effected in July, 2003 and has subsequently been disbursed on a quarterly basis. Recent disbursements have been delayed due to administrative difficulties with the MOHSW Financial Comptroller's office and these have led to delays in salary payments by CHAL Institutions. These delays coupled with

the additional work burden associated with processing salaries are the two negative implications of the new financing provisions which have otherwise had a very positive impact on the financial position of the CHAL health institutions.

The review has concluded that the delays experienced in obtaining Government approval for the Interim MOU and SEFF were to a large extent unavoidable given the change in government that took place. The new Government had the responsibility to thoroughly review the proposed agreement and to determine whether it was consistent with its perception of the public interest. The reality is that it was extremely difficult under the circumstances for the MOHSW and CHAL to advance the process any faster.

The evidence since then is that the process has worked more expeditiously and that it is unlikely that similar delays will occur (at least to the same degree) in the near future. *It will be very important, however, in this regard to take full advantage of the commitment on the part of the current Government, the Proprietors and CHAL to the partnership process and to do everything possible to implement the full MOU in the shortest time feasible*. The review team believes that it should be possible to achieve this objective without compromising the process or the outcomes even though there remain significant pre-conditions to achieve (e.g. articulation of the accreditation process and procedures, finalization of the financing framework including user fee determination and specification of the funding formula).

Though communications between the stakeholders has improved markedly since 2000 when the partnership process was re-initiated, the review determined that there remains a need to strengthen communications further between the partners (GOL, CHAL, Proprietors) and between CHAL (the Board, and Secretariat) and the CHAL Institutions (including training institutions) and between the CHAL hospitals and health centers. The latter is particularly the case for health centers that fall under direct hospital management.

A strong sentiment raised at the SEFF Performance Review workshop was that the partnership process would benefit greatly from the continued stewardship of the Government Secretary and that this involvement would be necessary for a bridging period encompassing the remaining time under the Interim Agreement and the first year under the new MOU.

The Organizational Framework for the Partnership. All stakeholders reported that the organizational structure adopted for overseeing and implementing the partnership process including the JTF, CHAL Secretariat, the GOL/CHAL Coordinating Unit, and the sub-committees, has been adequate.

The review determined that stakeholders appreciate the role played by the JTF in leading and facilitating the partnership process. Some concern was raised about ensuring that there is proportionality in membership between CHAL and the GOL on the JTF as well ensuring that the JTF benefits from the best available technical input from both sides.

Most informants agreed that the sub-committees of the **JTF** need to be activated in order to expedite the development of some the requisite systems and procedures that are to be annexed to the MOU. This includes in particular those associated with the accreditation of the CHAL Institutions. In addition, in reviewing the sub-committee structure of the JTF it was noted that there is technical overlap between the Monitoring and Evaluation

(M&E) and the Quality Assurance (QA) sub-committee. The review team believes that these two sub-committees have distinct roles to play during the development process but that once the accreditation process is in place it may be possible to consolidate them. The roles foreseen for the QA and M&E sub-committees during the development process are: the QA sub-committee will focus on overseeing the development of the hospital and health center accreditation programme as a component of, or adjunct to, the MOHSW's overall Quality Assurance Programme, while the M&E sub-committee will focus on issues pertaining to monitoring and evaluating the partnership process (i.e., the role of the GOL-CHAL Coordinating Unit and CHAL Secretariat), and strengthening data processing in general at CHAL Institutions in order to position them to provide data in a timely and accurate manner.

While it is recommended that the Government Secretary remain actively involved in stewarding the partnership process through the first year after the MOU has been signed, thereafter, it was felt that regular and direct oversight by the Government Secretary and Principal Secretaries would not be necessary. At this point, it is recommended that the new Joint Commission on Cooperation (JCC) that will replace the JTF once the new MOU is signed, would consist of an Executive Committee (essentially the JTF), and a Working Committee constituted by Director-level personnel from relevant ministries and chaired by the PS-MOHSW. It would be the Working Committee of the JCC that would be responsible for the routine oversight of the partnership process under the new MOU. The Executive Committee of the JCC would meet semi-annually and in special session as required. The sub-committee of the JTF would continue under the new JCC but would report to the Working Committee of the JCC. The performance review found that there is general agreement that the new **GOL-CHAL Coordinating Unit** has performed admirably, but that it needs to be expanded and strengthened in order to fulfill its mandate. This includes the need to hire at least one additional staff member to serve as an assistant to the GOL-CHAL Coordinator and to moving these posts to the Establishment. It also includes providing intermittent on-going technical assistance in the form that has recently been provided and to offering the staff opportunities for selective training and/or field visits to countries within the region that have implemented components of the partnership process (e.g. hospital accreditation etc). Strengthening the Unit in this way will also ensure that there is continuity in coordination in the event that the Coordinator is absent.

The Review makes clear that most stakeholders want to see the GOL-CHAL Coordinating Unit play an increased role in facilitating the work of the JTF sub-committees in particular as they relate to the finalization of the MOU and Operating Agreements. It is also anticipated that the Unit will be assisted by the MOHSW Financial Management Unit in preparing the SEFF and subvention submission and following-up on its timely disbursement.

The Unit itself learned how valuable it is to be able to visit the CHAL Institutions and to discuss the issues pertaining to the partnership with the various stakeholders. It recognized as well that not all stakeholders are informed about the role of the Unit and about the terms of the interim agreement and SEFF. For these reasons, it is considered essential for the GOL-CHAL Coordinating Unit to institute forums at the district level to

interact with stakeholders. It is anticipated that these forums can take place within the context of already scheduled reunions organized by the DHMTs or HSAs.

The review found that there was some disagreement over the appropriateness of having GOL representation on the **Board of CHAL**, but the Review Team has concluded that as one of the principal financiers of the CHAL Institutions, the GOL needs to be represented on the CHAL Board and the Hospital Boards governing these Institutions. This sentiment is strongly supported by Government.

The Review has also discerned that the Board of CHAL lacks the statutory authority under the CHAL Constitution to negotiate on behalf of its members (the Proprietors) and enter into binding agreements on their behalf with the Government. This represents one of the remaining impediments to instituting a viable and sustainable partnership under the proposed new framework.

Not only does the CHAL Constitution fail to accord the Board of Trustees this statutory authority, but a number of its other provisions make clear that an agreement between CHAL and the Government would not be enforceable in the event that a CHAL Institution or CHAL itself were to unilaterally and precipitously quit the agreement in contravention of the service continuity provisions contained in the MOU. In particular, the current CHAL Constitution permits Institutions to quit CHAL at will, for any action or decision taken by the Board of Trustees to be revoked, suspended or amended by the AGM, or for the AGM to disband CHAL altogether. Each of these provisions potentially contravenes the service continuity provisions of the MOU and puts the agreement at risk.

Though the Constitution of CHAL has been amended to allow for direct GOL participation in accordance with the recommendations of the GOL-CHAL Partnership Study and the GOL-CHAL Partnership Meeting, GOL participation has yet to commence. The Review determines that this should be commenced without further delay since it will strengthen communications between the key stakeholders and will thus facilitate the implementation of the new partnership agreement. An orientation for these new members of the Board should be carried out by the CHAL Secretariat with support as required from the GOL-CHAL Coordinating Unit.

The Review also determined that there is widespread agreement among stakeholders that the **CHAL Secretariat** has performed admirably during this interim period. It particularly, it is noted that the appointment of a Senior Economic Planner and Financial Manager with salary support from the Irish Government has enhanced the organization's capacity to implement the substantial new financial procedures required under the interim agreement and SEFF (e.g. payment of salaries, disbursement of SEFF, compilation of financial data, training in financial management etc).

In spite of these improvements to the capacity of the CHAL Secretariat, there is agreement that the institution needs to be strengthened further. First, staffing within the Financial Department needs to be increased to perform the substantial increase in work required under the interim agreement and SEFF. The workings of this Department may warrant further evaluation given that the new Financial Manager has reportedly been unable to allocate as much time to the SEFF process as was originally intended due to the other demands of the organization. It is also clear that the Senior Economic Planner is spending a large share of her time on routine accounting and financial reporting rather

than on performance monitoring and evaluation and systems development and planning as should be the case. It is anticipated that the new accounts position with CHAL would take over the routine accounting support for the independent health centers as well as relieving the Financial Manager of some of her routine responsibilities. In this way, both the Financial Manager and Senior Economic Planner could become more actively involved in the developing and rolling out the financial components of the partnership process and instituting new capacity within CHAL and its Institutions in this domain.

Second, though there is concern that the Secretariat develops expertise in the health services domain for which CHAL Institutions are being contracted by Government, to provide technical input on issues pertaining to quality assurance and accreditation as well as overseeing efforts to upgrade service quality at CHAL facilities. The Secretariat strongly felt that it would be misappropriation of resources if a physician was placed at the Secretariat while the hospitals had shortages in this regard, it also felt that they dealt more with managerial issues hence this candidate would be underutilized. They also indicated that the issue had been dealt with before at an AGM and it was not seen to be cost effective.

The review further noted a generalized interest in having the Secretariat improve its communications and public relations abilities. This would involve both strengthening the communications infrastructure between CHAL Institutions and the Secretariat (e.g. two-way radio and/or Internet etc) as well as instituting mechanisms for regular meetings and discussions between relevant Secretariat staff and personnel from the Institutions. Communications could also be enhanced through the introduction of a formal orientation for new staff on the partnership framework and processes.

The review was pleased to find that a high proportion of the **CHAL Institutions** had participated in the development of the new partnership framework and are conversant in its objectives, structures and methods. The only notable exception to this occured in the case of health centres that fall under the direct management of CHAL hospitals. Staff at these institutions tend to be less well informed about the interim agreement and SEFF and thus less involved.

There is also general apprehension on the part of most stakeholders about the potential impact that the **decentralization process** will have on the organizational structures for the partnership. It will be essential, therefore, for the GOL/CHAL Coordinator and a representative from the CHAL Secretariat (e.g. the Senior Economic Planner) to be involved / informed about developments with respect to decentralization and for those overseeing the decentralization process to fully account for the implications of this process on the partnership process and organizational structures. This should be easy to achieve given the fact that the principal authors of the health sector decentralization process – the DG of Health and Social Welfare and the DPHC – are both members of the MOHSW Working Committee for the Partnership Process.

Legal Provisions. The **Interim Service Provision and Financing Agreement** entered into between the GOL and CHAL in December 2002 has generally achieved the objectives that were set out in the GOL-CHAL Partnership Meeting held in June 2000. It has quite clearly succeeded in sustaining service delivery within the CHAL sector while

providing the framework for further development of the new partnership agreement under a new MOU and Operating Agreements.

A review of the *Report of Proceedings from the GOL-CHAL Partnership Meetings* (MCDI, June 2000) reveals that the original intent was for the Interim Agreement to be effective for a period of two (02) years from the date of signing of the new MOU. This time period was referred to as a "2-year Pre-Certification Period" within which the CHAL Institutions were expected to meet the Certification Requirements qualifying them for public financing under the terms of the financing framework defined in the new MOU (p. 12). The timeline was changed in the Interim Agreement by shifting the Pre-Certification Period from the two years immediately after the signing of the MOU to the two years before. In so doing, the Interim Agreement effectively assumed that the Certification Requirements were already in place at the time of the signing of the agreement. The fact is, however, that the Certification Requirements have yet to be defined while the two-year period for the Interim Agreement will be ending on March 31 2005.

Stakeholders within the GOL (including the JTF and the MOHSW) concur that the current two-year time frame is too short in light of the delays that have occurred in terms of finalizing the MOU and associated Certification Requirements. There is consensus that a one-year extension of the Interim Agreement (through March 2006) is warranted in order to permit the development of the Certification Requirements and Certification Review process prior to entering into the new partnership framework.

It is recommended, therefore, that the period of validity of the Interim Agreement should be extended through March 31 2006 by signature of the PS-MOHSW and the Chairman of the Board of CHAL. During this period, the final text and requisite annexes to the MOU should be finalized and an Initial Certification Review should be carried out starting in October 2005 and ending with a preliminary determination of certification status by March 2006. This preliminary determination of certification status should include a detailed report identifying any all performance deficiencies relative to the accreditation and quality assurance standards and specific recommendations on what steps are necessary for achieving compliance with the certification standards.

All CHAL Institutions should be certified in March 2006 or should be provided a provisional 2-year certification if they fail to satisfy initial certification based on the Initial Certification Review. For those Institutions that fail the Initial Certification Review, two additional certification reviews will be conducted over the course of the next two years. Institutions that fail to meet the certification standards after this third attempt will be de-certified and will receive future GOL funding (if any) in accordance with the needs/wishes of Government based on a separate arrangement with Government outside the purview of the MOU and LI framework.

The key will be to fully develop the MOU and LIs and have all Institutions producing services in accordance with this new framework either on an official basis or a provisional basis depending on their certification status by 2007.

While the Review has generally determined that the Interim Agreement has worked effectively, it is evident that clause (iv) of Article 4.1 which required the Institutions to retain their salary levels at levels prevailing at the time the agreement was signed was ill-

conceived. This clause has exacerbated the employment and service provision problems that are faced by CHAL Institutions and has rendered it very difficult for them to comply with clause (i) that requires them to sustain the current level of service coverage. All stakeholders agree that Clause (iv) has exacerbated the turnover problem faced by these Institutions and thus undermined their ability to sustain services and service quality. It is recommended, therefore, that this clause be amended immediately to allow CHAL Institutions to pay salaries at levels commensurate with those paid by the GOL. It is also recommended that the SEFF be adjusted accordingly based on a salary review to be undertaken jointly by the CHAL Secretariat and the GOL-CHAL Coordinating Unit.

CHAL Constitution. The Review has determined that the CHAL Constitution does not accord CHAL the legal or proprietary standing to enter into a binding and enforceable contract with Government for service provision on behalf of the Proprietors and Institutions. The problem arises in the event that either a CHAL Institution (Proprietor) or the AGM decided to unilaterally and precipitously quit the agreement without honoring its service continuity provisions. Because CHAL has no ownership entitlements over the Institutions and thus has no recourse to the their assets, a solitary agreement between the GOL and CHAL would be insufficient for Government to sue to keep an institution open while alternative service provision arrangements are made. Moreover, the CHAL Constitution in its current formulation allows Proprietors (Institutions) to quit at will and gives the AGM the power to amend or revoke any action or decision taken by the Board of CHAL – including presumably the MOU signed with Government. For these reasons, the Review recommends retaining the two-part legal framework based on an MOU between CHAL and the GOL and separate Operating Agreements between the MOHSW and each Institution. These latter will ensure that service continuity can be retained. For the MOU to work, however, it will be necessary to further amend the CHAL Constitution in order to safeguard the purchase agreement. This will include modifications to the articles governing (i) the timeline for CHAL members (Proprietors) resigning their membership in CHAL, (ii) the authority the AGM has over amending or revoking Board decisions relating to the MOU, and (iii) the timeline for dissolving CHAL will each need to be revised to ensure that they do not abrogate or contravene the MOU.

Financing Provisions. The agreement signed between the GOL and CHAL in December 2002 stipulated that the government would provide CHAL with a Supplementary Emergency Financing Facility (SEFF) during the pre-certification period subject to some conditions. Under the new arrangement, the total GOL funding included (i) the salary subvention that was already enjoyed by the CHAL institutions plus (ii) the SEFF converted to a lump sum grant rather than direct salary remuneration. The SEFF was meant to be sufficient to bring the Operating Margin (Current Assets – Current Liabilities) of each institution up to a threshold level equivalent to 20% of the total Allowable Operation Expenses based on the audited financial statements of each institution. For implementation, the 1999/00 audited financial statements were utilized.

The Review found that most stakeholders perceive that the SEFF has improved the capacity of CHAL Institutions to deliver health services. Though all hospitals are aware of how the SEFF is calculated and what it is intended for, it was determined that health centres are less well informed, particularly those under direct hospital management. Though the majority of the Institutions favored the conversion of the subvention to a

lump sum grant, one third of the hospitals cited the increased workload for their accounts departments associated with having to pay their staff. They also noted that bank charges have increased given the increased number of checks that need to be written.

The Review also determined that there is widespread uncertainty concerning the future funding formulation, either in terms of understanding the options presented in the GOL-CHAL Partnership Study or how exactly these options would be applied. A number of stakeholders cited concern over the institution of a drug trading account with the NDSO since they fear that it will lead to stock-outs.

Approximately 1/3rd of the Institutions interviewed were unaware that future funding would be tied to an accreditation process.

Impact of SEFF on Financial Position of CHAL Institutions. The overall perception of the stakeholders interviewed during the mid-term Review is that the SEFF has had a favorable impact on restoring the financial position of the CHAL Institutions. This perception is generally supported by the financial analysis undertaken based on the most recent financial data available from the Institutions, although a complete financial analysis was impossible given an absence of audited statements for FY 2003/04.

This latter – the lack of up-to-date financial data for all CHAL Institutions - is a significant problem that will need to be redressed as a matter of priority in the future to ensure that the Government subvention is based on the most recent available information. The financial assessment reveals that there is considerable variation between the SEFF that was actually disbursed (based on FY 99/00 financials) and the SEFF that should have been disbursed had it been based on more recent data.

Total Revenues. An evaluation of revenues over the past four years reveals that the subvention from Government contributed to increasing total revenues for nearly all CHAL Institutions evaluated. In the two hospital cases where total revenues declined in FY 2003/04 relative to FY 2002/03 – Paray and St. James - the decline was not due to a decrease in Government subvention which increased because of the addition of the SEFF, but to a decrease in earned income from fees and other sources. Thus, the evidence demonstrates that the SEFF had a positive impact on the revenue position of all CHAL Institutions, though the net impact was offset in a few cases by a decline in other revenues.

Contribution of the Government Subvention. Though the subvention from Government increased in absolute terms throughout the past four years, in half of the hospitals the relative share of total revenues attributable to the subvention actually decreased between FY 2000/01 and FY 2003/04. By FY 2003/04 the Government subvention accounted for at most 69% of total revenues at Seboche and as little as 55% at St James, with the median share being 66%. Clearly, the CHAL Institutions are heavily dependent on the Government subvention, but this dependence has decreased in recent years through increased revenue effort in non-grant areas.

The increase in earned income is unexpected to some degree given the conditionality of the SEFF which has restricted the CHAL Institutions to retaining fees at their pre-SEFF levels. Unfortunately, utilization data from the HMIS are incomplete and so it was not possible to ascertain whether the growth in earned income was associated with an

increase in demand, the introduction of new charges, or unauthorized rate increases on existing fees. It will be essential for the information system to evolve sufficiently in the coming year to permit this level of accountability.

Revenue Adequacy. The ability to assess the impact of the SEFF on the financial position of the CHAL Institution was again hampered by the deficiencies in financial data. However, for the three hospitals for which complete financial data through FY 02/04 were available, the evidence is that the SEFF contributed positively to improving their financial position though in each case there is still a need for further improvement in order to reach financial health. The financial position of Mamohau Hospital, for example, improved substantially relative to FY 2000/01, though its operating margin is still only 1/3 of the recommended level. As such, it will continue to require a positive SEFF grant in FY 04/05 in order to pay down its current liabilities. A similar situation prevails at St Josephs Hospital where the net income increased appreciably from a negative level if FY 2000/01 to a substantial positive level in FY 2003/04 equal to roughly ¼ of annual operating expenditures. In spite of this, the hospital appears to have substantial current liabilities that still need to be paid down (the latest balance sheet data are for FY 02/03) in order to achieve the desired fiscal health. Finally, the situation at St James Hospital suggests that it will continue to need a SEFF allocation that is equal to 20% of its annual operating expenditures.

For those Institutions for which there are no data for FY 03/04, their pre-SEFF financial status was mixed. On one extreme was Seboche whose financial position improved substantially through FY 2002/03 and in the process achieved the recommended operating margin as a percentage of operating expenditures. On the other extreme was Paray which experienced a significant worsening of its financial position and remained with a negative operating margin at the end of FY 2002/03. In the middle is Scott which experienced a substantial improvement in its financial position but still faced a negative operating margin as result of accrued liabilities. These cases are instructive since they reveal that had the first SEFF disbursement been based on FY 2002/03 financials rather than on FY 1999/2000, Seboche would not have received a SEFF, Paray would have received roughly Maloti 12 million more than it did (a 560% increase), and Scott would have received roughly 1/3 less than it actually did.

In addition to the SEFF, the CHAL Institutions have also been receiving subventions for the treatment of TB and malnutrition patients. These subventions account for only 2% and 4% of total GOL subventions, but they none-the-less provide revenue support for two vulnerable groups of particular public health interest. Anecdotal evidence from the review suggests that there are delays in reimbursements under this subvention that will need to be addressed.

Impact of SEFF on Expenditure Efficiency. The expenditure analysis reveals that the SEFF has led to substantial efficiency improvements as reflected in the fact that all hospitals have been able to reduce the share of total expenditures allocated to labor to less than 70%, and increase the share of expenditures on drugs, building and vehicle maintenance.

Impact of the SEFF on MOHSW Expenditures. The Review reveals that the introduction of the SEFF increased the total grant outlays by the MOHSW by roughly

Maloti 2.36 million. Though grant outlays increased by 5% between FY 2002/03 and FY 2003/04, total MOHSW recurrent expenditures increased by 12%. This suggests that the services provided by CHAL remain a relatively cost efficient substitute for publicly produced health care. If parity is maintained between the growth in outlays on the Government and CHAL sub-sectors, then it is evident that there is considerable scope for a further increase in total grant appropriations should this be required under the new MOU.

In summary, therefore, the available financial data reveal that the SEFF has had a positive impact on the financial position of CHAL Institutions improving both their revenue position and the efficiency of their expenditures. The introduction of the SEFF has enabled Institutions to increase expenditures on essential inputs complementary to labor which decreasing their labor share. Most Institutions will continue to require the SEFF in part to pay down accrued liabilities. However, with the deregulation of wages to restore parity between the GOL and CHAL sectors, SEFF levels will need to be increased at all Institutions in order to defray these increased allowable operating expenses. This increase should be possible while still keeping the growth in grant outlays at a rate below the growth in total MOHSW recurrent expenditures.

Outcome of the SEFF Review Workshop

The following points were agreed to at the SEFF Review Workshop held on September 15, 2004:

The Partnership Process

1. The Interim Agreement and Supplementary Emergency Financing Facility will be extended through March 31, 2006. An amended contract will be prepared (see more below) and will be signed by the PS-MOHSW and Chairman of the Board of CHAL as soon as possible.

The Organizational Framework

JTF

2. The sub-committees of the JTF (specifically the Legal, Quality Assurance, Human Resources and Financial Management and Monitoring & Evaluation sub-Committees) will be convened as soon as possible. They will ensure that plans of action with specific tasks are developed within each of their areas and appropriate timelines are specified that coincide with the overall work plan calendar for the partnership process presented in this report.

3. The JTF should continue to oversee the partnership process for at least one (01) year beyond the signing and effectiveness of the MOU. During this time, the JCC Working Committee will be constituted and a smooth transition of responsibilities will be effected. This will ensure the necessary continuity in leadership during the start-up of the new phase of the partnership process.

GOL-CHAL Coordinating Unit

4. The Health Planning & Statistics Department will be strengthened to ensure recruitment of an additional planner to assist the GOL-CHAL Coordinator and the creation of the position of the GOL-CHAL Coordinator within the MOHSW Establishment will be hastened.

Board of CHAL

5. Government representation on the Board of CHAL should be initiated as soon as possible and an orientation for these new Board members on the partnership process will be provided by the GOL-CHAL Coordinating Unit and the CHAL Secretariat.

CHAL Secretariat

6. An Assistant Accountant will be hired to capacitate the Accounts Department of the Secretariat and hence free some of the Financial Manager's time so that she can provide technical assistance to the Institutions in strengthening their financial management systems and procedures.

Legal Framework

7. All CHAL Institutions will need to be registered as official entities in Lesotho as soon as possible. This is a pre-condition for entering into a Letter of Intent to provide services under the new provider-purchaser facility being introduced under the new MOU.
8. The CHAL Constitution will be amended as necessary to ensure that it is consistent with the MOU and in particular safeguards the continuity of services in the event that CHAL were to be disbanded.
9. The Operating Agreement framework originally proposed will be replaced by Letters of Intent that will be appended to the MOU and will be signed by Institution Proprietors and the CHAL Board.
10. The Interim Agreement will be amended to eliminate the freeze on salaries and the SEFF will be adjusted to reflect an increment in salary levels to the next notch for all authorized CHAL employees.
11. The Interim Agreement will retain the clause which freezes user fees at their prevailing structure and level. The SEFF itself compensates the CHAL facilities for inflation in medical supplies since it is based on actual expenditures. In light of this fact and the fact that the SEFF will be increased to cover the incremental salary costs of CHAL personnel, it was concluded that CHAL Institutions would not be adversely affected by this provision of the Interim Agreement – a provision that will be eliminated when user fees are adjusted under the new MOU.

Financial Framework

12. The SEFF will be recalculated for the FY 04/05 budget in October 2004. It will only be recalculated for CHAL hospitals that provide audited FY 03/04 financials. Those hospitals that do not provide the GOL-CHAL Coordinating Unit with these updated audited statements will not receive a SEFF disbursement in FY 04/05. Because of the

limitations in the financial management systems for health centers, the SEFF for health centers will be based on the latest available audited financial statements.

13. Though CHAL Institutions have adopted a standard chart of accounts based on the MTEF the lack of standardization in their audited statements will need to be addressed in the future.

1 Introduction

This draft report is the second report from the SEFF Performance Review consultancy being undertaken by Medical Care Development International (MCDI) under contract to the Christian Health Association of Lesotho (CHAL) with funding from the Development Cooperation of Ireland (DCI). The purpose of the report is to summarize the findings of the SEFF Performance Review, to present draft recommendations for consideration by the key stakeholders in the partnership process, and to present a draft implementation plan the transition phase of the implementation of the Memorandum of Understanding between CHAL and the Government of Lesotho (GOL).

The report is a working draft that is expected to be thoroughly reviewed and commented on by key stakeholders. The findings and recommendations outlined here will then be discussed more fully at a stakeholders workshop scheduled for September 2004. The report will then be finalized to incorporate the feedback that has been received. This final version will, to the extent possible, also address any analytic deficiencies contained in this working draft, some of which have been inevitable because of a lack of up-to-date financial and service production data.

1.1 Context and Purpose of SEFF Review

In preparation to formalizing the longstanding partnership in health service provision, the GOL and CHAL are working towards a purchaser-provider agreement. In 2002, the two parties signed a Supplementary Emergency Financing Facility (SEFF) that was implemented starting in the fiscal year 2003/04 to 2004/05. The facility was designed to ensure that each CHAL institution remained in sound financial position with increased working capital during an interim pre-certification period. It was intended to help the institutions meet the requirements for certification prior to entering into a long term Memorandum of Understanding (MOU). The intention is to start implementing the MOU in the fiscal year 2005/06.

To facilitate the partnership process and ensure that the objectives of the Interim MOU and SEFF were being realized, it was decided that there was a need to review the performance of the process and of the CHAL health Institutions during this period.

The review was to be undertaken within a period that provided sufficient time to sensitize the parties on the results and allowed them to take timely remedial measures where required. The review was also intended to facilitate the timely preparation of the FY 2005/06 budget, ensuring that it incorporates the essential recommendations and concerns of the review.

The specific purpose of the review was to evaluate the extent to which the parties concerned (the MOHSW, the JTF, the CHAL Secretariat and the CHAL institutions) have complied with the terms and intent of the SEFF and are progressing towards entering into the MOU, and to assess the impact of the SEFF on the operations of the CHAL Institutions.

There were six specific objectives that were set for the review and these are summarized below.

1.2 Objectives of the Review

The specific objectives of the SEFF review as stated in the Terms of Reference are to:

1. To assess the efficiency of policies, structures and procedures put in place for the Interim Provision and Financing Agreement/SEFF.

2. To evaluate compliance with the conditions regarding Service Provision, Financing, Management, Monitoring and Supervision of the SEFF during the fiscal year 2003/04 by each role player (each CHAL Institution, CHAL Secretariat, MOHSW, and JTF), considering the following, before and during SEFF period:

a. Existence, efficacy and adequacy of the institutional and financing framework, funding formulas to include fee structures and SEFF disbursement mechanisms procedures
b. Existence and efficacy of supervision policies, procedures and methodologies
c. Availability of minimum standard equipment, drugs and supplies.
d. Availability, efficiency and retention of work-volume-based minimum staffing by type of institution.
e. Existence of Quality Assurance indicators and processes.
f. Quality and efficiency of services provided by each CHAL Institution
g. Existence and adequacy of certification standards and processes
h. Availability of quality financial and audit reports

3. To assess the impact of SEFF, and other GOL subventions for priority public health diseases, on the working capital of each CHAL institution.

4. To evaluate the current and future potential for proprietor financing.

5. To assess the viability and sustainability of the strategies for GOL/CHAL Partnership (SEFF and MOU) and recommend the way forward.

6. To recommend detailed remedial actions, and draw the implementation plan for the transition phase to implementing the MOU.

The terms of reference also stipulated that the review should be structured in a way that helped build the capacity of the CHAL Coordination Unit within the MOHSW and the CHAL Secretariat. This was to be achieved through the direct involvement of the GOL/CHAL Coordinator and a Senior Economic Planner from the CHAL Secretariat in data collection, analysis, report production and dissemination of results. MCDI's responsibilities were to (i) oversee the work, (ii) provide technical assistance to the national counterparts to carry out much of the data acquisition, analysis, report writing and presentation to stakeholders at the scheduled workshop, and (iii) assume ultimate responsibility for the deliverables of the consultancy.

2 Methodology

This review is based upon (1) a examination and analysis of written documentation and financial reports (see bibliography), (2) field visits to all CHAL Hospitals and a sample of 19 CHAL Health Centers, and (3) interviews with key informants and stakeholders who have been involved in the SEFF process.

The SEFF review also analyzes the annual financial statements for all CHAL hospitals for the latest years available. Where audited statements were not available for FY 2003/04, efforts were made to secure provisional financial data for the relevant institutions. This was important given that the first SEFF disbursement was made in FY 2003/04 (i.e., beginning in April 2003 and ending on March 31, 2004). Where it was not possible to obtain financial data for FY 2003/04, the analysis contrast the financial position and financial activity for the latest year available with the actual SEFF allocation for FY 2003/04.

Where possible, the financial assessment is based on a multi-year comparative analysis from FY 1998/99 through FY 2003/04 in order to evaluate the impact of the SEFF on the financial trends of the CHAL institutions. Because the FY 2003/04 SEFF was derived based on FY 1999/00 financial data, and there was a delay of two years in appropriating the grant, it will be important to ascertain whether the SEFF paid out in FY 2003/04 actually brought the CHAL institutions to the desired financial position.

The financial analysis also examines the use of SEFF funds and assesses its implications for future SEFF payments.

Field visits were made to each of the 8 CHAL district hospitals and 17 of the 73 CHAL health centers[1]. The health centers included in the survey sample are represented in Table 1 on the next page. The sample selection criteria sought to achieve comparable sampling proportions across the churches and at least one from each proprietor. The selection criteria also ensured that most HSAs were represented in the sample and that some of the health centers were in remote highland areas while others were in larger lowland population centers.

The purpose of the site visits to the health centers and hospitals was to acquire financial and service production data as required, and obtain first-hand perceptions and recommendations concerning the interim pre-certification SEFF agreement as well as the process that is underway to finalize the MOU and develop and institute the certification process. Interviews were conducted with the heads of churches using the "stakeholders" survey questionnaire presented in Annex 1. The "health center" and "HSA" survey questionnaires (see Annex 3) were also be administered at each health center and hospital respectively.

The "stakeholders" survey questionnaire sought to evaluate whether the heads of the institutions (1) are sufficiently informed about the purpose of the SEFF, (2) were involved in the SEFF negotiation process, (3) have concerns about the SEFF process and

[1] The other two health centers originally included in the sample could not be reached due to road inaccessibility caused by the weather.

Table 1: Health Centers Selected for SEFF Review Survey

HSA	RCC	SDA	ACL	LEC	BC	AOG	Total Health Centers/HSA
1. Maluti	3	3	0	0	0	0	6
		Maputsoe SDA					
2. Mants'onyane	2	0	3	0	0	0	5
3. Paray	1	0	0	1	0	0	2
				Mohlanapeng			
4. St Joseph (Roma)	5	0	0	0	0	0	5
	Fatima						
5. Scott	5	0	1	5	0	0	11
			St Barnabas				
	Motsekuoa						
				Matelile			
6. Seboche	1	0	0	0	0	0	1
	*St Peters **						
7. Tebellong	1	0	0	1	0	0	2
9. Berea	4	0	0	0	0	0	4
	Little Flower						
10. Butha-Buthe	2	1	0	0	0	0	3
11. Leribe	10	0	0	0	0	0	10
	Holy Trinity/Mahobong						
	Louis Gerald						
12. Mafeteng	3	0	0	0	0	1	4
						Mt Tabor	
	Mofumahali oa Rosari						
13. QE II (Maseru)	7	1	0	0	1	0	9
					Matukeng		
	Maqhaka/Holy Family						
	Good Shepard						
14. Mohale's Hoek	3	0	0	0	0	0	3
	Holy Cross						
15. Mokhotlong	3	0	0	0	0	0	3
	*St Peters **						
16. Machabeng (Qachas'nek)	2	0	0	0	0	0	2
	St Francis						
17. Quthing	3	0	0	0	0	0	3
	St Gabriel						
TOTAL	*55*	*5*	*4*	*7*	*1*	*1*	*73*

Notes

* Not visited due to inaccessibility

	N	Sampling Proportion
RCC =	13	0.24
SDA =	1	0.20
ACL =	1	0.25
LEC =	2	0.29
BC =	1	1.00
AOG =	1	1.00
n =	19	0.29

Health Centres recommended for decommissioning

Proprietor / Management

Proprietor	Health Centre(s)
1. Pastor/Father/Bishop (Different management)	
2. Holy Family Sisters	Maqhaka (Deco)
3. Good Shepherd Sisters	Good Shepard (Deco)
4. Holy Names Sisters	Little Flower
5. St Josephs Sisters	St Peters Mokhotlong (Deco)
6. Under Direct Hospital Administration	St Peters + Fatima (under different hospitals) + Matelile + Maputsoe SDA
7. Holy Cross	Holy cross
8. Grey Nuns	Louis Gerard (Deco)
9. Qacha Sisters	St Francis
10. Other Sisters	Mofumahali oa Rosari and Motsekuoa
11. Holy Trinity/Mahobong (Deco and the only one)	

Factors considered:
1. All the 6 proprietors are represented.
2. BC and AOG, each have one Health Center which were chosen.
3. LEC, selected one that is
4. ACL: Chose the only Health Center that is not under direct hospital management with an assumption that for all others under hospital management it could be found out how they get included them in the SEFF.
5. SDA - All health centers are under direct hospital management, therefore whichever that was already selected is OK.
6. There are many congregations within RCC which were clustered into the 12 above. Each of them is represented and priority was given to those identified for decommissioning.

in particular with the length of time that the process has taken to unfold, (4) believe that the organizational framework established to oversee the SEFF process has been adequate, (5) are informed about the terms of the SEFF agreement, (6) consider the SEFF to have been adequate to secure their financial viability during the interim pre-certification period, (7) are informed about the certification process and its link to future funding under the MOU, (8) are informed about the quality assurance process that is underway in the health sector, (9) believe that the Essential Services Package has been adequately defined, (10) are knowledgeable about the financing options proposed for the MOU and agree with the recommendations of the *User Fee Study*, (11) believe that suitable

financial management systems and procedures are being put in place to position their institutions to manage the future financing agreement, (12) are engaged in the developments taking place with regards to strengthening the HMIS, (13) have been instituting improved HR policies and procedures in line with the new approach adopted by the MOHSW, and (14) are satisfied with the work that has been undertaken to develop supporting legislation for the partnership framework.

The “Health Center” survey questionnaire sought to ascertain the extent to which the health centers have implemented improved financial management procedures as required under the interim SEFF financing agreement, and to ascertain whether the SEFF has been effective in facilitating improved health service delivery e.g. availability of drugs.

A “CHAL” questionnaire (see Annex 2) was administered to senior management in CHAL as well as to representatives from the Board of CHAL. This survey sought to identify what steps have been taken to (1) increase the level of representation on the Board of Trustees, (2) secure non-Governmental funding to supplement the SEFF, (3) participate in the development and institution of the MOU framework, (4) assume financial management responsibility for the independent health centers, and (5) build capacity of the Secretariat to fulfill its coordination role.

The following itinerary was followed for the field survey work.

Table 2: Proposed Field Survey Itinerary

HSA	DISTRICT/AREA	INSITUTION	PROPOSED DATE
WEEK 1			
Tebellong	Qacha's Nek	Tebellong Hospital	21-Jun-04
Qacha's Nek	Qacha's Nek	St Francis Health Center	21-Jun-04
Queen II	Maseru	Matukeng	22-Jun-04
Berea	Peka	Little Flower Health Center	23-Jun-04
Queen II	Maseru	Good Shepard	23-Jun-04
Queen II	Berea	Holy Family	23-Jun-04
Quthing	Quthing	St Gabriel Health Center	24-Jun-04
Mohale's Hoek	Mohale's Hoek	Holy Cross Health Center	24-Jul-04
Mafeteng	Mafeteng	Mofumahali oa Rosari Health Center	25-Jul-04
Mafeteng	Mafeteng	Mt Tabor Health Center	25-Jul-04
Scott	Mafeteng	Matelile Health Centre	25-Jul-04
WEEK 2			
Paray	Thaba-Tseka	Paray Hospital	28-Jun-04
Paray	Thaba-Tseka	Mohlanapeng	28-Jun-04
Maluti	Mapoteng	Maluti Hospital	29-Jun-04
Maluti	Maputsoe	Maputsoe SDA	29-Jun-04
St Josephs	Roma	St Josephs Hospital	30-Jun-04
St Josephs	Roma	Fatima Health Center	30-Jun-04
Mamohau	Leribe	Mamohau Hospital	1-Jul-04
Mokhotlong	Mokhotlong	St Peters Health Center	1-Jul-04
Leribe	Leribe	Louis Gererd Health Center	2-Jul-04
Leribe	Mahobong	Holy Trinity	2-Jul-04
WEEK 3			
Seboche	Botha-Bothe	Seboche Hosptal	5-Jul-04
Seboche	Botha-Bothe	St Peters Health Center	5-Jul-04
St James	Mants'onyane	St James Hospital	6-Jul-04
Scott	Morija	Scott Hospital	7-Jul-04
Scott	Masite	St Barnabas Health Center	7-Jul-04

3 Adequacy of Process, Organizational Structures, Provisions and Procedures put in place for the Interim Provision and Financing Agreement (SEFF) and Development of the MOU

3.1 Adequacy of Implementation Process

3.1.1 Review of the implementation process (milestones achieved; timeline)

The implementation process started in July 2000 following the adoption of the recommendations of the GOL/CHAL Partnership Study at the June 2000 GOL-CHAL Partnership Meeting. Table 3 provides a snapshot of the progress that has been made since then.

Table 3: Milestones in the GOL/CHAL Partnership Process

ACTIVITY	RESPONSIBLE OFFICE	MILESTONE	DATE ACHIEVED	CHALLENGES / CONSTRAINTS
1. Reconstitute the GOL/CHAL Joint Task Force (JTF)	MOHSW	JTF reconstituted in 1997 under the chairmanship of the Prime Minister's office. The chairmanship was later transferred to the office of the Government Secretary.	1997	Regular participation in the JTF meetings
2 Prepare interim MOU and SEFF	MOHSW	Interim MOU and SEFF prepared	2000	Imposed a number of constraints on CHAL Institutions that need to be rescinded
3. Financial audit of all CHAL institutions	CHAL	The first comprehensive financial audit of all CHAL institutions was carried out for the 1999/2000 fiscal year.	2001	Non-standard hospital charts of account makes comparability difficult and incomplete financial data from most health centers
4. Preparation of SEFF financing estimates based on audited Statements	MOHSW	Financing estimates prepared based on audits prepared by Ernst and Young	2002	Based on 1999/00 audits; not updated since
5. Submit Interim MOU and SEFF for Cabinet approval	MOHSW	Cabinet approves Interim MOU and SEFF	December 2002	Change in government delays review and approval process
6. Signing of the SEFF Agreement	MOHSW	Agreement signed	December, 2002	Timely implementation of the Agreement
7. Strengthen the CHAL Secretariat	CHAL	Financial Manager and Senior Economic Planner recruited	2002 and 2003	Ensuring that positions are permanent not contract based

ACTIVITY	RESPONSIBLE OFFICE	MILESTONE	DATE ACHIEVED	CHALLENGES / CONSTRAINTS
8. Revise the CHAL Constitution	CHAL	Revised Constitution available	May, 2003	The Constitution does not give CHAL legal standing to enter into contract with GOL and to enforce provisions of the partnership agreement. Member churches and institutions can quit CHAL and CHAL decisions can be reversed by 2/3 vote of ½ of the members constituting a quorum at the AGM
9. Establish the GOL/CHAL Coordinating Unit	MOHSW	Coordination Unit established; GOL/CHAL Coordinator recruited, with salary top-up under DCI support	September, 2003	Establishment of the position under GOL Staff Establishment
10. Establishment of the JTF Sub Committees	MOHSW & CHAL	Terms of Reference and membership of the Committees defined, however Committees not operational	January, 2004	
11. Institute program of assistance to strengthen CHAL Secretariat, Institutions and Coordinating Unit		The CHAL Institutional Strengthening component of the Lesotho Health Study Investment Project has not been implemented		Not included in sector investment programme as yet
12. Draft MOU with input from the Task Force and Legal Advisers	GOL, CHAL, Task Force	A zero draft has been produced and discussed extensively by the Task Force.		Dependent on development of Annexes; Needs to be finalized and signed prior to next election cycle
13. Developing a Health & Social Welfare Policy	MOHSW	Policy document available	March, 2004	Requires endorsement by Cabinet
14. Developing and defining Quality Assurance Indicators	MOHSW	Quality Assurance Programme (QAP) defined. No indicators defined at this point	April, 2004	Defining the quality indicators
15 Develop certification process and standards for accreditation of CHAL Institutions	MOHSW	No work has begun on the certification process although it is seen as being linked to the QAP		Certification can be costly to implement; Need a process that accommodates Institutions that fail to comply in the first (second?) round
16. Define the Essential Service Package for Lesotho	MOHSW	The Lesotho ESP draft is available	June, 2003	Costing of the Package and defining specific Packages for each CHAL facility
17. Developing Standard Treatment Guidelines and the Essential Drug List	MOHSW	The drafts are available, and the final documents are being edited following an Expert Committee review.	July, 2004	

ACTIVITY	RESPONSIBLE OFFICE	MILESTONE	DATE ACHIEVED	CHALLENGES / CONSTRAINTS
18. Defining a Decentralization Framework	MOHSW	Framework available and District boundaries adopted in the three learning districts	April, 2004	Sensitization of all Stakeholders and clarification of how CHAL fit in the system.
19. Defining the Standard Equipment List	MOHSW	Standard Equipment List available, inventory and audit conducted in 5 districts; Berea, Thaba-Tseka, Mohales'hoek, Maseru and Qachas'nek	May, 2004	Ensuring that all CHAL facilities understand and conform to the set standard
20. Defining the Standard Staffing Criteria	MOHSW	Report of the Human Resource Skills Assessment available, and minimum staffing proposed available.	July, 2004	Specifying staffing standards for each CHAL facility
21. Improve the Health Management Information Systems (HMIS)	MOHSW	Policies and Strategic Plan documents available for Information & Communication Technology, HMIS, and Monitoring & Evaluation. District Information Officer and data clerks identified for the three learning areas	2003/04	Implementation of the Policies & Strategic Plans
22. Establish the current Proprietor Contribution to provision of health service delivery	CHAL	Proprietors' funding study conducted	December, 2001	Sustaining the Proprietor contribution
23. Conduct a Health Centre Rationalization study	CHAL & MOHSW	Study conducted	July,2002	Adoption and implementation of the recommendations pertaining to decommissioning of facilities
24. Draft the MOU and Operating Agreements	MOHSW & CHAL	Draft MOU available, and pending further discussions pertaining to the Operating Agreements	2004	Reaching consensus on whether to sign only the MOU or also have contractual arrangements with the institutions
25 Refinement and finalization of the financing framework and formula for the full MOU	MOHSW	Proposed formulas presented in GOL-CHAL Partnership Study have been reviewed by CHAL Finance Committee; No further work undertaken as yet.		Needs to be linked to User Fee assessment and Proprietor financing capacity
26 User Fee Study	MOHSW	Study conducted	July 2002	Recommendations need to be reviewed by MOHSW and CHAL and decision taken
27. Undertaking the Performance Review for the SEFF	MOHSW & CHAL	Review completed	July, 2004	

The first milestone achieved after the GOL-CHAL Partnership Meeting was the reconstitution of the Joint Task Force (JTF), which was initially constituted in 1991 to develop the original Memorandum of Understanding between Government and CHAL. In

its current form, the JTF is chaired by the Government Secretary. Membership from Government is comprised of the Principal Secretaries (PSs) of the Ministries of Health and Social Welfare, Finance and Development Planning, Education and Training, Cabinet, Public Service, Local Government, the Office of the Attorney General, and the Auditor General. CHAL membership consists of representatives from each Proprietor, and from CHAL.

The Partnership Meeting agreed that an interim period of two to three years would be necessary to fully develop the MOU and Operating Agreements and to develop the capacity of CHAL Institutions, the Secretariat, and the GOL to implement these agreements and to preposition the CHAL Institutions to become certified to implement and adhere to the new Quality Assurance Programme standards. During this period it was deemed necessary to institute an Interim MOU and a Supplementary Emergency Financing Facility (SEFF) in order to sustain CHAL services during the pre-certification period. The SEFF was an incremental grant that was added to the pre-existing salary subvention in order to ensure the financial viability of the CHAL Institutions.

The MOHSW and CHAL, with technical assistance from MCDI, prepared a draft Interim MOU and SEFF formula that were presented to Cabinet, debated and ultimately approved in December 2002.

In order to define the amount of the SEFF it was agreed that an external financial audit would be undertaken of all CHAL Institutions (hospitals and health centers). This was carried out with technical assistance from Ernst and Young in June 2001. The result of the audit of the FY 1999/00 accounts were used to determine the funding requirements for the SEFF that were presented to Cabinet in 2002.

The Interim MOU and SEFF were signed by the Principal Secretary of the MOHSW and the Chairperson of the Board of Trustees of CHAL in December 2002.

A number of studies and assessments were carried out during this time in preparation for the full MOU. These included (1) a *Proprietor's Funding Study* to determine the level of current and future potential Proprietor funding; (2) a *Health Center Rationalization Study* to determine the need for the existing health centers and whether their geographic location and/or service mix should be rationalized in order to eliminate redundancies prior to the initiation of the new partnership framework; and (3) a *User Fee Study*.

Preparations towards the signing of the SEFF took longer than had been anticipated in the plan of action agreed to in the Partnership Meeting, with the signing only taking place in December 2002 and disbursements starting the following fiscal year (FY) 2003/04.

Though the SEFF disbursements began in FY 2003/04 they were based on the original budget estimates for CHAL derived from the FY 1999/2000 audit statements. The implications of this lag in time between derivation of the SEFF and its disbursement are considered further in section 3.5.3 below.

The first SEFF disbursement was realized in July, 2003 and has subsequently been disbursed on a quarterly basis. Recent disbursements have been delayed due to administrative difficulties with the MOHSW Financial Comptroller's office and these have led to delays in salary payments by CHAL Institutions. These delays are a negative implication of the new financing provisions which decouple the CHAL subvention from

direct salary payments, treating the subvention as a lump sum grant to be administered by the Institutions themselves.

In the initial year of SEFF implementation, CHAL submitted quarterly financial and activity reports. The financial reporting format was revised in December 2003 because it was limited to reporting specifically on the use of SEFF funds and thus did not provide a total picture of the overall CHAL financial position. The new format provides a complete expenditure accounting consistent with the requirements of the Medium Term Expenditure Framework (MTEF) instituted by the MOHSW, but does not discern between the sources of funds. There is also a need to design the activity report that will match the new financial reporting format.

As recommended by the *GOL-CHAL Partnership Study* and subsequent Partnership Meeting the CHAL Secretariat was strengthened to build capacity in financial management and monitoring. The capacity of the MOHSW to oversee and monitor the implementation of the partnership framework was also strengthened through the creation of the GOL-CHAL Coordination Unit and the recruitment of a GOL/CHAL Coordinator who acts as the liaison between the GOL and CHAL in all matters pertaining to the partnership. See details in Section 3.2.

In order to fully specify the terms of the new MOU, a number of technical annexes to the agreement had to be produced. These included: (1) an Essential Service Package, (2) Standard Treatment guidelines, (3) an Essential Drug/Medicines List, (4) a Standard Equipment List, (5) Staffing Criteria, and (6) a Quality Assurance Programme. Considerable progress has been made on the articulation of a number of these Annexes. For details see Section 3.4.

The effort to decentralize health, social welfare and other public services has been a key structural development that is expected to have a substantial impact on the new partnership framework and its implementation. Under the decentralization process the MOHSW will shift from jurisdictions based on a Health Service Area[2] concept to district jurisdictions aligned to the 10 Government administrative or District boundaries as adopted for the overall local government system. The process is to be piloted in three districts; Thaba-Tseka, Berea and Mohales' Hoek.

From Table 3, it can be seen that there has been considerable progress achieved in developing the new partnership framework, though the pace has been slower than originally anticipated in the Partnership Meeting action plan. The principal delay that occurred was in securing Cabinet approval for the Interim MOU and SEFF. It was only possible for the MOHSW to include the SEFF in its budget when it was clear that the Cabinet would approve the agreement in December of 2002 (at the mid-point of the FY2002/2003 budget cycle). The SEFF was thus included in the FY 2003/04 budget and officially came on stream in April of 2003.

Due to the fact that the SEFF was a new subvention there were some negotiations that were needed with Treasury to affect the first transfer. As such, it was not until the 2nd Quarter of FY 2003/04 that the first payment was made.

[2] Based on catchment population of the 17 hospitals; 9 - GOL and 8 - CHAL

No attempt was made at the time to revise the basis for the FY 2003/04 SEFF calculation (i.e., based on more recent audited financial data). The reason for this was that it was felt that this would only lead to further delays. As such, the FY 2003/04 SEFF was based on the FY99/00 financial position of the CHAL Institutions.

One of the objectives of this review is to ascertain what impact the lag time between the financial audit and the disbursement had both on the financial position of the CHAL Institutions and on the public finance requirements for the GOL. The other implications of the delay are discussed later in this review.

Annex A illustrates the details of all activities that should have been conducted during the interim period as per recommendations of the GOL/CHAL Partnership study.

3.1.2 Knowledge and perceptions by stakeholders of the implementation process

The Partnership Meeting was widely attended by representatives of the MOHSW and CHAL (Secretariat, Proprietors and Institutions) as well as by other departments within government and representatives of donor organizations. Inevitably, there has been some turnover in staff in all these organizations, but this Review found that there had been universal participation in the formulation of the partnership framework by all stakeholders other than the health centers. Of the randomly sampled health centres interviewed for this Review, half actually participated in the preparations for the SEFF – a relatively high percentage given the number of health centers involved (73 in all). The review found, however, that it is the health centers under direct hospitals management that are the least informed about the SEFF. This is not surprising given that their SEFF allocation is included in the lump sum for the hospitals and they all remit their income to the hospitals where their accounts are maintained.

Almost all health centres view the SEFF as support for payment of drugs and medical supplies rather than as a lump sum grant designed to be used in a flexible manner on whatever expenditures are required to sustain services and maintain quality. This can be attributed to the fact that the CHAL Secretariat in consultation with the Working Committee made a decision to use the SEFF allocation for the health centres solely for payment of their drugs and medical supplies – a decision taken to ensure accountability in the use of funds in a manner that would impact positively on the health centers.

The Review found that all hospitals understand the overall purpose of the SEFF. However, it also found that of the four hospitals with Nursing Schools, only St Josephs made a distinct allocation for its school of nursing.

The Review indicates that the almost all of the hospitals but only a third of the health centres felt that the time between the approval of the SEFF and its implementation had been too long. The following implications of the delay were cited by the respondents:

1. The support was meant to be an emergency facility since the Institutions were facing deep financial constraints, and the fact that it took so long undermined its effectiveness and left many of the Institutions in a serious financial predicament.
2. There was a lot of uncertainty at the facility level as a result of poor communication during the process. Staff are reported to have lost confidence in

management since they were told that improvements were imminent but then they experienced delays. High staff turnover resulted due to the continued insecurity pertaining to salaries.

3. For most of the facilities the working capital continued to deteriorate (e.g., a number of hospitals were charged interest on accumulated overdue electricity and water bills). Some also lost a number of suppliers and they had problems running their Nursing Schools since the NMDS which sponsors students always pays fees about 6 months into the academic year. The upshot was that they had to spent a lot of their time on crisis management rather than on planning for and implementing the improvements required under the new partnership framework.
4. The Institutions could not pay benefits for staff due for retirement and for those in remote areas. The inability to pay these allowances led to increased staff turnover.
5. There was also a feeling that since the SEFF allocation was based on the 1999/00 audited statements it did not realistically reflect their accumulated debts and the fact that their operating margin[3] had decreased. Had the SEFF been based on the FY02/03 financials, the Institutions believed that they would have received a higher SEFF payment.
6. Health centres experienced drugs and medical supplies stock-outs because they could not pay the National Drug Supply Organization (NDSO).
7. In the absence of the SEFF and lump sum subvention, irregular payment of salaries by the Ministry of Public Service continued due to management problems within the Human Resource department of MOHSW.

3.1.3 Lessons learned about the implementation process

The delays in obtaining Government approval for the Interim MOU and SEFF were to a large extent unavoidable given the change in government that took place. The new government had the responsibility to thoroughly review the proposed agreement and to determine whether it was consistent with its perception of the public interest. The reality is that it was extremely difficult under the circumstances for the MOHSW and CHAL to advance the process any faster.

The evidence since then is that the process has worked more expeditiously and that it is unlikely that similar delays will occur (at least to the same degree) in the near future. *It will be very important, however, in this regard to take full advantage of the commitment on the part of the current Government, the Proprietors and CHAL to the partnership process and to do everything possible to implement the full MOU before the next elections*. This should be achievable without compromising the process or the outcomes.

The other lesson learned is that there is a need to strengthen communications both between the partners and between CHAL and the CHAL Institutions in order that those impacted by the process are fully informed about what is happening and why. Though it is not evident that this would have resolved any of the issues identified in the preceding

[3] Operating margins are equal to current assets minus current liabilities. Debts are current liabilities. Thus if debts increased, the operating margin would have decreased. Under the SEFF formula, a decrease in the operating margin would have led to an increase in the SEFF.

section, it may have reduced some of the level of discontentment and fostered a more productive overall climate. It must be remembered that one of the reasons for the development of the new partnership process is that past relations were strained and that improved communications has done a great deal to improve the overall situation and assure that all partners work effectively towards a feasible and sustainable arrangement.

3.1.4 Way forward

In order to strengthen and expedite the implementation process for the development of the full partnership, it is recommended that:

1. The MOHSW ensure that all relevant Ministries (especially the MOF&DP and MPS, but others as well) are on board very early in the process at each stage where their involvement will be necessary.
2. The partners should agree to a more realistic (somewhat less ambitious) time frame that adequately accommodates the bureaucratic requirements of government processes, but that none-the-less ensures that unnecessary delays do not occur.
3. The process for implementing the full partnership should be adjusted in whatever ways necessary to ensure that the full MOU is signed and enacted before the next election cycle, and that associated Operating Agreements are signed and implemented at least on a provisional basis subject to institutional accreditation (see more later).
4. The MOHSW seek to improve its internal and external communications pertaining to developments in the partnership process.
5. The CHAL Secretariat improves its sharing of information with the Proprietors and its Institutions pertaining to developments in the partnership process.
6. The hospitals that manage health centers directly provide briefings to the health center staff on the partnership process and keep them informed of developments.

3.2 Adequacy of the organizational structure for the partnership process

The Partnership study recommended an organizational framework for overseeing the implementation of the MOU to include (1) reconstituting the Joint Task, and its sub-committees, (2) establishing a GOL/CHAL Coordinating Unit within MOHSW, (3) strengthening of the CHAL Secretariat. These structures were to be responsible for spearheading the partnership process towards the development signing and implementation of the full MOU.

All stakeholders reported that the proposed organizational structure including the JTF, CHAL Secretariat, the GOL/CHAL Coordinating Unit, and the sub-committees, has been adequate in overseeing the Partnership. A number of the stakeholders feel, however, that the fact that the sub-committees of the JTF have not been activated has been an impediment to developing some the requisite systems and procedures that are to be

annexed to the MOU. This includes in particular those associated with the accreditation of the CHAL Institutions.

For some stakeholders, the requirement that the GOL be represented on the CHAL Board and Hospital Boards is seen as an infringement on their autonomy. Other feel by contrast that as long as the GOL is a principal financier of the CHAL Institutions it should be represented in the governing bodies of these Institutions.

There is also a general concern that the decentralization process will have an impact on the organizational structures for the partnership, particularly the relationship between the health centres and the hospitals.

Specific issues related to the various organizational entities engaged in the partnership process are reviewed in more detail below.

3.2.1 The Joint Task Force (JTF)

The Joint Task Force, chaired by the Government Secretary (GS), ensures that both Government and CHAL are involved in the development of the partnership process through discussions at the JTF meetings. As per the developed terms of reference[4] for the sub-committees, they are to report to the Joint Commission of Corporation (JCC) which shall replace the JTF once the MOU is signed. Five sub-committees have been proposed and their membership draws relevant expertise from both the GOL and CHAL. These sub-committees include: (1) Finance Management, (2) Quality Assurance, (3) Coordination, Monitoring & Evaluation, (4) Human Resources, and (5) Legal. All sub-committees with the exception of Legal are envisaged to be permanent structures that shall ensure technical monitoring of the implementation process in order to advise the JCC accordingly.

A number of JTF members see the sub committees as temporary entities that should be constituted on an as-needed basis for specific assignments. They also believe that the Joint Commission of Corporation (JCC) that will replace the JTF should not require the membership of the PSs and the GS, but should include senior officers from the MOHSW, CHAL, and other relevant sectors such as the private sector. The GS would then be called in for specific interventions only.

Half the stakeholders feel that the JTF has performed its functions adequately, while 1/4 feel otherwise and the remaining 1/4 do not know. The following improvements to the JTF organization were suggested by those who feel it needs improvement:

1. CHAL proprietor representation on the JTF should be proportional to the number of health facilities owned.
2. More active participation is needed on the part of the GOL representatives to ensure that meetings are more productive. This is important given the heavy demands on the time of the members of the JTF.
3. Selection of CHAL representatives to the JTF should be drawn from members who are more conversant with health-related issues.

[4] Annex B – TOR for the Sub Committees

4. The CHAL Representatives should be more pro-active in sharing information with the Heads of Churches and the Boards of the Institutions.
5. Activate the JTF sub committees.

3.2.2 GOL-CHAL Coordinating Unit

The Partnership Meeting recommended the establishment of a GOL/CHAL Coordinating Unit that was set up in September 2003. This is a notable accomplishment that has been instrumental in shepherding the process forward as far as it has. To date the office is manned by only one officer who is responsible for the overall coordination and monitoring of all activities leading to the formulation of the MOU, as well as for facilitating the JTF meetings, and ensuring GOL compliance to its terms of the SEFF Agreement.

Two thirds of the hospital officials interviewed and 1/3 of the health centres indicated that they felt that the GOL/CHAL Coordinating Unit has performed its functions adequately. However, a relatively high proportion (1/3 of the hospitals and 2/3 of the health centers) did not know that the Coordinating Unit even existed.

Those interviewed indicated a number of ways that they felt the Coordinating Unit could be improved. These included the need to:

1. Increase the number of staff in the Unit in order to ensure (i) that the office is manned at all times, (ii) the workload is manageable, and (iii) continuity and skills transfer in case the present officer resigns.
2. Improve on the quarterly disbursement of SEFF so that it is timely, and follow up on the outstanding arrears to CHAL.
3. Improve communications on the budget process and the budget outcome.
4. Ensure that the Unit develops the necessary capacity to effectively carry out routine monitoring of the SEFF and later the MOU.

3.2.3 CHAL

3.2.3.1 Board

The Board of CHAL is the body that oversees and guides the direct affairs of CHAL. Its Executive Committee is charged with executing its decision. The Board is composed of representatives of the member denominations in proportion to the number of facilities they own. Among the Board’s duties are to oversee the implementation of the GOL/CHAL partnership as recommended by the Partnership Meeting.

As per the recommendation of the GOL/CHAL Partnership Meeting, 2/3 of the Board’s members are health professionals and the rest are drawn from other areas of expertise as found necessary by the member denomination. CHAL’s constitution was amended in 2003 to accommodate a recommendation of the Partnership Meeting that three members be appointed to represent the GOL. To date, the GOL has not formally communicated their representation; however the JTF had identified the PSs from the MOHSW, MOF and Cabinet as the possible candidates.

While the CHAL hospitals are well represented on the Board, the same cannot be said for the health centers given in part that they are too numerous to accommodate similar representation. It appears, however, that this lesser representation has meant that a large number of health centers feel that they are not informed concerning progress made by the Board. Some health centers are even not aware of the function of the Board. Many observed that communication systems between the health centers and their Board representatives are unclear.

The Board, in its capacity as CHAL's governing body should be in a position to make decisions on behalf of CHAL's members. The Review reveals, however, that the Board feels that it has not been given the statutory authority by the Proprietors to negotiate with the MOHSW on their behalf. As a consequence, it refers most issues to the Proprietors for decision making, and high level discussions with the Government are generally carried out by the Proprietors. The Proprietors in turn feel strongly that they have sufficiently empowered the Board via the CHAL Constitution to undertake these responsibilities. They welcome a further review of the CHAL Constitution and other statutory or procedural provisions in the context of the partnership process in order to ensure that CHAL has the requisite authority and accountability.

3.2.3.2 Secretariat

The Secretariat is directly responsible for the day-today running of CHAL under the direction of the Executive Secretary. It represents CHAL in direct working relations and communications with the GOL and other stakeholders. The CHAL Constitution provides for the Secretariat having an advisory role vis-à-vis the Institutions and has to ensure accountability of funds disbursed to the Institutions. Among its other responsibilities, the Secretariat coordinates donor funds and monitors implementation of donor-funded projects undertaken by Institutions. The *GOL-CHAL Partnership Study* concluded that the Secretariat needed to be strengthened both in terms of personnel and skills. This recommendation was endorsed by the Partnership Meeting with the view to ensuring that it could assume more responsibility for the implementation of the SEFF agreement.

In order to strengthen the Secretariat's capacity with respect to implementing the SEFF, a Financial Manager (FM) and Senior Economic Planner (SEP) were recruited in 2002 and 2003, respectively. The FM was charged with directly assisting the Institutions in improving their accounting systems. However, due to the heavy reported workload in the CHAL Accounts Department, the FM has been fully engaged in other accounting duties for CHAL thus only being able to allocate limited time to assisting Institutions as intended. The SEP was recruited to assist the FM in training health centers in adhering to the MTEF being instituted by the MOHSW and to assisting the Institution in complying with the budgeting and financial reporting requirements of the SEFF. Both of these positions are project based, which raises questions about their future sustainability.

One of the principal constraints to capacity-building within CHAL and its Institutions has been the high staff turnover. Faced with this situation it has become necessary to regularly train replacement personnel to perform functions that have already been strengthened through training efforts. The high turnover rate and difficulty in keeping up with the training requirements means that financial reports have to be checked carefully every time they are submitted to CHAL for consolidation. The responsibility for

reviewing and consolidating the financial reports is handled exclusively by the SEP. When the SEP is out of office or otherwise engaged, Institutions have to produce the financial reports without assistance.

As indicated above, the fact that the Accounts Department is reportedly overloaded with work means that there is no backup support to assist the Institutions when the SEP is otherwise engaged. This situation has been exacerbated under the Interim MOU and SEFF by the fact that the Secretariat is now responsible for paying the salaries of the health center employees – a task previously undertaken by Government. The disbursement of salary cheques to the health centers is therefore sometimes delayed due to lack of capacity within the CHAL Secretariat.

The recruitment of one more person in the Accounts Department has been proposed in an attempt to improve the capacity of CHAL and to ensure that the FM can address other job responsibilities.

3.2.3.3 Institutions

The CHAL Institutions are the major role players in the partnership agreement as the recipients of the GOL funding and the providers of health services. It is reassuring therefore that all hospitals reported having participated in the partnership negotiations. It is further reassuring that those not represented reportedly received regular updates via different forums or have been able to rely on published documents to inform themselves.

As mentioned earlier, health centers that are managed directly by hospitals tend to be less well informed about the SEFF. Many of these health centers are not aware, for example, that the GOL is no longer paying their salaries, but rather that they are being paid directly by the referral hospital.

The Review reveals that there is inadequate transparency within the CHAL with regards salaries in particular. The fact that salaries are different from one institution to another, and between CHAL and the MOHSW, engenders a lack of trust in Institutional management.

3.2.4 Lessons learned about the organizational structure for the partnership process

1. There is recognition that the JTF needs to continue to play the lead role in pushing for the timely development and implementation of the partnership framework and processes. It is also recognized that JTF performance needs to be enhanced during the period prior to the signing of the new MOU through fuller and better prepared involvement by its members and through activation of its sub-committees which should take responsibility for stimulating the development and implementation of the annexes to the MOU.
2. There is concern on the part of some CHAL members that the CHAL representation on the JTF is not optimal and should be adjusted to better reflect ownership proportionality and to ensure that CHAL's views and concerns are well represented when dealing with technical health-related issues.

3. There is concern that decisions taken by, or requests made by, the JTF are not being effectively transferred to stakeholders within the Government (most specifically within the MOHSW) and CHAL (including health centers). There is a need to improve communications throughout the partnership structures to better disseminate information emanating from the JTF. Similar improvements in the lines of communication from the Institutional level up need to occur in order to ensure that the JTF is acting on the best and most complete information possible.
4. While the contribution of the GOL-CHAL Coordinating Unit in furthering the partnership process is recognized by many stakeholders, there is widespread acceptance that the Unit needs to be expanded and strengthened. In particular, it is recognized that there is a need to ensure service continuity in the absence of the Coordinator (i.e., when on leave etc.). There is also recognition that the Unit is considerably overstretched during this development phase of the partnership framework and that this has understandably slowed the implementation process down to some degree.
5. There is some disagreement between stakeholders over the need for GOL representation on the CHAL Board and Hospital Boards as agreed to at the Partnership Meeting in 2000. This disagreement is a natural outcome of a process that has involved a great deal of change in which lines of communication, though vastly strengthened, could be strengthened further. Those who feel that the authority and autonomy of CHAL and its Institutions is being undermined by this provision will need to adjust to the changing paradigm under which the Government is willing to support health service provision by CHAL. As a principal financier of CHAL health services, the GOL must have representation on the CHAL Board and Hospital Boards in order to ensure that the GOL’s concerns are accurately reflected in board proceedings and in order to participate in and understand the decision-making process within CHAL and its Institutions.
6. There is some disagreement as to whether the CHAL Board has adequate statutory authority to act on behalf of the Proprietors in matters pertaining to health service delivery through the partnership framework. What is clear, it is that there is an openness and willingness on the part of the Proprietors to review the CHAL Constitution in order to ensure that the CHAL Board has this authority and that the Board is prepared to take on the responsibilities as accorded under the Constitution.
7. There is a desire on the part of stakeholders at the Institutional level to strengthen communications between themselves and the CHAL Board and the Secretariat. This pertains not only to reporting on the partnership process, but also on communicating routine information pertaining to service provision. Efforts will also need to be instituted to ensure that staff from outlying institutions are well received by Secretariat personnel and that the constraints on the time and technical abilities of these facility staff (e.g. within the financial management domain) are taken into account.
8. The role of the Senior Economic Planner (SEP) in the CHAL Secretariat has become progressively one of a counterpart to the GOL-CHAL Coordinator within the MOHSW. The allocation of these responsibilities to the SEP and the increasing

confidence with which the SEP has assumed these responsibilities has been favorably noted by the MOHSW and is seen as contributing positively to strengthened relations between the partners.

9. Health centre finances (revenues and expenditures) are not being differentiated from hospital finances within the financial reporting system for CHAL. Thus, while the SEFF is calculated and disbursed with the explicit intention of funds being appropriated to each health center in relation to its financial needs, it is not clear that this is occurring, or on what basis it is occurring.
10. There is evidence that funds are occasionally forwarded to institutions without clear instructions on what they were mobilized for or what the source of the funds is. This creates problem in accurately reporting on the source and use of the funds.
11. There is a general concern that the decentralization process underway in Government will have an appreciable impact on the organization of the partnership process, though the nature of this impact is not understood.

3.2.5 Way Forward

With the above lessons learned during the study, the following are suggested as from the institutions opinion.

1. The GOL-CHAL Coordinating Unit needs to institute procedures for ensuring that JTF members are adequately informed and prepared for meetings. JTF members should, to the maximum extent possible, receive necessary documentation prior to meetings and with sufficient time to review them. This will help facilitate effective participation while minimizing the time required for JTF sessions.
2. The GOL-CHAL Coordinating Unit needs to work with the GS's Office to institute procedures for facilitating, following-up on, and reporting on work assigned by the JTF. This should include the use of a work plan and checklists that are reviewed at each JTF meeting.
3. The JTF needs to convene its sub-committees to stimulate the MOU development process and hold the partners accountable for the development and implementation of the various annexes to the MOU (e.g., accreditation process, financing formula etc.).
4. The JTF should be disbanded once the MOU is signed and should be replaced by the Joint Commission of Cooperation (JCC) as currently envisaged. Membership on the JCC should no longer include the GS or PSs of ministries other than the MOHSW. The JCC should, however, be responsible to the GS and should be able convene Executive Sessions under the direction of the GS as required. The Executive Sessions should be able to be convened either at the direction of the GS or with a majority vote of the JCC.
5. Minutes of the JTF/JCC should be shared with appropriate stakeholders and a system put in place both to disseminate decisions or request from the JTF/JCC to stakeholders and to ensure that stakeholder concerns/views/recommendations are shared with the JTF/JCC. The GOL-CHAL Coordinating Unit and CHAL Secretariat need to take the lead in strengthening the lines of communications.

6. CHAL membership on the JTF/JCC should be reviewed by the CHAL Board in order to ensure that it suitably reflects concerns over ownership proportionality and that representatives are adequately placed to participate fully in technical discussions and decision-making.
7. The GOL-CHAL Coordinating Unit should be expanded to include an Assistant to the Coordinator. This will enhance the capacity of the Unit and ensure continuity when the Coordinator is otherwise engaged.
8. The GOL-CHAL Coordinating Unit needs to institute periodic field visits to the Districts in order to meet with stakeholders in the partnership process both to brief them on developments as well as to provide them with an opportunity to report on and discuss their concerns. These field visits should be undertaken in coordination with the CHAL Secretariat in much the same way as this Review has been conducted.
9. The GOL-CHAL Coordinating Unit needs to work with the PS-MOHSW, the Financial Management Unit of the MOHSW, the Financial Comptroller of the MOHSW, and the CHAL Secretariat to develop a clear timeline and task definition for timely preparation and processing the CHAL subvention and financial reporting within the annual budget cycle. An Officer within the Financial Comptroller's Office should be assigned responsibility for processing the subvention payment and should be trained accordingly. A counterpart within the CHAL Secretariat (e.g., the Financial Manager) should be designated to facilitate communications and ensure timely submission of requisite financial information.
10. Monitoring and evaluation systems and procedures for the partnership framework need to be developed as does the capacity of the GOL-CHAL Coordinating Unit to oversee and implement them.
11. GOL participation in the CHAL Board sessions should be initiated without further delay. It may not be realistic to designate PSs to represent the GOL on the Board given the intense demands on their time. It may be preferable instead to designate individuals at the Director level from the MOHSW, the MOF and MPS. A decision in this regard should be taken soon by the JTF and should be communicated to the Chairperson of the CHAL Board so that the government representatives can be invited to the next CHAL Board meeting. A formal orientation for the new Government representatives to the CHAL Board should be organized by the Secretariat prior to the first Board meeting.
12. The statutory authority of the CHAL Board needs to be strengthened by according it explicit authority to negotiate on behalf of its members and enter into a binding agreement with the GOL via the MOU on all issues pertaining to the partnership framework and processes within the health and social welfare sector. Letters of Intent between the CHAL Proprietors and CHAL Board would continue to protect the individual and distinct interests of the CHAL Institutions so long as they do not contravene the letter or spirit of the MOU.
13. The statutory authority of the CHAL Board should be further strengthened by enabling it to set the subscription levels for CHAL members, upper and lower limits to the rates charged by CHAL Institutions for user fees and other charges, and

negotiate the funding formula that will be used to determine the level of Government, Proprietor and User financing under the MOU and LIs. This authority should be codified within the CHAL Constitution and should be subject to the following recommended restriction on the powers of the AGM.

14. The CHAL Constitution should be amended to restrict the Powers of the AGM to revoke, suspend or amend actions or decisions by the CHAL Board in such cases where doing so would contravene the terms and/or conditions of the partnership framework between CHAL, its Institutions and the Government as defined in the MOU and LIs.
15. Communication between the CHAL Secretariat, its Board, and the Institutions (including most notably the health centres) needs to be strengthened. In large part this is deemed to be a function of the inadequate communications infrastructure that exists between these often remote facilities and the Secretariat offices. It is strongly recommended that this communications deficiency be redressed as a matter of some priority through the provision of a cost-effective and sustainable voice and data communications system.
16. It is also recommended that Secretariat personnel undertake a regular field-visit circuit to attend HSA meetings and/or quarterly health centre meetings in order to better discern the needs and concerns of staff at the Institutional level.
17. The capacity of the Secretariat should be enhanced by filling the positions proposed in the new organogram that can be sustained. This is particularly the case for the Financial Management Unit of the Secretariat where there is a need to assume responsibility for managing the finances of the "independent" health centers, the disbursement of their subvention and/or salary and other payments, and the maintenance of their accounts. The cost of this administrative backstopping function should be covered under the allowable expenses of these independent health centers and should be defrayed in accordance with the agreed funding formula.
18. A Personnel Deployment Plan needs to be developed that identifies the posts that should to be permanently absorbed into the CHAL Establishment and the long term source of funding for these posts.
19. The Secretariat should develop orientation procedures for its newly recruited personnel to maximize their effectiveness. The orientation should include a description of the partnership framework and how individual posts fit into the partnership's organizational structure.
20. Secretariat personnel need to receive training in public relations and communications skills to improve their interpersonal relations with the institutions.
21. The Government subvention for health centers and hospitals should be accounted for separately and should not be used to cross-subsidize one-another (i.e., hospitals should not use Government funds earmarked for health centers to finance hospital expenditures).
22. Where earmarked funds are disbursed directly to health institutions for specific expenditure purposes, clear instructions should be provided by the disbursing agent as to how the funds should be employed and the source from which they are derived.

23. In an attempt to reduce the irregularity in dates of salary disbursements, the Secretariat should expedite the process of instituting direct-deposits into employee bank accounts. Though the date for salary deposits should be advertised and adhered to, it does not necessarily have to be on the 25th of the month as was initiated by the GOL. Any delays should be promptly communicated with institutions so that personnel can be notified and the nature and expected length of the delay fully explained.
24. The future financial monitoring system implemented under the interim MOU and SEFF as well as the new MOU and LI should separately account for health center and hospital revenues and expenditures.
25. It is reasonable to assume that the decentralization process will have an impact on the organizational structure for the implementation of the partnership process. It is recommended that the JTF work in close consultation with those in the GOL who are designing and overseeing the implementation of the decentralization process to ensure that the objectives and requirements of both processes (decentralization and partnership) are adequately addressed and do not contravene one another.

3.3 Adequacy of Legal Provisions

3.3.1 SEFF

The Interim Service Provision and Financing Agreement (hereafter referred to as the Interim Agreement) entered into between the GOL and CHAL in December 2002 was developed by the MOHSW under the direction the of the JTF with legal input from the Government of Lesotho lawyers. The service and financial conditions stipulated in the agreement were based on recommendations provided by MCDI following the Partnership Meeting.

3.3.1.1 Timing of the Interim Agreement

The Interim Agreement was signed for a two year period that most stakeholders feel is too short. A review of the *Report of Proceedings from the GOL-CHAL Partnership Meetings* (MCDI, June 2000) reveals that the original intent was for the Interim Agreement to be effective for a period of two (02) years **from the date of signing of the new MOU**. This time period was referred to as a 2-year Pre-Certification Period within which the CHAL Institutions were expected to meet the **Certification Requirements** qualifying them for public financing under the terms of the financing framework defined in the new MOU (p. 12).

The timeline appears to have been changed in the final preparation of the Interim Agreement by shifting the Pre-Certification Period from the two years immediately **after** the signing of the MOU to the two years **before**. In so doing, the Interim Agreement effectively assumed that the Certification Requirements were already in place at the time of the signing of the agreement. The fact is, however, that the Certification Requirements have yet to be defined while the two-year period for the Interim Agreement will be ending on March 31 2005. As such, the intent of the Pre-Certification Period – to enable

the CHAL Institutions to meet the Certification Requirements – can as yet not be achieved, and will not be realizable until the Certification Requirements are defined and agreed to (i.e., when the MOU is signed[5]).

Even if the Certification Requirements had been in place when the Interim Agreement was signed in 2002, Institutional stakeholders have indicated that it has taken them a year to clear their debts and re-establish good financial relations with their creditors after beginning to receive the SEFF and thus it has only been in the second year of the Interim Agreement period that they have begun to have the flexibility to finance investments that would position them to meet the Certification Requirements[6].

Stakeholders within the GOL (including the JTF and the MOHSW) concur that the current two-year time frame is too short in light of the delays that have occurred in terms of finalizing the MOU and associated Certification Requirements.

Most stakeholders agree that at least a one-year extension of the Interim Agreement (through March 2006) is warranted assuming the Certification Requirements are rapidly developed and codified under a new MOU.

A review of **Article 7.1** of the Interim Agreement governing "Revisions to the Interim Agreement" reveals that it will be possible to adjust the timeline of the agreement without having to seek Cabinet approval again. **Article 7.1** reads:

> "It is agreed that:
>
> (a) Should either of the parties consider it desirable to review the terms of this Agreement, it shall request consultation between the parties. Such consultation shall commence within a period of sixty (60) days from the day of request.
>
> (b) Any review, which may be agreed upon between the parties, shall come into force after it has been confirmed in writing." (p. 5)

What is clear here is that a change in the time period of the Interim Agreement can be affected through written agreement between the parties (the PS-MOHSW and the Chairperson of the Board of Trustees of CHAL). It will not require re-submission to Cabinet, as Cabinet has already approved the Interim Agreement including **Article 7.1**.

Assuming that the Certification Requirements can be defined and agreed to, a number of stakeholders recommend that an Initial Certification Review take place in January 2006 in order to provide the Institutions with a detailed assessment of what, if anything, they would need to do to satisfy the Requirements. Those Institutions that pass the Initial Certification Review would then enter into a permanent Operating Agreement with the MOHSW. Those that fail would be given a two-year period to meet the standard. During this two-year period, they would be accorded a "Provisional Operating Agreement" under the MOU they would have signed with Government.

[5] Recall that the Certification Requirements are supposed to be one of the Annexes to the MOU.

[6] In reality, the recommendations of the *GOL-CHAL Partnership Study* and the Partnership Meeting were that CHAL and its Institutions would receive external investment assistance through a CHAL Strengthening Initiative that would assist them in meeting the Certification Requirements. This investment has not taken place and as such it is unlikely that the Institutions could meet the Certification Requirements even with the SEFF financing.

The intention should be to sign Operating Agreements with each CHAL Institution based either on the Provisional Operating Agreement or permanent Operating Agreement by April 2006 under a revised subvention for FY 2006/07 prepared on the basis of the new funding formula and the FY 2004/05 approved audited financial statements. For this to occur, and in order to provide sufficient time for the Initial Certification Review and dissemination of findings, it is recommended that the Initial Certification Review be **completed** by February 2006. Based on the experiences of Zambia and South Africa in this regard, it is recommended that the Initial Certification Review be initiated by October 2005 at the latest.

3.3.1.2 Conditions precedent

The Interim Agreement includes **Clause (iv) under Article 4.1** that reads:

> "That the CHAL institutions retain their levels of salary remuneration and fill positions vacated after the signing of the Interim Agreement." (p. 4)

The intent of this clause was to ensure that the total wage bill for CHAL Institutions would not increase markedly after the introduction of the SEFF through increased hiring or salary payments. This was considered prudent as a means of capping the Government's expenditure commitments during the Interim Agreement period.

In retrospect, it is clear now that this condition was ill-conceived and has exacerbated the employment and service provision problems faced by CHAL Institutions and has rendered it very difficult for them to comply with Clause (i) that requires them to sustain the current level of service coverage. All stakeholders agree that Clause (iv), which has required CHAL Institutions to continue to pay their staff at the first notch of whatever salary grade they are on, has exacerbated the turnover problem faced by these Institutions and thus undermined their ability to sustain services and service quality. Staff turnover has been exacerbated because CHAL Institutions have been unable to pay comparable salaries to those offered by the MOHSW. As such, CHAL has only been able to attract beginning workers (those who would be on the same notch whether in CHAL or the MOHSW) or workers over 55 who cannot work for the Government under prevailing retirement age restrictions. Capable mid-career workers who have the qualifications and opportunity to work for the MOHSW, have been leaving the CHAL sector when the chance arises.

The freeze on salary levels has also made it very difficult to comply with the requirement that CHAL Institutions fill vacant positions after the signing of the Interim Agreement since few qualified workers could be attracted at these lower wage levels.

The mid-term Review has revealed that there is unanimous agreement among the stakeholders that this condition (Clause iv) should be removed immediately from the Interim Agreement, and an initiative in this regard has already begun based on the discussions held during the Review.

There is also widespread agreement among stakeholders that CHAL Institutions should rapidly adopt a common salary and benefits structure to that prevailing in Government. This will eliminate any remuneration-based competition between the two sub-sectors for employment and should help ensure that all institutions (GOL and CHAL) are able to employ the workers they need.

Clause (v) of Article 4.1 of the Interim Agreement stipulates that the Institutions should retain their fee structure and rates at prevailing levels until otherwise instructed by the MOHSW and until adequate supplementary compensatory financing is provided by the GOL. This clause was intended to protect the beneficiary population from further increases in the user fees at CHAL facilities since these institutions tend to serve a more remote and less well-to-do population.

While many stakeholders (including ¾ of the health centers) felt that this was a good constraint and should be retained, others felt that when coupled with the freeze on salaries it prevented the Institutions from generating own-source revenues with which to hire additional workers. In the face of increased demand (see more below), the inability of the Institutions to fund additional workers from non-subvention resources meant that the workload for existing workers increased substantially and the overall quality of care diminished.

Assuming Clause (iv) of Article 4.1 is repealed and the SEFF adjusted accordingly, there should be no need for CHAL Institutions to increase their user fees, and so it is recommended that Clause (v) be retained as currently specified in the Interim Agreement.

3.3.2 CHAL Constitution

As indicated earlier, the CHAL Constitution was revised in 2003 in accordance with the recommendations of the GOL-CHAL Partnership Meeting. The amendments provided for GOL representation on the Board of CHAL and ensured that there is sufficient Institutional representation on the Board.

A further review of the amended CHAL Constitution was considered particularly salient at this time given the reported inclination by both the Board of CHAL and the JTF to consider abandoning the original proposal to codify the partnership agreement through individual Operating Agreements between the CHAL Institutions and the MOHSW – retaining only the MOU between the GOL and CHAL.

Under the new contractual formulation being discussed, the GOL would sign a single contract with CHAL on behalf of the Proprietors and their Institutions. The appeal of this approach is that it (i) appears to simplify the contractual process by eliminating the need for separate Operating Agreements between the MOHSW and each Institution, and (ii) it reinforces the concept that the churches are operating as a single entity through CHAL rather than as separate entities with separate agendas. The new MOU would require CHAL to serve as the intermediary between the Government and the CHAL Institutions with respect to compliance with the terms of the service purchase contract.

While the single contract idea has certain merit, a review of the CHAL Constitution reveals that CHAL has not been accorded the necessary legal and proprietary standing by its members to represent the Proprietors and their Institutions in a contract with Government. In particular, though the Constitution indicates under Article 14.3.6 that "The Board shall have the power to sue or be sued in the name of CHAL," it does not stipulate that the Board (CHAL) can be sued in the name of the Institutions. This is critical given that it is the Institutions that will be providing the services purchased by Government, and not CHAL. Thus, if any of the Institutions failed to adhere to the terms of the contract with Government, CHAL could not be sued in their name, and since the

Institutions would not be signatories to the contract, they could not be sued either. A single contract between the GOL and CHAL, thus fails to provide the Government with legal recourse to sue a non-compliant Institution if necessary.

Though the circumstances under which the Government might need to sue a non-compliant Institution may seem very remote (and one would certainly hope that it would never need to occur), it would not be prudent for Government to enter into an agreement with CHAL that prevented it from doing so. One compelling circumstance under which the capacity to sue would be absolutely essential would be if an Institution (Proprietor) unilaterally and suddenly decided that it was going to shut down without adhering to the article(s) governing continuity of service provision (i.e., that the Proprietor commits itself to supplying the contracted services for a fixed period of time after notifying the Government that it intends to shut down a given Institution)[7]. In this situation, Government should be able to sue to keep the Institution open while it made alternative service provision arrangements.

The reason that a contract with CHAL would not be sufficient is that CHAL has no ownership entitlements over the Institutions and thus has no recourse to the assets of the Institutions. Since neither the Institution nor the Proprietor would have signed an Operating Agreement with Government that commits it directly to a service purchase agreement that can be adjudicated in a court of law if necessary, Government would only be able to hope that CHAL could prevail upon a non-compliant Institution to adhere to the terms of a contract it has not signed.

Whether or not CHAL could "enforce" compliance by non-compliant Institutions is debatable. What is clear is that the CHAL Constitution does not provide CHAL with this enforcement authority. Much to the contrary, the Constitution provides members (and thus the Institutions) with the ability to resign from CHAL at any time and thus no longer be bound in any way by the obligations of CHAL. This is made clear in **Article 9.2** of the CHAL Constitution governing Cessation of Membership reads:

> [membership] "shall cease when [a] member fails to pay [its] annual subscription fee before [the] next AGM, or if [a] member resigns, or if [a member] fails to meet [the] qualifications of [**Article**] **9.1**[8]."

Not only does CHAL not have legal recourse to enforce Institutional compliance with the terms of a single purchase agreement with Government, but its "authority" vis-à-vis its members with respect to enforcing any provision under the MOU must be questioned. This is because the Constitution clearly stipulates through **Articles 13.1**, **13.4** and **20** that the Annual General Meeting (AGM) is the supreme authority of CHAL and can amend, override, revoke, or suspend any actions or decisions taken by the Board (including any articles of the Constitution).

[7] See Article 7.4 of the draft Operating Agreement presented in *Report of Proceedings for the GOL and CHAL Partnership Meeting* (MCDI, 2000; p. 29).

[8] Article 9.1 indicates that a member must be recognized by the MOHSW – presumably through certification.

Article **13.4** states:

> "AGM may revoke, suspend, amend or alter actions or decisions of the Board by a simple majority of the delegates present at such a meeting."

When combined with the fact that quorum for the AGM is attained when ½ of the total number of delegates are present, **Article 13.4** implies that decisions of the Board can be theoretically be reversed by just over ¼ of the members voting for a reversal of decision (½ of members for quorum x ½ for simple majority).

Article 20 of the CHAL Constitution states:

> "The Articles of the Constitution may be revoked, suspended, amended or otherwise changed at an AGM of CHAL after two months notice has been given of the intended changes. A two-thirds (2/3) vote of those members present or by written proxy at such AGM shall be required to effect any amendments to the Constitution."

With this provision, rights and responsibilities of members with respect to CHAL and any of its decisions or actions can be amended or revoked by agreement of as few as 1/3 of the members (2/3 x ½).

Finally, **Article 23** of the CHAL Constitution potentially puts at risk any agreement between CHAL and the GOL. It states:

> "CHAL may be dissolved by the adoption of a resolution to that effect by three quarters (3/4) majority vote of all members at an AGM, specifically convened for such a purpose."

In the unlikely event that CHAL should be dissolved, **Article 23.2.1** stipulates that its assets (and **not** those of the members – i.e., the Institutions) can be distributed after payment of all debts and outstanding financial obligations.

In order to safeguard the interests of Government and the people of Lesotho who are served by the CHAL Institutions, there is a need to revise the Articles of the CHAL Constitution pertaining to contracts undertaken by CHAL and the ability of members to resign from CHAL and thus presumably from any contractual obligations undertaken by CHAL, and there remains a need for Government to sign individual Operating Agreements with the CHAL Institutions that bind them to service provision terms and provide Government with legal recourse in the event that an Institution chooses to be non-compliant with the terms of the agreement.

3.3.3 Memorandum of Understanding (MOU)

Considerable work has been undertaken on the production of a "Zero Draft" of the Agreement in Respect of the Post-Certification Service Provision and Financing Agreement Entered into Between the Government of Lesotho and the Christian Health Association of Lesotho," hereafter referred to as the Draft MOU.

The Draft MOU delineates the framework for the new partnership between the GOL and CHAL, specifying the legal status of the agreement, the organizational framework under which it will be administered, the powers and functions of the Joint Commission for Cooperation (JCC) that will replace the JTC, the governance structures pertaining to

CHAL, its Board and Institutions and their relationship to the MOHSW and DHMTs, the conditions for continued financing, the services to be financed at different levels, terms under which the SEFF would be withdrawn or reduced, the conditions for certification, re-certification and/or decertification, the obligations of the MOHSW, the obligations of CHAL, and terms governing the termination of the partnership and disputes resolution.

The Draft MOU continues to make reference to individual Operating Agreements (OAs) between the MOHSW and the Institutions. Individual Operating Agreements will be replaced by Letters of Intent that will be annexed to the MOU and signed by the Proprietors of each CHAL Institution and the CHAL Board.

Aside from the points raised above in section 3.3.2 pertaining to the need to revise the CHAL Constitution, a number of more specific issues will need to be addressed in the final version of the MOU. These are presented below in order of the Articles to which they pertain.

Article 3.2.2 stipulates that the JCC – GOL/CHAL "shall report to the Sub-Committee of Cabinet Ministers and Heads of Churches, under the chairmanship of the Right Honorable Prime Minister or his delegate, who in turn shall report to the Cabinet." It is not clear whether this Sub-Committee of Cabinet Ministers and Heads of Churches exists already and, if it does, what need there is for it to serve as another intermediary between the JCC and Cabinet. In particular, given that the Heads of Church are *de jure* (if not *de facto*) signatories to the MOU via CHAL, it is not clear why they would need to be represented in the aforementioned Sub-Committee. This would bring into question the authority they have reportedly intended to vest in the Board of CHAL.

Article 3.2.3 states that the "JCC-GOL/CHAL shall be chaired by the Government Secretary or his/her delegate and shall be made up of the Principal Secretaries of the MOHSW, the Ministry of Finance and Development Planning (MOFDP), the Ministry of Local Government (MOLG), the Ministry of Education and Training (MOET), the Ministry of Public Service (MPS), the Office of the Auditor General, Cabinet Office, and the Delegates of the CHAL Proprietors." This is an Article that will need to be reviewed again in light of the concerns on the part of some JTF delegates that the JCC should not be chaired by the GS and should not include the PSs of ministries other than the MOHSW. It is also not clear why the CHAL Proprietors should have delegates on the JCC as opposed to the Board of CHAL which again should represent the Proprietors in this agreement.

Article 3.4.7 should be amended to indicate that the relationship between CHAL hospitals, the District Health Management Teams (DHMTs) and other **decentralized** structures that may be developed will be governed through policies and procedures established by the Government of Lesotho and the Ministry of Health and Social Welfare. Where these policies and procedures governing decentralized health service provision conflict with the Articles of the MOU, the Legal Sub-Committee of the JCC-GOL/CHAL will need to review them and either recommend appropriate amendments to the MOU or modifications to the Government's policies and/or procedures governing decentralized health service provision.

Procedures for amending the MOU need to more fully developed as a separate section of the MOU or as an amplification to **Section 9.0** pertaining to "Non-Variation."

Article 3.5.1 may need to be amended to include “temporary certification” which would be accorded to all Institutions that have not yet undergone an Initial Certification Review or have failed the Initial Certification Review.

Article 3.5.2 needs to be amended to stipulate a level of support to the CHAL Secretariat that is deemed acceptable. In its current form it requires a perpetual increase in level of financial support relative to an un-stated initial level.

Article 3.5.3 may need to be amended to reflect a feasible level of contribution on the part of the Proprietors to the funding of their institutions. The reference made to “total revenues” should be changed to read “total operating costs” which in turn should include the annualized cost of all hospital and health center plant and equipment owned by the Proprietor. The *CHAL Proprietor’s Funding Study* does not estimate this Proprietor contribution though this should be feasible through an external evaluation of the value of the Institutional fixed assets – something that should be done for all Institutions as a requirement of the MOU. The stipulation of a “minimum percentage” should depend upon the results of this external fixed asset valuation and its incorporation in the balance sheets of each of the Institutions.

Article 3.5.7 should be amended to read “The CHAL Secretariat shall provide the technical oversight and support necessary to ensure that Institutions prepare and submit for audit the following financial statements not later than three months after the close of the Financial Year…” The requirement to deliver these financial statements within three months after the close of the Financial Year should be added to each of the Letters of Intent within the MOU and should be included in the indicators of Quality Assurance and Re-Certification. The Secretariat cannot be expected to have enforcement capacity over the Institutions (unless the CHAL Constitution is changed accordingly). The only exception to this might occur in the case of the so-called independent health centers that are to be managed with direct support from the CHAL Secretariat. Here again, however, this should be stipulated in their Letters of Intent within the MOU.

Article 3.5.8 should provide a timeline within which the Auditor General’s Office should review and authorize the audited statements from the CHAL Institutions. This should coincide with a timeline that would permit the annual budget submission for the GOL subvention to CHAL Institutions for Financial Year t+1 to be based on the approved financial statements for Financial Year t-1. For example, the audited statements for FY 04/05 would be submitted to the Auditor General’s Office by the first week of July 2005 (i.e., during FY 05/06), and the authorized audited statements would be released to the MOHSW’s Financial Management Unit and GOL-CHAL Coordinating Unit to prepare the FY 06/07 budget by September 2005.

Article 3.6 should be amended to read

> “The services to be purchased by the GOL from CHAL Institutions shall be based primarily on the Essential Health Package of the MOHSW. The specific package of services and the service mix will be determined within the Operating Agreements in accordance with MOHSW Policy and through an assessment of the health needs of the communities served by the CHAL Institutions. If deemed necessary, the package of services may include supplementary services that are not defined within the Essential Service Package. Both the Essential Health

> Package and the specific package of services and service mix to be purchased from individual Institutions may be revised by the MOHSW in consultation with CHAL from time to time to reflect changing circumstances."

Article 3.6.3 should be corrected to read:

> "Training services purchased by the MOHSW…. will be designed on a **capitated** basis to cover the full operating costs of the school, where the capitation is based on the prospective number of nurses enrolled in accordance with the National Human Resources Development Plan."

Article 4.6 should be amended to read:

> "The MOHSW will include CHAL Institutions that are either provisionally certified or certified as required in its annual operating plans and budgets…"

3.3.4 Operating Agreements (OA) and Letters of Intent (LI)

The original proposal for the new partnership legal framework recommended that individual Operating Agreements be signed between each CHAL Institution and the MOHSW. The purpose of this OA was to enable the MOHSW to agree on an Institution-specific set of services to be purchased and to ensure that each Institution's grant provision (subvention) is tailored to their circumstances (e.g. accounts for structural cost differences, funds relevant carved-out services etc.). Both the GOL and the Board of CHAL expressed serious reservations about the OA approach for different reasons. They propose instead that the OA be replaced by Letters of Intent (LI) that will be annexed to the MOU. These LI will provide the same basic content envisaged for the OA but will not require Government to enter into a set of separate service provision contracts. A draft version of the Operating Agreements was presented in the Report of Proceedings of the GOL and CHAL Partnership Meeting (MCDI, 2000). This will need to be amended now and reviewed by the Legal Sub-Committee of the JTF. A final version of the Letter of Intent will need to be ready by March 2006 if the intention is to accord all CHAL Institutions "provisional certification" for a period of two years following the Initial Certification Review and to initiate funding under the new MOU and LIs in FY 06/07.

3.3.5 Supporting Legislation and Statutes

There has been no review undertaken of the supporting legislation and statutes that may affect the MOU and LI. This should be undertaken as a matter of priority in order to ensure that the final versions of the MOU and LI are fully consistent with applicable legislation and statutes and make reference to these as required.

3.3.6 Lessons Learned

1. The period of validity of the Interim Agreement is too short. It does not provide the two-year "pre-certification" window initially envisaged during which CHAL Institutions would make the necessary improvements to satisfy the certification standards required for future funding under the MOU.
2. CHAL Institutions have only recently been able to re-establish good financial relations with their creditors using the funds provided under the SEFF. They are only

now in a position to begin investing in the improvements required to meet Certification Requirements. Since the SEFF does not factor in the costs of the requisite investments needed to meet the Certification Requirements, these investment costs will need to be defrayed through other means such as the CHAL Strengthening Project specified under the *Lesotho Health Study*.

3. The mid-term Review found unanimity for the proposition that the Interim Agreement be extended by at least one year through March 2006. Assuming that an Initial Certification Review can be conducted by February 2006 and the final text of the MOU and LIs (including Annexes) completed in time for them to be signed by the end of March 2006, then the partnership will move forward under the new MOU starting in FY 2006/07.
4. There appears to be unanimity in support of the proposal that CHAL Institutions be allowed a 2-year provisional certification period if required from the date of signing of their LIs within the MOU. This would take place starting in April 2006 for FY 2006/07.
5. Amending the Interim Agreement will only require the signature of the PS MOHSW and the Chairman of the Board of CHAL. It will not require Cabinet approval.
6. Clause (iv) of Article 4.1 of the Interim Agreement which restricts the CHAL Institutions to paying salaries at the first notch of the relevant grades for their technical staff has fostered a situation of excessive personnel turnover. There is already agreement within the JTF and the MOHSW that this provision clause should be amended to allow the CHAL Institutions to pay salaries and benefits that are commensurate with those paid in the MOHSW.
7. Though the restriction on increasing user fees (Clause v of Article 4.1) has meant that CHAL Institutions have not had the financial flexibility to hire additional staff to meet the increased demand for services observed with the advent of the SEFF, it is widely believed by stakeholders that this clause should be retained if Clause iv is amended as stipulated in point 6 above.
8. Though the CHAL Constitution has been amended in accordance with the recommendations of the GOL-CHAL Partnership Meeting, there are a number of other amendments that will be necessary in order to safeguard the purchase agreement codified through the MOU and LIs. In particular, articles governing (i) the timeline for CHAL members (Proprietors) resigning their membership in CHAL, (ii) the authority the AGM has over amending or revoking Board decisions relating to the MOU, and (iii) the timeline for dissolving CHAL will each need to be revised to ensure that they do not abrogate or contravene the MOU.
9. The Zero Draft of the MOU requires some changes that are stipulated in the preceding section.
10. Work on a Zero Draft of the Letter of Intent should be initiated soon and the final text should be ready for signature by March 2006.
11. There has been no review undertaken of the supporting legislation and statutes that may affect the MOU and LI. This should be undertaken as a matter of priority in

order to ensure that the final versions of the MOU and LI are fully consistent with applicable legislation and statutes and make reference to these as required

3.3.7 Way Forward

1. The period of validity of the Interim Agreement should be extended through March 31 2006 by signature of the PS-MOHSW and the Chairman of the Board of CHAL.
2. A CHAL Strengthening Investment Program needs to be funded and launched as soon as possible and no later than March 2006 that will pre-position the CHAL Institutions to satisfy Certification Requirements.
3. A valuation of the fixed assets of all CHAL Institutions should be carried out by December 2004 as the basis for deriving the Proprietor's annualized contribution to financing services.
4. A review of supporting legislation and statutes that have a bearing on the MOU or LIs should be undertaken by January 2005.
5. Text and Annexes to the MOU and LI should be finalized by October 2005.
6. An Initial Certification Review should be carried out starting in October 2005 and ending with a preliminary determination of certification status by March 2006. This preliminary determination of certification status should include a detailed report identifying any all performance deficiencies relative to the accreditation and quality assurance standards and specific recommendations on what steps are necessary for achieving compliance with the certification standards.
7. All CHAL Institutions should be provided an initial 2-year provisional certification if they fail to satisfy initial certification based on the Initial Certification Review. Two additional certification reviews will be conducted over the course of the next two years. Institutions that fail to meet the certification standards after this third attempt will be de-certified and will receive future GOL funding (if any) in accordance with the needs/wishes of Government based on a separate arrangement with Government outside the purview of the MOU and LI framework.
8. Clause (iv) of Article 4.1 of the Interim Agreement will be amended immediately to allow CHAL Institutions to pay salaries at levels commensurate with those paid by the GOL. The SEFF will be adjusted accordingly based on a salary review to be undertaken jointly by the CHAL Secretariat and the GOL-CHAL Coordinating Unit.
9. The CHAL Constitution needs to be amended in order to safeguard the purchase agreement. This will include modifications to the articles governing (i) the timeline for CHAL members (Proprietors) resigning their membership in CHAL, (ii) the authority the AGM has over amending or revoking Board decisions relating to the MOU, and (iii) the timeline for dissolving CHAL will each need to be revised to ensure that they do not abrogate or contravene the MOU. Final amendments should be enacted by the AGM by March 2005.

3.4 Adequacy of Service Provision Conditions

3.4.1 Ability of CHAL to sustain service provision under the SEFF

One of the conditions of the SEFF was that each CHAL institution would sustain their level of health service coverage at pre-SEFF levels.

While all health centers interviewed consider this a realistic condition, half of the hospitals do not. Those stakeholders that argue that it has not been a realistic condition cite (i) the rising cost of drugs and medical supplies, (ii) their inability to adjust user fees to cover inflationary cost increases, (iii) the difficulties they have had in retaining and recruiting staff given the disparity in salary levels vis-à-vis the MOHSW, and (iv) the increased demand for services associated with the HIV/AIDS pandemic and a growing realization on the part of consumers that conditions and service quality is improving at CHAL institutions.

Figure 1 presents a comparative analysis of the utilization of the hospitals based on reported outpatient and inpatient statistics.[9] The graph illustrates that in the period between 2001 and 2004 the CHAL hospitals have not only managed to sustain the level of service provision but the utilization has actually increased in all hospitals except at St James and Tebellong. The decline in utilization levels at these two hospitals in 2004 is worth evaluating further given that it occurred in the year that the SEFF was introduced.

The statistics also indicate that patient volumes has increased slightly more than 20% per year since 2001 at Mamohau, attaining a level that now exceeds utilization at Tebellong. This increased demand (the second highest rate of all CHAL hospitals) has occurred primarily among outpatients with inpatient admissions having increased by about 80 patients per year to just under 700 annual admissions. As such, the increase in demand does not appear to alter the recommendations of the *Lesotho Health Study* (MCDI, 2000) which suggested that the hospital be downsized to a Type IIIA filter clinic level[10].

Aside from Mamohau, the largest increase in demand has occurred at Scott (23% per year), and Maluti (19% per year). As indicated, only St James and Tebellong have seen a decline in utilization during the period under review.

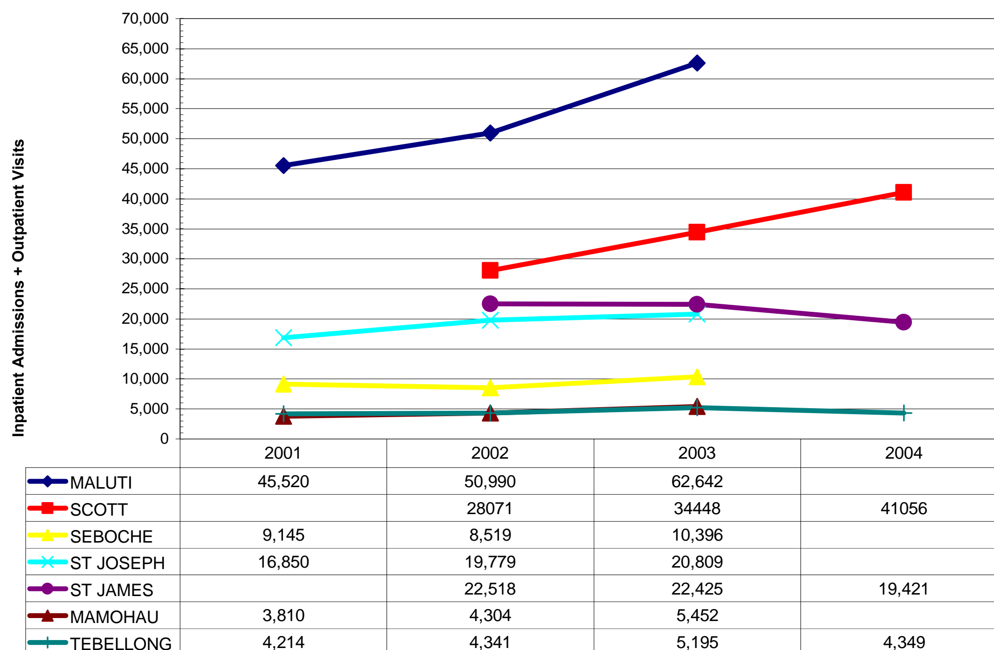
Further scrutiny of the service statistics reveals that the reported bed occupancy rate increased from 47% to 59% at Scott, 34% to 36% at St Joseph and 54% to 57% at Seboche, during the 4 year period. While Tebellong reports a 77% annual bed occupancy no baseline data were provided for comparison, so it not clear whether bed occupancy has always been so high especially in cognizance of the stable average length of stay per patient during the period[11].

[9] Comparison between Institutions should be undertaken with some caution as some of the data are reported by calendar years while others are reported by financial year. At the time this report was being drafted utilization statistics for Paray hospital were not available for inclusion. It would have been very interesting to look at the patient levels at this hospital especially in light of the recommendations to upgrade the hospital to a Type IIA status and to expand the nursing school.

[10] Refer to the hospital typology presented in the Health Study Phase I (August 2000) report.

[11] Other hospitals have not reported on this indicator.

Figure 1: Hospital Utilization



	2001	2002	2003	2004
MALUTI	45,520	50,990	62,642	
SCOTT		28071	34448	41056
SEBOCHE	9,145	8,519	10,396	
ST JOSEPH	16,850	19,779	20,809	
ST JAMES		22,518	22,425	19,421
MAMOHAU	3,810	4,304	5,452	
TEBELLONG	4,214	4,341	5,195	4,349

3.4.1.1 Development of accreditation process and procedures

Rooney L. and P. Ostenberg (1999) describe the accreditation process as one in which an authorized body, either a governmental or non-governmental organization, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. In the context of the purchase agreement that is being developed under the new partnership framework, the MOHSW as the purchaser in the agreement will conduct an assessment of each CHAL facility to ascertain whether the CHAL Institutions meet a defined set of standards that will be stipulated an as annex to the MOU. Without this certification, CHAL Institutions will not be recognized as having the necessary requirements to provide the services that Government wants to purchase and they will therefore not be financed by the GOL under the MOU[12].

Evidence from other countries that have implemented hospital accreditation within the region (e.g. Zambia and South Africa) reveals that it can be an involved, costly and very time-consuming exercise. The time required in Lesotho will depend upon how detailed the accreditation standards are (i.e., how many performance indicators are used). In this regard it must be kept in mind that less detail (fewer indicators) will reduce the ability to discern between Institutions and to ascertain why an Institution does not satisfy the overall accreditation standards. Given that the objective is to assure adequate quality and to avoid disqualifying hospitals unless they are really non-performing it is likely that the

[12] Government may still opt to finance some or all of the care provided by non-qualifying Institutions if doing so is deemed to be in the public interest. It may also opt to purchase the care from other Institutions or finance the construction of a replacement MOHSW facility.

accreditation process will need to be fairly detailed and time-intensive. For this reason it is recommended that an Initial Accreditation Review be initiated in October 2005 and finalized by March 2006.

Though no direct work has been undertaken as yet on developing the accreditation process, work has indirectly begun since it will be based in part to the Quality Assurance Programme that is being developed within the MOHSW[13], as well as the Standard Treatment Guidelines, Essential Drug and Medical Equipment Lists that have been produced. In addition, the parameters of the service package to be purchased from the CHAL Institutions – those which would need to be evaluated within the context of the accreditation and quality assurance processes – has begun to be articulated through the drafting of the Essential Service Package (ESP)[14].

The specific services to be procured from each CHAL Institution remain to be specified, though they will conform to the defined ESP while also taking into consideration the specific features of each facility e.g. its population coverage, hospital typology, location, religious beliefs etc. Among the specific services may be certain "carved out" services – those that certain Institutions have a technical specialization in producing (e.g., ophthalmology, rehabilitation etc) which the MOHSW did not include in the ESP at a particular service level.

While these accomplishments are important, work needs to be undertaken on fully specifying how the accreditation process should be implemented in Lesotho and what it will cost. Since funding for this activity will need to be secured, it will be important to undertake the specification process in the near future.

3.4.2 Lessons Learned

1. Though most stakeholders feel that it has been realistic for CHAL Institutions to maintain service coverage at pre-SEFF levels, half of the hospitals report that they have faced difficulties given input cost inflation, staff turnover and recruitment difficulties, and growing demand for services. Utilization data, however, reveal that all but one hospital have maintained service coverage and actually experienced an increase in demand since 2001.
2. Though no direct work has been initiated on the accreditation process, considerable indirect work has been initiated. Experience with hospital accreditation in the region has shown that the process can be very time intensive and costly depending on how detailed the set of indicators are. While reducing the detail will speed up the process and render it less costly to implement, the loss of detail will reduce the ability to discern why certain institutions are performing less well than others and are not satisfying the overall accreditation standards.

[13] The decision whether the Quality Assurance Programme will be placed under the purview of the Director General or together with the Monitoring & Evaluation Unit is still pending.
[14] The document follows the World Health Organization standard of minimum package of health services.

3.4.3 Way Forward

1. In order to provide sufficient time for carrying out the Initial Accreditation Review, it is recommended that the process be fully specified and costed in the near future and that the Initial Review be initiated by October 2005 and finalized by March 2006.

3.5 Adequacy of Financing Provisions

3.5.1 Description of Financing Provisions

The agreement signed between the GOL and CHAL in December 2002 stipulated that the government would provide CHAL with a Supplementary Emergency Financing Facility (SEFF) during the pre-certification period subject to some conditions. Under the new arrangement, the total GOL funding included (i) the salary subvention that was already enjoyed by the CHAL institutions plus (ii) the SEFF converted to a lump sum grant rather than direct salary remuneration.

The SEFF was meant to be sufficient to bring the Operating Margin (Current Assets – Current Liabilities) of each institution up to a threshold level equivalent to 20% of the total Allowable Operation Expenses based on the audited financial statements of each institution. Allowable Operating Expenses were defined as Actual Operating Expenses as reflected in each institution's statements of financial activity or income statement plus an agreed to increment to cover any allowable funded costs at the discretion of the GOL. For implementation, the 1999/00 audited financial statements were utilized.

As indicated, in addition to the SEFF, the salary subvention was converted to a lump sum grant. Under the previous arrangement salaries were paid by the GOL by check and sent to the employees through their institutions via CHAL. Some institutions deposited the checks into their accounts and paid the employees with deductions of their debts due to the institutions such as rent, electricity and loans. To implement the new arrangement CHAL receives a quarterly lump sum equivalent to their professional staff salaries that gets transferred to individual hospitals. The hospitals are therefore directly responsible for paying their employees based on the GOL salary structure.

Most independent health centers lack the capacity to administer and account for the lump sum grant. As such, the Secretariat has assumed responsibility for accounting for the health center funds and paying their employees. The Secretariat is in the process of instituting electronic banking to facilitate direct transfer of salaries into the employees' accounts. This will enable employees to choose banks with branches nearest to the workplace as opposed the current system that relies on Nedbank which does not have branches in some districts.

On receiving the first disbursement of the SEFF, Institutions were able to pay salary arrears that had accumulated from April through July 2003 amounting to M 229,996, and then pay salaries at the right amounts thereafter. However, there are still some arrears accumulated from before the SEFF period as a result of either payment of staff at wrong salary grades (M83, 502) or non-payment on first appointment (M255,018). The GOL has yet to reimburse CHAL for these discrepancies despite various efforts to follow-up on the part of the Secretariat. Below is the total of arrears owed to the Nurse Educators by

year, which resulted from noncompliance with the reviewed salary structure for the Educators.

Table 4

INSTITUION	1998/99	1999/00	2000/01	2001/02	2002/03	TOTAL
Nurse Tutors	251,095	357,296	256,817	224,859	136,389	1,226,389

3.5.1.1 Requirement to freeze salary remuneration at first notch

The agreement also stipulated freezing of CHAL salaries remuneration at first notch commensurate with the MOHSW salary levels. The staff only enjoyed the inflation salary increments at the rate approved by the GOL. This condition prevailed since the inception of GOL funding. The institutions were expected to top up payment of salaries for notch movement from other sources. However, none of the institutions managed due to the financial predicament they were facing as proven by the identified need for SEFF.

3.5.1.2 Requirement to maintain employment at pre-SEFF levels

The requirement to maintain employment at the pre-SEFF levels implied that positions could be filled only if vacated after the signing of the agreement and no new could be created. At the time when the posts were frozen, there was no consideration of the level of staff per institution, whether it was anywhere near full complement of staff as per standard staffing pattern or to respond to the demand of services from the institution. The basis for the condition was to ensure that the personnel would fit within the prepared budget with no adjustments.

3.5.1.3 Requirement to retain fees at pre-SEFF structure and levels

The institutions were instructed to maintain the fee structure at pre-SEFF structure and level until otherwise instructed by the MOHSW and until adequate supplementary compensatory financing was provided by the GOL to make up for any anticipated losses. The fees charged by CHAL institutions were aligned with the cost incurred for providing the services.

The prevailing condition as indicated by the GOL/CHAL Partnership study was that OPD and inpatient fees charged by CHAL hospitals were more or less similar the GOL charges except for after-hours and emergencies. The other significant difference was on seen in charges for surgical procedures. However, CHAL charged fees for drugs and other services. The charges were aligned with the cost of proving the service. Some of the health centers did charge fees greater than the GOL fees.

3.5.1.4 Finalization of the MOU/LI Funding Formula

Since the SEFF implementation, the MOU was developed to form basis of the agreement to be entered into after the interim period. The draft MOU is available with a number of documents that form part of the annexure[15] to the MOU still being finalized.

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[15] Std Equipment list, Essential Service Package, Essential drug list, Std Treatment Guidelines, Quality Assurance Indicators, Std Staffing pattern as suggested by HRS

The funding formula for the certification period ought to have been finalized during the interim period. However, to date, the eight options as suggested by the GOL/CHAL study were presented to the JTF to ensure that all members appreciated the financial implications of the funding formulae as in the minutes of the JTF of 21st October 2003. The understanding developed from the meeting was that option eight[16] was more appropriate.

3.5.2 Knowledge and perceptions by stakeholders of financing provisions

3.5.2.1 SEFF Formula

SEFF is perceived as financial assistance from GOL to improve the health service delivery as per CHAL request based on the financial problems that were encountered by the institutions. The health centers under direct hospital management are not aware of SEFF hence do not know the purpose while others understand it as funds for professional staff salaries and procurement of drugs, based on the fact the SEFF is utilized for that only.

The hospitals are fully informed on how it is calculated. Health centers do not know the formulae however; they assume the amount is based on: (i) Population coverage. (ii) Staff requirements. (iii) Other sources of income; (iv) Actual expenditure of institutions for previous years and (v) Location of the institution, service provided, however pre-determined by the budget.

This is an indication of lack of communication.

3.5.2.2 Conversion to lump sum grant; no longer salary payments

All health centers and 68% of hospitals agree that the condition to convert salaries to lump sum was realistic. Reasons sited include

i. Improvement of the loyalty of employees to the employer and reduced confusion of who the employer is.
ii. Reduces amount of time taken to fill in vacated positions.
iii. Enhances accountability of CHAL and to some extend reflects trust of GOL to CHAL.

However, the health centers had their reservations. Those under direct hospital management believe hospitals are not yet financially viable, which may lead to diversion of salary funds or keeping of inflation salary increase to take care of other hospital requirements. The independent health centers indicated that since SEFF implementation, salary disbursements have been delayed and the dates been irregular.

The hospitals not agreeable indicate that the condition came with increased workload for their accounts departments and more bank charges borne by the hospital.[17] They also have a feeling the staff has lost confidence in the hospitals management.

[16] Replacing the existing subvention with a matching and equalizing grant coupled with a fixed budget Trading Account for drugs and medical supplies, and a fixed budget grant for the costs of operating the nurses training institutions.

[17] The bank charges M 3.50 per check leaf.

3.5.2.3 Requirement to freeze salary remuneration at first notch

Almost all institutions with an exception of 18% of the sampled health centers were not in favor of this condition. The reason stated being that the qualifications obtained, the populations served and the services delivered are the same for all health personnel regardless of where they practice from, which justifies total parity of salary remuneration. Moreover, one institution indicated that the GOL institutions nearby are always out of stock for drugs, which increases their patient load and yet not remunerated sufficiently for that.

A few institutions that felt the condition was reasonable were appreciating the fact that GOL is assisting CHAL financially therefore has the right to dictate conditions.

Table 5:

INSTITUION	POSITION	NUMBER
Mamohau Hospital	N/A	4
	N/S	3
Scott	Nurse	Over 20%
Seboche	N/A	5
	N/S	3
St James	Doctors	2[18]
St Josephs	Nurses	5/6
Paray	Nurses	No estimates
Tebellong	Nurses	No estimates

The impact felt by the institutions as a result of these conditions has been, (i) demotivation of staff leading to poor service delivery and high attrition rates for CHAL to GOL. The institutions are able to attract new graduated only, who cannot be retained. A rough estimate of the number of staff that left institutions in 2003/04 as reflected in the table above.

No impact had bee felt by 29% of the health centers. However, some of the staff indicated that they were not aware and their loyalty may not last now that they are informed.

3.5.2.4 Requirement to maintain employment at pre-SEFF levels

The JTF together with 35% of health centers feel that the condition to maintain employment at pre-SEFF levels is realistic. The JTF feels that CHAL should use other sources of funds to hire additional staff if required.

The rest of the interviewed institutions showed that the condition does not accommodate a change in workload increase especially with the current health challenges such as the HIV/AIDS pandemic. Among other factors[19] the existence of HIV/AIDS has led to increased demand for health services and community work done by health personnel. Again, since SEFF was implemented, drugs availability is maintained in the institutions and the coverage has expanded. They therefore feel putting up acceptable number of staff

[18] Another reason attributable to staff turnover is the remoteness of the location of the institution and lack of access to communication means.

[19] Holy Cross realized increased workload after introducing free health service for CHWs and their families, which is when the SEFF began. Seboche has increased demand for x-ray service since the x-ray for both Botha-Bothe and Leribe Hospitals are not functioning.

in the facilities should have preceded the condition, especially because they were already understaffed[20] as a result of the salary disparities with the GOL.

The overall impact resulting from the increased workload as sited by the institutions is that;

b. Where, there is one nurse, service provisions doe not continue when the nurse is not around.
c. Infrastructure of some health centers is underutilized.
d. Service delivery in some areas of the hospitals gets compromised.

Maluti opened a new health center and felt compelled to hire more staff[21] even for the hospital to avoid poor service delivery. The staff is paid for the allocation of operating expenses.

3.5.2.5 Requirement to retain fees at pre-SEFF structure and levels

25% of the hospitals and 71% of health centers find this condition to be realistic on the basis that there is additional funding from SEFF. However, they together with those that find it unrealistic believe there should have been room for adjustment that accommodates inflation and other expenditure increases[22]. The SEFF has not been enough to bridge the gap as the drugs prices kept increasing.

On the other hand, they still consider that patients need not be overcharged. Some institutions have actually reduced the fees for chronic illnesses because they have realized that when fees are kept at a higher level than the GOL, patients prefer to utilize GOL facilities. Given the poverty rate, about 30% of the served population cannot afford to pay for the services and this needs to be recovered somehow because income fees gets lower with time.

The impact resulting from maintaining higher fees has been the felt completion for patient with GOL facilities. It was suggested that a standard fee structure be introduced for CHAL institutions to avoid patients' movement resulting from lack of affordability[23].

3.5.2.6 MOU/LI Funding Formula

Results of the study indicate that all institutions and other stakeholders do not know the progress made to date on the finalization of the funding formula for the post certification agreement. Not all of them were familiar with the components of the proposed formula. However, they all suggested that on adoption of the formula, the mechanisms for handling the fixed budget drug trading account need to be negotiated. Fear of it being administered like the GOL institutions is based on the fact that they run out of stock of drugs so often, probably due to the administration problems.

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[20] Holy Trinity indicated that is has one nurse paid by GOL subvention and yet the patient load has increased an average of 500 patients per month. They hired another nurse, which they pay from the other sources of funds.

[21] They recruited the following personnel (1 N/C and 1N/A for the health center and 1 Doctor, 1 R/N, 1 N/S, 2 N/A for the hospital).

[22] Introduction of 14% VAT from 10% sales tax increased the prices of drugs considerably.

[23] St James get considerable number of patients (inpatients) from Paray's catchment area due to user fee differences, who in the end fail to pay all their fee hence increasing the hospitals bad debts.

64% of the health centers and seven hospitals are aware that future funding of the GOL will be based on certification and that some documents are being developed as part of the arrangements for the MOU process they have not had access to them. Some health centers though could not link the developments with the MOU.

The secretariat, which is fully informed, indicated that the arrangements for the post-certification are in progress and the formula has not yet been finalized.

3.5.3 Impact of SEFF on Financial Position of CHAL Institutions

3.5.3.1 Adequacy

The overall perception of the stakeholders interviewed during the mid-term Review is that the SEFF had a favorable impact on restoring the financial position of the CHAL Institutions. Those who had examined the quarterly financial reports from the CHAL Institutions noted that a number of institutions used their entire quarterly allocation within a month – a fact that suggests that the SEFF plus salary subvention were insufficient to cover operating costs. Institutions mentioned in this regard were Paray, Tebellong, St James, Seboche, Mamohau and Mt Olivette Health Center.

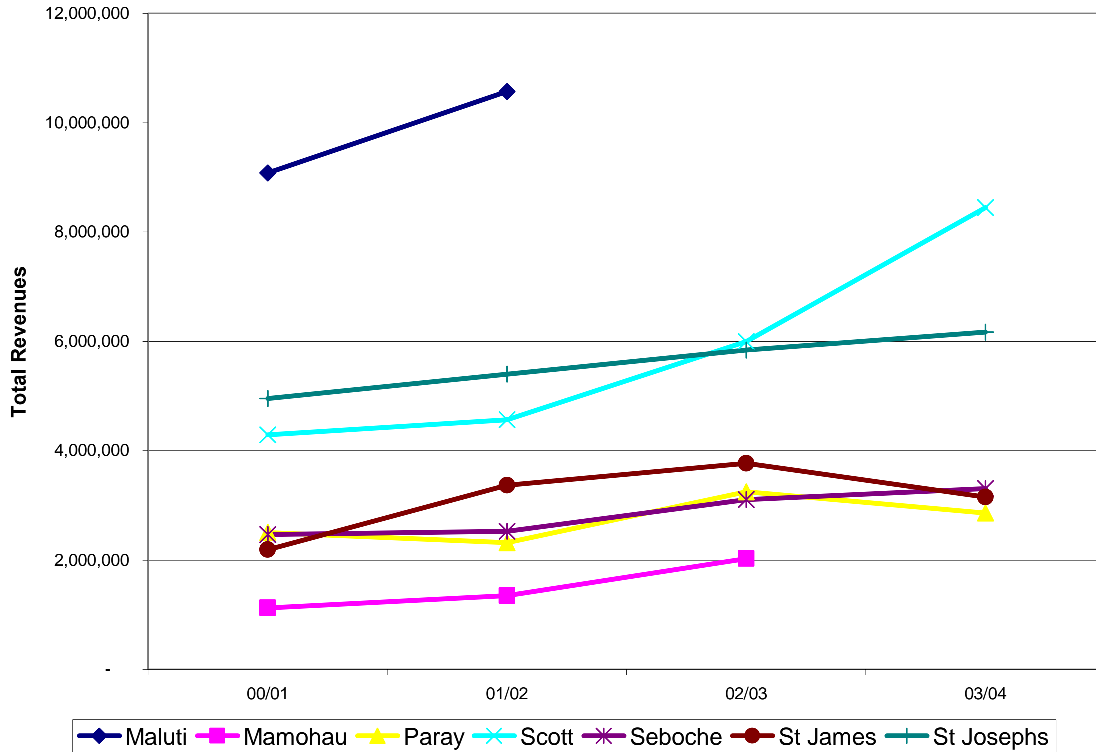
Evidence from the financial statements of the CHAL Institutions and the quarterly financial reports provides only a partial answer to whether the SEFF was sufficient to improve the financial position of the hospitals.

Figure 2 reveals that total revenues from earned income and grants increased at all hospitals for which data were available between FY 2000/01 and FY 2003/04[24] though in a couple of cases (Paray and St James) it appears to have increased through FY 2002/03 and then fallen off somewhat in FY 2003/04 the year the SEFF was disbursed.

In the case of Paray, the decline in total revenues in FY 03/04 was **not** due to a decrease in the Government subvention (it actually increased by M 168,000), but was due instead to a decrease in earned income from fees and other sources and a decrease in non-governmental grants. A similar situation occurred at St James, where the total GOL subvention increased by M 177,500 while revenues from earned income decreased by approximately M 550,000 between FY 02/03 and FY 03/04 and revenues from non-governmental grants decreased by roughly M 232,000.

[24] No financial data were available for Tebellong Hospital.

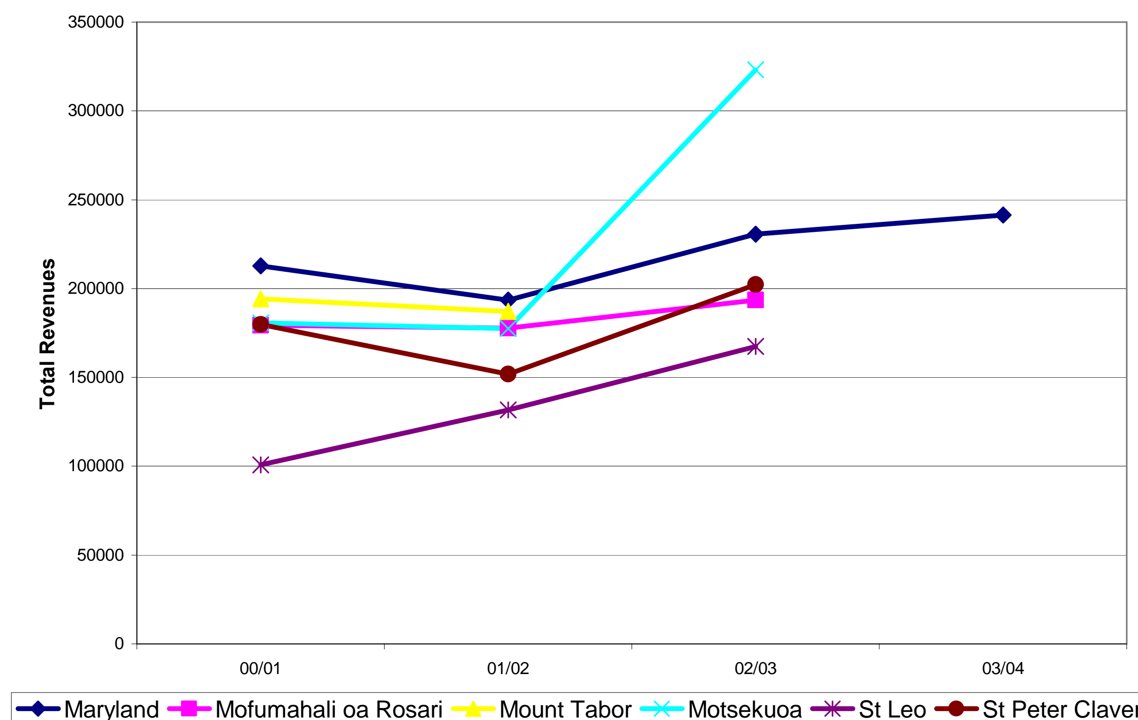
Figure 2: Total Hospital Revenues – FY 2000/01 through FY 2003/04



Financial data for the health centers is less complete and does not extend through FY 2003/04 in most cases. Figure 3, however, reveals that total revenues increased at all but one of the sampled health centers between FY 2000/01 and FY 2002/03, and in the case of the Maryland Health Center increased again in FY 2003/04.

The growth in total revenues at Maryland Health Center were the result of an increase in the GOL subvention over time as well as an increase in earned income, though there was a slight decrease in the latter between FY 2002/03 and FY 2003/04. The growth in revenues at the other health centers was also due to a simultaneous increase in the GOL subvention and earned income. The particularly large observed increased in total revenues at the Motsekuoa Health Center was due primary to a large increase in patient fee revenues between FY 2001/02 and FY 2002/03 and a smaller increase in the subvention.

Figure 3: Total Health Center Revenues – FY 2000/01 through FY 2003/04



3.5.3.1.1 Relative Contribution of GOL (SEFF, Other subventions for Public Health), Proprietors and Clients

While total revenues from the GOL subvention (SEFF plus salary grant) actually increased over time at each of the hospitals, the relative contribution of the GOL subvention as a share of total revenues varied over time depending on the hospital. As depicted in Figure 4, at three of the hospitals (Mamohau, St James and St Josephs) the share of total revenues derived from the GOL subvention actually decreased, while at three others (Paray, Scott and Seboche) it increased. Overall, the Government financing share ranged from a low of 55% of total revenues at St James in FY 2003/04 to a high of 69% at Seboche with a median level of 66%. Thus, with the SEFF included, the Government is currently providing approximately 2/3rds of the total financing for the CHAL hospitals.

At those hospitals where the GOL subvention decreased as a share of total revenues, this occurred because the growth in earned income from fees and revenues from non-governmental grants outpaced the growth in GOL subvention. Each of these cases represents a situation where the Institution exerted substantial revenue effort even under the constraints imposed by the Interim Financing Agreement. At **Mamohau** Hospital, for example, earned income from fees increased at a very high average annual rate of 58% between FY 2000/01 and FY 2003/04 with a large share of the growth resulting from an increase in inpatient fees in FY 2003/04. The latter will require further investigation because the available utilization data suggests that number of inpatients did not increase appreciably during this time, and it would not be expected that the mix of patients would

have changed much either. As such, the large reported growth in inpatient fee revenues would appear to have been generated from an increase in the rates charged. To the extent that this holds up under further scrutiny, it would suggest that Mamohau increased it user fee rates in contravention to the terms of the Interim Financing Agreement.

At **St James**, the decrease in the GOL subvention share of total revenues was due to a large increase in earned income from miscellaneous non-fee sources and in particular revenues from the "Mohale Water Supply and Sanitation Project (WSSP) Contract." Some increase was also observed in outpatient fee revenues, but this increase was commensurate with the reported increase in demand for care.

At **St Josephs**, the decrease in the GOL subvention share of total revenues was due to a nearly six fold increase in outpatient fee revenues. Unfortunately, it was not possible to obtain up-to-date utilization data for outpatient services at St Josephs and so it is not possible to discern whether this increase in outpatient fee revenues was commensurate with an increase in utilization.

Each of these three cases demonstrates clearly why it will be essential for the GOL-CHAL Coordinating Unit to be able to obtain up-to-date financial and service production/utilization data in order to monitor performance and identify cases that require further in-depth scrutiny. They also underscore how difficult it is going to be to evaluate performance – as will be necessary for the accreditation process – based on aggregate indicators. In cases where there appear to be performance problems, it will be necessary to examine the detailed underlying data and circumstances in order to clearly discern what is going on and what would need to take place to improve performance.

At **Seboche** Hospital the share of total revenues funded from Government subventions increased appreciably as depicted in Figure 4 while contributions from earned income (fees, drug sales etc) and donors and NGOs decreased[25]. Though non-GOL revenues have decreased as a share of total revenues, the absolute level of revenues from earned income and donor and NGO contributions has increased since FY 2000/01. The largest increase has been in contributions from donors and NGOs[26], though revenues from earned income also increased at a rate nearly commensurate with the growth rate in GOL subventions[27].

[25] The unaudited FY 2003/04 Income Statement for Seboche suggests that the institution did not receive the total SEFF plus salary subvention. The total computed subvention for FY 2003/04 (excluding for TB and other programs) should have been M 2,133,224, but Seboche's Income Statement reports a total Government subvention of M 1,631,674 - a difference of M 501,550. This discrepancy will require further investigation since it represents a 15% potential loss in total reported revenues. According to Seboche's Income Statement, the GOL share of total revenues in FY 2003/04 is 52% - a decrease relative to FY 2000/01 levels when the GOL subvention accounted for 58% of total revenues.

[26] Grants from donors and NGOs increased at an average annual rate of 37% between FY 2000/01 and FY 2003/04. Nearly 2/3 of this funding was provided by Solidermed in FY 2003/04.

[27] Earned income from fees, drug sales and other miscellaneous sources increased at an average annual rate of 12% between FY 2000/01 and FY 2003/04.

Figure 4: Comparative Hospital Revenues Shares – FY 2000/01 vs FY 2003/04

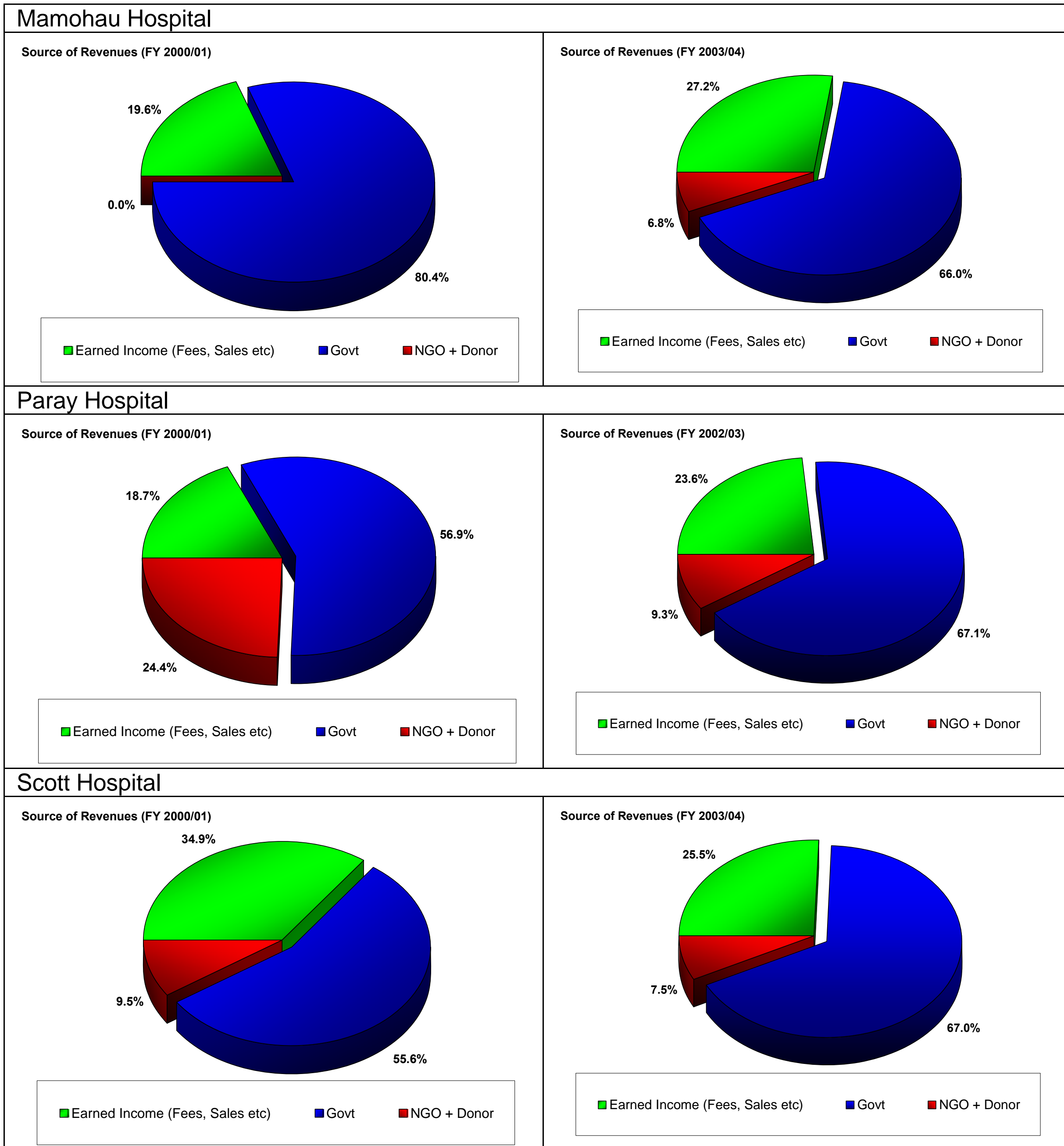
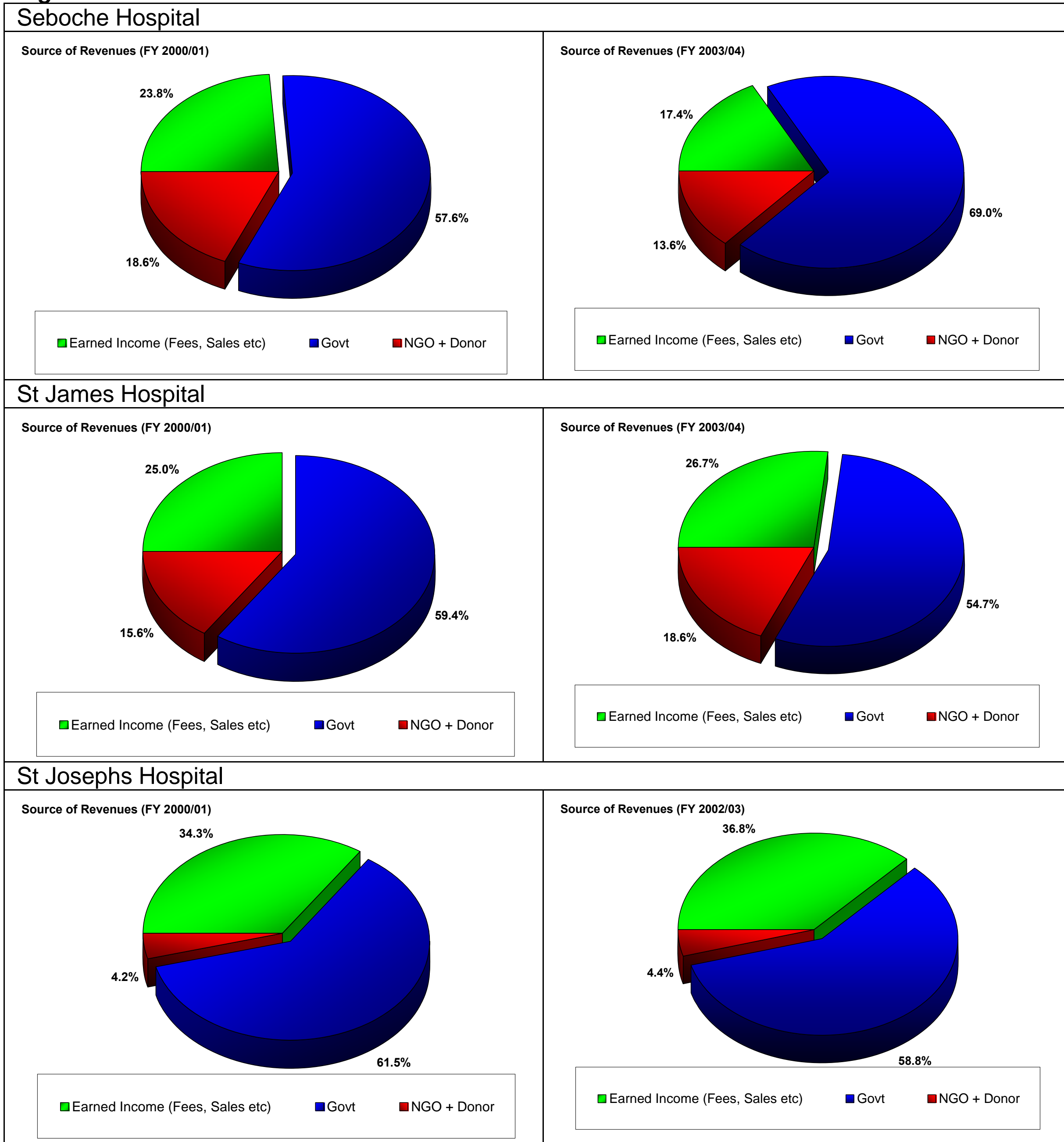


Figure 4 continued…



At **Scott** Hospital GOL funding increased as percentage to total revenues, while earned income and donor contributions decreased in 2003/04 as compared to 2000/01. A review of Scott's Statement of Financial Activity reveals that earned income from fees decreased slightly at the hospital level though increased appreciably at the health center level. In addition, revenues from the sale of drugs increased appreciably at the hospital level. Revenues from non-governmental grants also increased in absolute terms. The observed increase in the share of total revenues funded from the GOL subvention was thus due to the fact that the latter grew at a fast rate than the increase in revenues from earned income and non-governmental grants.

At **Paray** Hospital the share of total revenues funded from Government subventions increased because the growth in revenues from the GOL subvention exceeded the growth in revenues from earned income and non-governmental grants. Though revenues from earned income nearly doubled in absolute terms, fee revenues from both inpatients and outpatients reportedly fell with the revenue loss being more than compensated for through increased revenues from the sale of drugs and through charges on TB treatment etc. Unfortunately, there were no utilization data available for Paray so it was not possible to assess the reason for the decrease in fee revenues.

Figure 5 presents a similar comparative analysis of the change in revenue shares for a sample of health centers. It reveals that 5 of the 6 health centers experienced a decrease in GOL financing share between FY 2000/01 and the latest year for which financial data were available. The largest decline reportedly occurred at St Leo Health Center where the GOL subvention share fell from 70% of total revenues in FY 2000/01 to 46% of total revenues in FY 2002/03. In three of these cases (Maryland and Mofumahali oa Rosari in particular and to a lesser extent St Peter Claver) the GOL subvention actually increased in absolute terms, but the increase in revenues derived from earned income exceeded the growth rate in the GOL subvention. In the case of St Leo and Motsekuoa the GOL subvention reportedly decreased through FY 2002/03 while earned income increased.

Figure 5: Comparative Health Center Revenues Shares – FY 2000/01 vs FY 2003/04

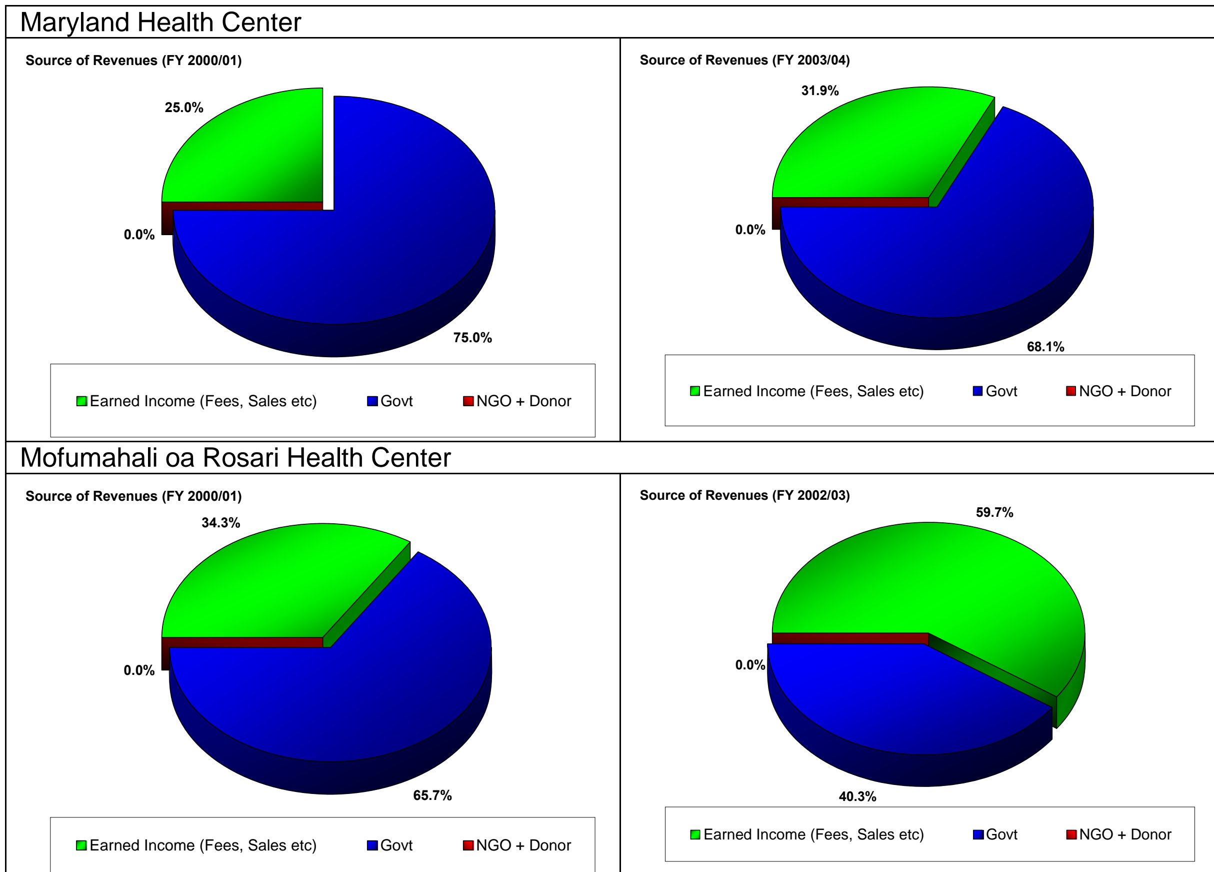
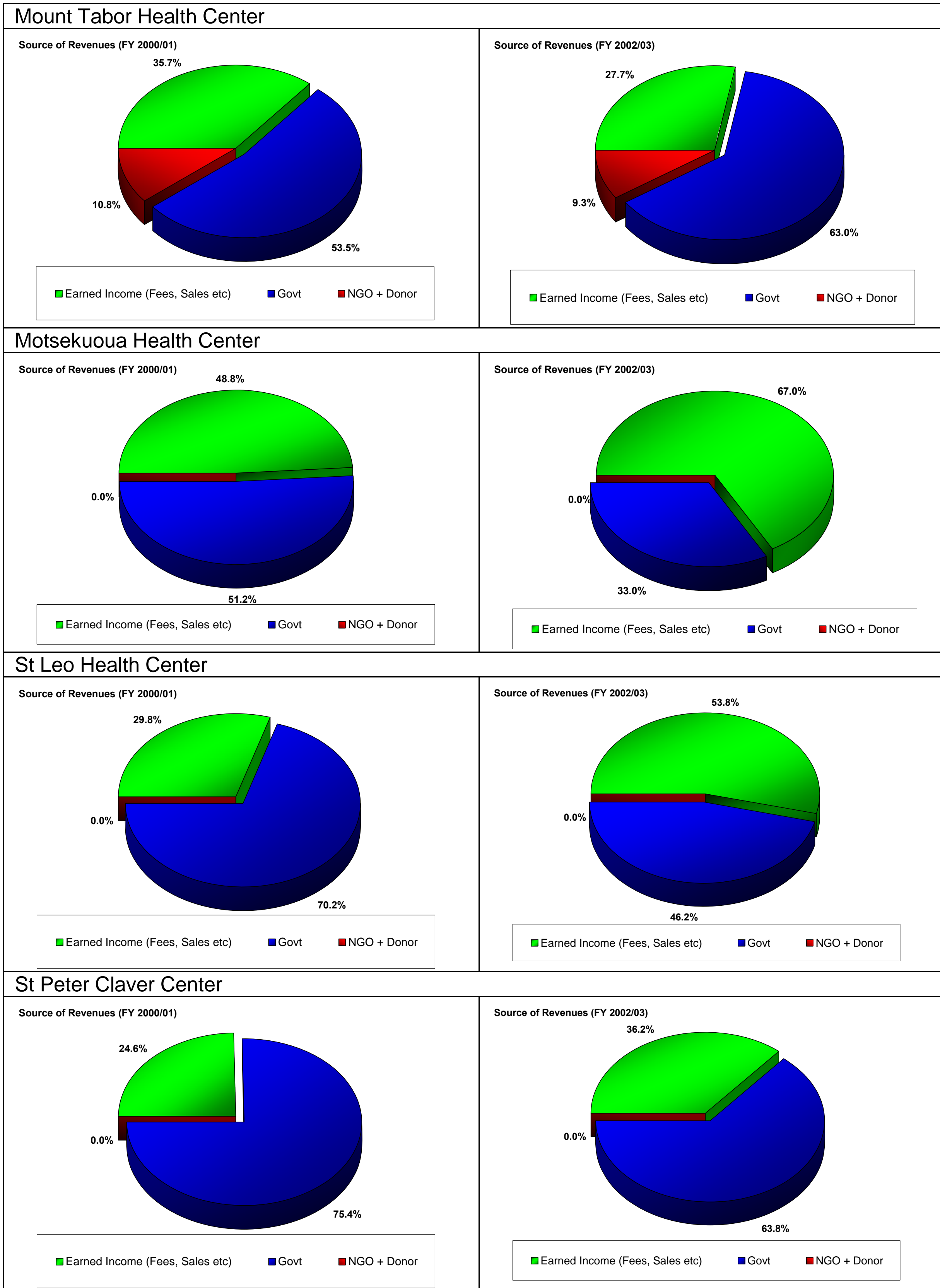


Figure 5 Continued….



3.5.3.1.2 Revenue Adequacy – Working Capital and Ability to cover allowable expenditure

The net result of the increase in the Government subvention provided under the SEFF has been positive on the overall financial position of the CHAL hospitals for which complete financial data were available for FY 2003/04: Mamohau, St James and St Josephs. In spite of their improved financial status, however, there is still need for considerable further improvement (see more below). For those hospitals that only provided complete financial data through FY 2002/03 (Paray, Scott, and Seboche) performance was mixed. On one extreme is Seboche whose financial position improved substantially through FY 2002/03 and in the process achieved the recommended operating margin as a percentage of operating expenditures. On the other extreme is Paray which experienced a significant worsening of its financial position and remained with a negative operating margin at the end of FY 2002/03. In the middle is Scott which experienced a substantial improvement in its financial position but still faces a negative operating margin as result of accrued liabilities which it is in the process of clearing.

The net impact of the SEFF on the health centers sampled in the mid-term Review has been positive. Unfortunately, 4 of the 6 health centers cannot provide complete financial data including a valuation of net worth. Evidence from the two for which complete data are available (Maryland and Mofumahali oa Rosari) reveal that their financial position has improved but that there is considerable variability in their status. While Mohumahali oa Rosari HC has far surpassed the financial position recommended under the SEFF (its operating margin is 5 times its annual operating expenses), and thus does not require any further SEFF allocations, Maryland HC still needs to improve its operating margin and so still needs the SEFF.

A summary of a range of financial performance indicators is presented for each hospital and health center in Tables 6 through 18. We consider the financial performance of each Institution separately below.

The net result of the increase in Government subvention provided under the SEFF, the increased revenue effort exerted by **Seboche**, and the increased grant contributions from donors and NGOs has been a marked improvement in the overall financial position of the institution. This has been reflected both in improvements in indicators of short-run financial performance and long run performance as summarized in Table 10. The improved short run financial performance indicators include: (i) an elimination of the operating budget deficit (as reflected in the conversion of net income from a negative value in FY 2000/01 to a positive value in FY 2003/04); (ii) a decrease in the loss ratios; (iii) an increase in the operating margin to recommended levels (i.e., equal to 20% of annual operating expenses); and (iv) an appreciable improvement in cash reserves as reflected both in an increase in the days of cash-on-hand and the low cash-to-claims payable, which reflects the fact that relatively little of Seboche's cash reserves are tied up with current liabilities. The improved overall financial position for Seboche is also reflected in the 11% growth in net worth from FY 2000/01 through FY 2002/03. The fact that Seboche has succeeded in increasing its operating margin to recommended levels will mean that it does not need to continue to receive the SEFF in FY 2004/05.

Table 6: Financial Performance Indicators – Maluti Hospital

	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04
1 Total Revenues	M 5,755,652	M 5,997,117		M 9,078,269	M 10,566,603		
2 Net Income	-M 208,202	-M 765,936		M 225,031	-M 146,355		
3 Net Worth	M 1,266,497	-M 28,755		M 1,137,286	M 989,931		
4 Loss Ratio (based on earned income)	208%	227%		175%	186%		
5 Loss Ratio (based on earned income + grants)	104%	113%		98%	101%		
6 Days of Cash on Hand	40.1	19.7		25.4	6.0		
7 Cash to Claims Payable	1.72	0.22		0.37	0.18		
8 Days in Receivables	24.43	59.45		39.86	25.29		
9 Operating Margin (Working Capital = Current Assets - Current Liabilities)	M 1,066,102	M 13,542	M 103,458	M 109,555	M 150,236		
10 Recommended Operating Margin (20% of operating expenses)	M 1,192,771	M 1,352,611	M 1,749,520	M 1,770,648	M 2,142,592		
11 Operating Margin as % of Recommended Level	89%	1%	6%	6%	7%		
12 SEFF (10 - 9) [Simulated for FY 2000/01 & FY 2001/02; 1999/00 value is basis for 2003/04 SEFF]			M 1,646,062	M 1,661,093	M 1,992,356		M 1,646,062
13 MOHSW Salary Grant				M 2,982,860	M 3,398,915		M 3,350,556
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 & 2001/02]				M 4,643,953	M 5,391,271		M 4,996,618
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]				52%	50%		
16 Adjusted Net Income (including SEFF) [Simulated for FY 2000/01 & 2001/02]				M 1,886,124	M 1,846,001		
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2000/01 & 2001/02]				82%	85%		

Notes:

Fiscal year ends on 31 March of each year

A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits

Indicators are calculated as follows:

2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 7: Financial Performance Indicators – Mamohau Hospital

	1999/2000	2000/01	2001/02	2003/2004	2003/2004
		A	A	A	B
1 Total Revenues		M1,128,416	M1,348,428	M2,027,902	
2 Net Income		M80,104	M50,967	M163,768	
3 Net Worth		-M12,576	M5,195	M101,011	
4 Loss Ratio (based on earned income)		474%	511%	338%	
5 Loss Ratio (based on earned income + grants)		93%	96%	92%	
6 Days of Cash on Hand		10.8	1.9	28.6	
7 Cash to Claims Payable		0.6	2.9	2.1	
8 Days in Receivables		-	-	-	
9 Operating Margin (Current Assets - Current Liabilities)	M24,136	-M12,576	-M9,879	M101,011	M24,136
10 Recommended Operating Margin (20% of operating expenses)	M245,262	M209,662	M259,492	M372,827	M245,262
11 Operating Margin as % of Recommended Level	10%	-6%	-4%	27%	[a]
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	M221,126	M222,238	M269,371	M271,816	M221,126 [b]
13 MOHSW Salary Grant	M1,028,443	M907,250	M1,094,478	M1,081,892	M1,028,443 [b]
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]		M907,250	M1,094,478	M1,303,018	M1,249,569 [b]
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]		87%	84%	70%	102%
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]				M435,584	M384,894
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]		78%	80%	81%	

Notes:

Fiscal year ends on 31 March of each year

A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits

Indicators are calculated as follows:

2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 8: Financial Performance Indicators – Paray Hospital

	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2003/2004
		A	A	A	A	B
1 Total Revenues		M2,505,664	M2,315,617	M3,247,969	M2,861,290	
2 Net Income		M324,306	-M29,837	M1,202	M126,579	
3 Net Worth		M266,321	M127,001	-M26,198	[a]	
4 Loss Ratio (based on earned income)		466%	482%	429%	405%	
5 Loss Ratio (based on earned income + grants)		87%	101%	100%	96%	
6 Days of Cash on Hand		27.6	44.8	8.3	[a]	
7 Cash to Claims Payable		0.7	0.7	0.1	[a]	
8 Days in Receivables		4.9	1.3	23.1	[a]	
9 Operating Margin (Current Assets - Current Liabilities)	-R 35,855	R 23,900	-R 72,526 [a]	-R 511,598 [a]	[a]	-R 35,855
10 Recommended Operating Margin (20% of operating expenses)	M139,857	M2,181,358	M469,091	M649,353	M546,942	M139,857
11 Operating Margin as % of Recommended Level	-26%	1% [a]	-15% [a]	-79% [a]	0% [a]	[a]
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	R 175,712	R 2,157,458 [a]	R 541,617 [a]	R 1,160,951 [a]	R 175,712 [a]	M175,712 [b]
13 MOHSW Salary Grant	R 1,334,606	R 1,390,397 [a]	R 1,606,346 [a]	R 1,818,100 [a]	R 1,742,900 [a]	M1,334,606 [b]
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M1,334,606	M1,390,397	M1,606,346	M1,818,100	M1,918,612	M1,510,318 [b]
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]		13%	68%	56%	70%	216%
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]		M2,481,764	M511,780	M1,162,153	M302,291	M302,291
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]		70%	89%	86%	73%	73%

Notes:
Fiscal year ends on 31 March of each year
A Based on unaudited income statement.
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a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits
Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 9: Financial Performance Indicators – Scott Hospital

	1997/98	1998/1999	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2003/2004
							A	B
1 Total Revenues	M6,224,000	M3,812,000		M4,292,875	M4,568,538	M5,999,461	M8,445,092	
2 Net Income	M479,000	M244,000		-M225,865	M13,629	-M127,949	M718,695	
3 Net Worth	[a]	[a]		-M773,004	-M511,356	-M597,668	[a]	
4 Loss Ratio (based on earned income)	349%	279%		302%	262%	362%	359%	
5 Loss Ratio (based on earned income + grants)	92%	94%		105%	100%	102%	91%	38%
6 Days of Cash on Hand	[a]	[a]		43.1	72.4	92.4	[a]	
7 Cash to Claims Payable	[a]	[a]		0.4	0.4	0.6	[a]	
8 Days in Receivables	[a]	[a]		15.7	39.5	21.7	[a]	
9 Operating Margin (Current Assets - Current Liabilities)	[a]	[a]	-M1,474,435 [b]	-M416,835	-M279,604	-M322,760	[a]	
10 Recommended Operating Margin (20% of operating expenses)	R 1,149,000	R 713,600	M834,005 [b]	M903,748	M910,982	M1,225,482	M1,545,279	M1,545,279
11 Operating Margin as % of Recommended Level	[a]	[a]	-177% [b]	-46%	-31%	-26%	[a]	
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	[a]	[a]	M2,308,440 [b]	M1,320,583	M1,190,586	M1,548,242	[a]	M2,308,440
13 MOHSW Salary Grant	M2,885,000	M2,282,000	M3,928,719 [b]	M2,386,253	M2,333,765	M3,507,598	[a]	M3,928,719
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M2,885,000	M2,282,000	M6,237,159 [b]	M3,706,836	M3,524,351	M5,055,840	M5,444,625	M6,237,159
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]	50%	64%	150% [b]	82%	77%	83%	70%	81%
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]	M479,000	M244,000		M1,094,718	M1,204,215	M1,420,293	M718,695	M3,027,134
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]		[a]		80%	79%	81%	91%	72%

Notes:
Fiscal year ends on 31 March of each year
A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits
Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 10: Financial Performance Indicators – Seboche Hospital

	1998/99	1999/2000	2000/2001	2001/2002	2002/2003	2003/2004	2003/2004
						A	B
1 Total Revenues	M2,061,087	[a]	M2,469,092	M2,525,809	M3,109,856	M3,306,905	
2 Net Income	-M34,701	[a]	M131,161	-M878,092	M316,223	M205,783	
3 Net Worth	[a]	[a]	M2,010,453	M2,044,619	M2,230,663	[a]	
4 Loss Ratio (based on earned income)	377%	[a]	384%	418%	369%	342%	
5 Loss Ratio (based on earned income + grants)	102%	[a]	95%	135%	90%	94%	81%
6 Days of Cash on Hand	[a]	[a]	11.5	11.7	45.6	66.2	
7 Cash to Claims Payable	[a]	[a]	1.5	1.2	3.8	[a]	
8 Days in Receivables	[a]	[a]	26.1	27.0	21.1	[a]	
9 Operating Margin (Current Assets - Current Liabilities)	[a]	M92,601 [b]	M301,817	M354,940	M554,168	[a]	
10 Recommended Operating Margin (20% of operating expenses)	[a]	M428,325 [b]	M467,586	M680,780	M558,727	M620,224	M620,224
11 Operating Margin as % of Recommended Level	[a]		65%	52%	99%	[a]	
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	[a]	M335,724 [b]	M165,769	M325,840	M4,559	[a]	M335,724
13 MOHSW Salary Grant	[a]	M1,797,500 [b]	M1,302,658	M1,260,707	M1,490,215	[a]	M1,797,500
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	[a]	M2,133,224 [b]	M1,468,427	M1,586,547	M1,494,774	M1,631,674	M2,133,224
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]		[a]	63%	47%	54%	53%	69%
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]	[a]	[a]	M296,930	-M552,252	M320,782	M205,783	M541,507
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]		[a]	89%	119%	90%	[a]	

Notes:
Fiscal year ends on 31 March of each year
A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits
Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 11: Financial Performance Indicators – St James Hospital

	Indicator	1997/98	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	
1	Total Revenues	M 584,885	M 1,923,578	M 0	M 2,188,977	M 3,368,053	M 3,770,203	M 3,154,243	
2	Net Income	M 150,641	-M 39,698	M 0	-M 335,285	M 529,740	M 485,435	-M 160,325	
3	Net Worth	M 1,700,777	M 1,670,086		-M 973,288	M 313,734	M 1,482,330	M 1,944,252	
4	Loss Ratio (based on earned income)	169%	489%		462%	163%	213%	350%	
5	Loss Ratio (based on earned income + grants)	74%	102%		115%	84%	87%	105%	
6	Days of Cash on Hand	228.3	29.6		32.1	59.0	50.5	67.8	
7	Cash to Claims Payable	1.1	0.6		0.7	1.4	2.4	4.2	
8	Days in Receivables	227.9	38.8		16.9	82.6	108.3	129.3	
9	Operating Margin (Current Assets - Current Liabilities)	M 213,656	M 57,813	M 80,482	-M 1,792,615	-M 1,035,831	-M 411,441	-M 7,447	
10	Recommended Operating Margin (20% of operating expenses)	M 86,849	M 392,655	M 180,126	M 504,852	M 567,663	M 656,954	M 662,914	
11	Operating Margin as % of Recommended Level	246%	15%	45%	-355%	-182%	-63%	-1%	
M 12	SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]			M 99,644 [b]	M 2,297,467	M 1,603,494	M 1,068,395	M 670,361	M 99,644 [b]
13	MOHSW Salary Grant			M1,391,515 [b]	M1,300,580	M1,167,046	M1,300,160	M1,486,763 a	M1,391,515 [b]
14	Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]			M1,491,159 [b]	M3,598,047	M2,770,540	M2,368,555	M2,157,124	M1,491,159 [b]
15	Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]			166% [b]	143%	98%	72%	65%	
16	Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]				M1,962,182	M2,133,234	M1,553,830	M510,036	
17	Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]				56%	57%	68%	87%	

Notes:
Fiscal year ends on 31 March of each year
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a Not calculable from available financial data
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Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 12: Financial Performance Indicators – St Josephs Hospital

		1999/00	2000/01	2001/02	2002/03	2003/04	
1	Total Revenues		M 4,954,875	M 5,403,892	M 5,841,422	M 6,169,964	
2	Net Income		-M 229,390	M 222,733	M 143,524	M 1,428,909	
3	Net Worth		M 4,394,673	M 5,123,615	M 5,281,032	[a]	
4	Loss Ratio (based on earned income)		274%	249%	240%	194%	
5	Loss Ratio (based on earned income + grants)		105%	96%	98%	77%	
6	Days of Cash on Hand		18.1	25.0	27.1		
7	Cash to Claims Payable		0.21	0.33	0.30		
8	Days in Receivables		24.4	36.8	50.1		
9	Operating Margin (Current Assets - Current Liabilities)	-M 147,212	-M 885,793	-M 476,803	-M 463,933	[a]	
10	Recommended Operating Margin (20% of operating expenses)	M 971,761	M 1,036,853	M 1,036,232	M 1,139,580	M 948,211	
11	Operating Margin as % of Recommended Level	-15%	-85%	-46%	-41%	[a]	
12	SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	M 1,118,973 [b]	M 1,922,646	M 1,513,035	M 1,603,513	[a]	M 1,118,973
13	MOHSW Salary Grant	M 3,462,725 [b]	M 2,869,456	M 2,955,236	M 3,167,930	M 3,670,772 [a]	M 3,462,725
14	Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M 4,581,698 [b]	M 4,792,102	M 4,468,271	M 4,771,443	M 3,670,772	M 4,581,698
15	Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]	94% [b]	92%	86%	84%	77%	
16	Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]		M1,693,256	M1,735,768	M1,747,037	M1,428,909	
17	Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]		75%	75%	77%	77%	

Notes:

Fiscal year ends on 31 March of each year

- A Based on unaudited income statement.
- B Based on subvention estimates prepared by the MOHSW
- a Not calculable from available financial data
- b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits

Indicators are calculated as follows:

- 2 Net operating position = (Earned Income + Grants) - Operating Expenditures
- 3 Total Assets - Total Liabilities
- 4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
- 5 Operating Expenditures / Earned Income + Grants
- 6 Cash / (Operating Expenses /365)
- 7 Cash / Current Liabilities
- 8 Accounts Receivable / (Operating Expenses / 365)
- 9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
- 10 Recommended Operating Margin = 20% of Operating Expenses
- 12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 13: Financial Performance Indicators – Maryland Health Center

	1999/2000	1999/2000	2000/01	2001/02	2002/2003	2003/2004
	A	B				
1 Total Revenues	M210,350		M212,836	M193,635	M230,726	M241,459
2 Net Income	M16,696		M19,783	M32,839	-M35,427	M52,002
3 Net Worth	M9,305		M10,478	M43,317	M0	M4,719
4 Loss Ratio (based on earned income)	305%		363%	318%	345%	246%
5 Loss Ratio (based on earned income + grants)	92%		91%	83%	115%	78%
6 Days of Cash on Hand	3.4		4.5	80.1	-	68.0
7 Cash to Claims Payable			3.7	48.1		
8 Days in Receivables	3.4		6.3	7.4	-	-
9 Operating Margin (Current Assets - Current Liabilities)	M4,533	M4,533	M5,706	M38,545	M0	M4,719
10 Recommended Operating Margin (20% of operating expenses)	M38,731	M38,731	M38,611	M32,159	M53,231	M37,891
11 Operating Margin as % of Recommended Level	12%	12%	15%	120%	0%	12%
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	R 34,198	R 34,198	R 32,905	-R 6,386	R 34,198	R 32,905
13 MOHSW Salary Grant	R 146,864	R 146,864	R 159,703	R 143,064	R 153,668	R 164,551
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M146,864	M181,062	M192,608	M136,678	M187,866	M197,456
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]	76%	93%	100%	85%	71%	104%
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]	M50,894	M53,981	M65,744	-M41,813	M86,200	M32,905
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]	79%	78%	71%	119%	69%	0%

Notes:
Fiscal year ends on 31 March of each year
A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits
Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 14: Financial Performance Indicators – Mofumahali oa Rosari Health Center

	1999/2000 A	1999/2000 B	2000/01	2001/02	2002/2003
1 Total Revenues	M103,070		M179,357	M177,762	M193,630
2 Net Income	-M5,860		M3,858	M14,497	M85,612
3 Net Worth	M245,729		M249,586	M264,083	M349,695
4 Loss Ratio (based on earned income)	339%		281%	237%	95%
5 Loss Ratio (based on earned income + grants)	106%		97%	88%	57%
6 Days of Cash on Hand	29.5		39.3	18.5	-
7 Cash to Claims Payable			12.2	1.7	
8 Days in Receivables	1.7		9.7	14.1	357.6
9 Operating Margin (Current Assets - Current Liabilities)	R 10,459	R 10,459	R 14,316	R 28,813	R 114,425
10 Recommended Operating Margin (20% of operating expenses)	M21,786	M21,786	M21,341	M20,699	M22,682
11 Operating Margin as % of Recommended Level	48%	48%	67%	139%	504%
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	R 11,327	R 11,327 [a]	R 7,025 [a]	-R 8,114 [a]	R 11,327 [a]
13 MOHSW Salary Grant	R 70,968	R 70,986	R 72,651	R 74,268	R 80,220
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M70,968	M82,313	M79,676	M66,154	M91,547
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]	65%	76%	75%	64%	81%
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]	M5,467	M15,185	M21,522	M77,498	M11,327
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]	95%	88%	83%	59%	0%

Notes:
Fiscal year ends on 31 March of each year
A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits
Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 15: Financial Performance Indicators – Mount Tabor Health Center

	1999/2000	1999/2000	2000/01	2001/02	2003/2004
	A	B			
1 Total Revenues	M241,446		M194,182	M187,072	
2 Net Income	-M23,027		M9,595	-M26,883	
3 Net Worth	M154,587		M164,182	M137,299	
4 Loss Ratio (based on earned income)	306%		213%	351%	
5 Loss Ratio (based on earned income + grants)	110%		95%	114%	
6 Days of Cash on Hand	27.0		42.0	-	
7 Cash to Claims Payable	0.8		1.7	-	
8 Days in Receivables	3.8		8.6	5.2	
9 Operating Margin (Current Assets - Current Liabilities)	R 7,136	R 7,136	R 16,731	-R 10,152	[a]
10 Recommended Operating Margin (20% of operating expenses)	M52,895	M54,625	M209,662	M259,492	
11 Operating Margin as % of Recommended Level	13%	13% [a]	8% [a]	-4% [a]	[a]
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	R 45,759	R 47,489 [a]	R 192,931 [a]	R 269,644 [a]	R 47,489 [a]
13 MOHSW Salary Grant	R 129,134	R 129,134	R 107,519	R 126,059	R 129,134
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M129,134	M176,623	M107,519	M126,059	M176,623
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]		65%	10%	10%	
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]			M166,048	M298,345	
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]			49%	45%	

Notes:
Fiscal year ends on 31 March of each year
A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits
Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 16: Financial Performance Indicators – Motsekuoa Health Center

		1999/2000	1999/2000	2000/01	2001/02	2003/2004
		A	B			
1	Total Revenues	M178,184		M180,691	M177,495	M323,213
2	Net Income	-M24,696		M29,938	M24,409	M111,931
3	Net Worth	a		a	a	a
4	Loss Ratio (based on earned income)	233%		182%	195%	98%
5	Loss Ratio (based on earned income + grants)	114%		83%	86%	65%
6	Days of Cash on Hand	a		a	a	a
7	Cash to Claims Payable	a		a	a	a
8	Days in Receivables	a		a	a	a
9	Operating Margin (Current Assets - Current Liabilities)	a		a	a	a
10	Recommended Operating Margin (20% of operating expenses)	M40,576	M40,576	M30,151	M30,617	M42,256
11	Operating Margin as % of Recommended Level	a	a	a	a	a
12	SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	a	a	a	a	a
13	MOHSW Salary Grant	R 91,184	R 91,184	R 98,041	R 98,977	R 106,728
14	Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M91,184	M91,184	M98,041	M98,977	M91,184
15	Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]		45%	65%	65%	43%
16	Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]	a	a	a	a	a
17	Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]	a	a	a	a	a

Notes:

Fiscal year ends on 31 March of each year

A Based on unaudited income statement.

B Based on subvention estimates prepared by the MOHSW

a Not calculable from available financial data

b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits

Indicators are calculated as follows:

2 Net operating position = (Earned Income + Grants) - Operating Expenditures

3 Total Assets - Total Liabilities

4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)

5 Operating Expenditures / Earned Income + Grants

6 Cash / (Operating Expenses /365)

7 Cash / Current Liabilities

8 Accounts Receivable / (Operating Expenses / 365)

9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds

10 Recommended Operating Margin = 20% of Operating Expenses

12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 17: Financial Performance Indicators – St Leo Health Center

	1999/2000	1999/2000	2000/01	2001/02	2002/2003
	A	B			
1 Total Revenues	M80,890		M100,744	M131,795	M167,484
2 Net Income	-M30,827		-M1,378	M27,060	M38,764
3 Net Worth	[a]		[a]	[a]	[a]
4 Loss Ratio (based on earned income)			340%	174%	143%
5 Loss Ratio (based on earned income + grants)	138%		101%	79%	77%
6 Days of Cash on Hand	[a]		[a]	[a]	[a]
7 Cash to Claims Payable	[a]		[a]	[a]	[a]
8 Days in Receivables	[a]		[a]	[a]	[a]
9 Operating Margin (Current Assets - Current Liabilities)	[a]	[a]	[a]	[a]	[a]
10 Recommended Operating Margin (20% of operating expenses)	M22,343	M22,343	[a]	[a]	[a]
11 Operating Margin as % of Recommended Level		[a]	[a]	[a]	[a]
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	R 22,343	R 22,343 [a]	[a]	[a]	[a]
13 MOHSW Salary Grant	R 0	R 80,890	R 70,699	R 71,704	R 77,340
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M0	M80,890	M70,699	M71,704	M80,890
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]		72%	[a]	[a]	[a]
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]			a	a	a
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]			[a]	[a]	[a]

Notes:

Fiscal year ends on 31 March of each year

- A Based on unaudited income statement.
- B Based on subvention estimates prepared by the MOHSW
- a Not calculable from available financial data
- b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits

Indicators are calculated as follows:

- 2 Net operating position = (Earned Income + Grants) - Operating Expenditures
- 3 Total Assets - Total Liabilities
- 4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
- 5 Operating Expenditures / Earned Income + Grants
- 6 Cash / (Operating Expenses /365)
- 7 Cash / Current Liabilities
- 8 Accounts Receivable / (Operating Expenses / 365)
- 9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
- 10 Recommended Operating Margin = 20% of Operating Expenses
- 12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

Table 18: Financial Performance Indicators – St Peter Claver Health Center

	1999/2000		2000/01	2001/02	2002/03	2003/2004
	A	B				
1 Total Revenues	M170,736		M179,824	M151,852	M202,304	
2 Net Income	M26,514		M8,866	M90,345	M44,182	
3 Net Worth	M379,847		M370,584	M432,667	M471,058	
4 Loss Ratio (based on earned income)	343%		407%	101%	216%	
5 Loss Ratio (based on earned income + grants)	84%		95%	41%	78%	
6 Days of Cash on Hand	79.7		41.3	-	-	
7 Cash to Claims Payable	[a]		11.6	-	-	
8 Days in Receivables	-		8.0	-	-	
9 Operating Margin (Current Assets - Current Liabilities)	M32,350	M32,350	M23,087	-M114,497	-M76,106	[a]
10 Recommended Operating Margin (20% of operating expenses)	M28,844	M28,844	M34,192	M12,301	M31,624	
11 Operating Margin as % of Recommended Level	112%	112%	68%	-931%	-241%	[a]
12 SEFF (10 - 9) [Simulated for FY 2000/01 through FY 2002/03]	-M3,506	-M3,506	M11,105 [a]	M126,798 [a]	M107,730 [a]	-M3,506
13 MOHSW Salary Grant	M128,657	M128,657	M129,134	M107,519	M126,059	M128,657
14 Total MOHSW Grant (Salaries + SEFF) [Simulated for FY 2000/01 through FY 2002/03]	M128,657	M125,151	M140,239	M234,317	M233,789	M125,151
15 Total MOHSW Grant as % of Total Operating Expenses [Simulated for FY 2000/01 through FY 2002/03]	89%		82%	381%	148%	
16 Adjusted Net Income (including SEFF) [Simulated for FY 2001/02 & 2002/03]	M23,008	M5,360	M101,450	M170,980	M107,730	
17 Adjusted Loss Ratio (based on earned income + grants + SEFF) [Simulated for FY 2001/02 & 2002/03]	86%		90%	22%	51%	

Notes:
Fiscal year ends on 31 March of each year
A Based on unaudited income statement.
B Based on subvention estimates prepared by the MOHSW
a Not calculable from available financial data
b Based on Interim Subvention Estimates prepared from FY 1999/2000 audits
Indicators are calculated as follows:
2 Net operating position = (Earned Income + Grants) - Operating Expenditures
3 Total Assets - Total Liabilities
4 Operating Expenditures / Earned Income (or the inverse of the Cost Recovery Ratio)
5 Operating Expenditures / Earned Income + Grants
6 Cash / (Operating Expenses /365)
7 Cash / Current Liabilities
8 Accounts Receivable / (Operating Expenses / 365)
9 Current Assets = Cash + Accounts Receivable + Loans Receivable; Current Liabilities = Accounts Payable + Funds
10 Recommended Operating Margin = 20% of Operating Expenses
12 SEFF is calculated on "allowable" operating expenses which may not be equal to actual operating expenses

The overall improvement in the financial position of **Mamohau** Hospital is reflected in Table 7 by (i) a two-fold increase in its net income and the attainment of a budget surplus of roughly M 163,000; (ii) a drop in loss rates attributable largely to an improvement in earned income; (iii) an increase in the operating margin to a level that is now approximately 1/3 of the recommended level; and (iv) a three fold increase in cash reserves. As indicated above, Mamohau still has to improve its financial position by paying down its liabilities in order to increase its operating margin to recommended levels. It will thus continue to need the SEFF in FY 2004/05.

The significant deterioration in the financial position of **Paray** Hospital is reflected in Table 8 by (i) a two-fold decrease in its net income; (ii) an increase in loss rates attributable largely to an increase in expenditures at a rate that has exceeded the growth in revenues; (iii) a substantial decrease in the operating margin which reached a negative value of roughly M 512,000 in FY 2002/03 due to an increase in current liabilities associated with accrued severance pay and accounts payable; and (iv) a three fold decrease in cash reserves. Without up-to-date financial data for FY 2003/04 it is impossible to discern whether the situation at Paray has improved or worsened since FY 2002/03. Based on the FY 2002/03 financial data, the hospital would appear to need a substantial increase in its SEFF allocation relative to the current level that was based on the FY 1999/2000 financials. As can be seen in Table 8, the estimated SEFF for Paray would have been M 1,160,951 as compared with the current level of M 175,712.

The overall improvement in the financial position of **Scott** Hospital is reflected in Table 9 by (i) a large increase in its net income from a negative value to a surplus of roughly M 719,000; (ii) a drop in loss rates attributable largely to an improvement in the Government subvention; and (iii) a two fold increase in cash reserves. Based on the FY 2002/03 financial data, Scott still had a negative operating margin of approximately M 323,000 which it will need to pay down in order to bring its financial position into line with recommended levels. Without up-to-date financial data for FY 2003/04 it is impossible to discern whether the situation at Scott has improved or worsened since FY 2002/03. Based on the FY 2002/03 financial data, the hospital would appear to continue to need the SEFF, but possibly at a slightly lower level than is currently provided.

The overall improvement in the financial position of **St James** Hospital is reflected in Table 11 by (i) a drop in loss rates; and (ii) a two fold increase in cash reserves. In spite of these improvements, the hospital still faces a small budget deficit (negative net income) and a small negative operating margin. The operating margin is none-the-less much less negative than it had been in FY 2000/01 when it reached M 1,792,000. Based on its current financials, St James will continue to need the SEFF at a level approximately equal to 20% of its annual operating expenditures.

The overall improvement in the financial position of **St Josephs** Hospital is reflected in Table 12 by (i) an appreciable increase in its net income from a negative level to roughly M 1,429,000; (ii) a substantial drop in loss rates; and (iii) a small increase in cash reserves. Though its operating margin remains negative it is currently about half the level it was in FY 2000/01. Based on its current financials, St Josephs will continue to need the SEFF in order to cover its negative operating margin and bring it up to a level equal to 20% of its annual operating expenses.

3.5.3.1.2.1 Impact of Lag between Year of Determination and Year of Issue

The four-year lag between the calculation of the SEFF based on FY 1999/2000 financial audits and its disbursement in FY 2003/04 has had a variable impact on the hospitals. Based on the financial data presented in Tables 6 – 18, it is evident that had the SEFF been recalculated for the hospitals it would have been increased for all but Scott and Seboche and thus would have helped strengthen the financial position of most of the hospitals even further. Table 19 summarizes the estimated change in the SEFF that would have occurred if Table 19 summarizes the estimated change in the SEFF that would have occurred if it had been recalculated based on more recent financial information.

Table 19 reveals that the total SEFF for 6 of the 8 CHAL Hospitals would have been 23% higher than the amount based on the 1999/00 audit and that it would have increased five fold for St James and Paray while being virtually eliminated for Seboche.

Table 19: Recalculated SEFF based on updated financial data

Institution	SEFF Based on FY 1999/00 Financials	SEFF Based on Updated Financials		% Change in SEFF
	Maloti	Fiscal Year	Maloti	
St James	99,664	03/04	670,361	+573%
Paray	175,712	02/03	1,160,951	+ 561%
St Josephs	1,118,973	02/03	1,603,513	+43%
Mamohau	221,126	03/04	271,816	+ 23%
Scott	2,308,440	02/03	1,548,242	-33%
Seboche	335,724	02/03	4,559	-99%
Total	***4,259,639***		***5,259,442***	***+23%***

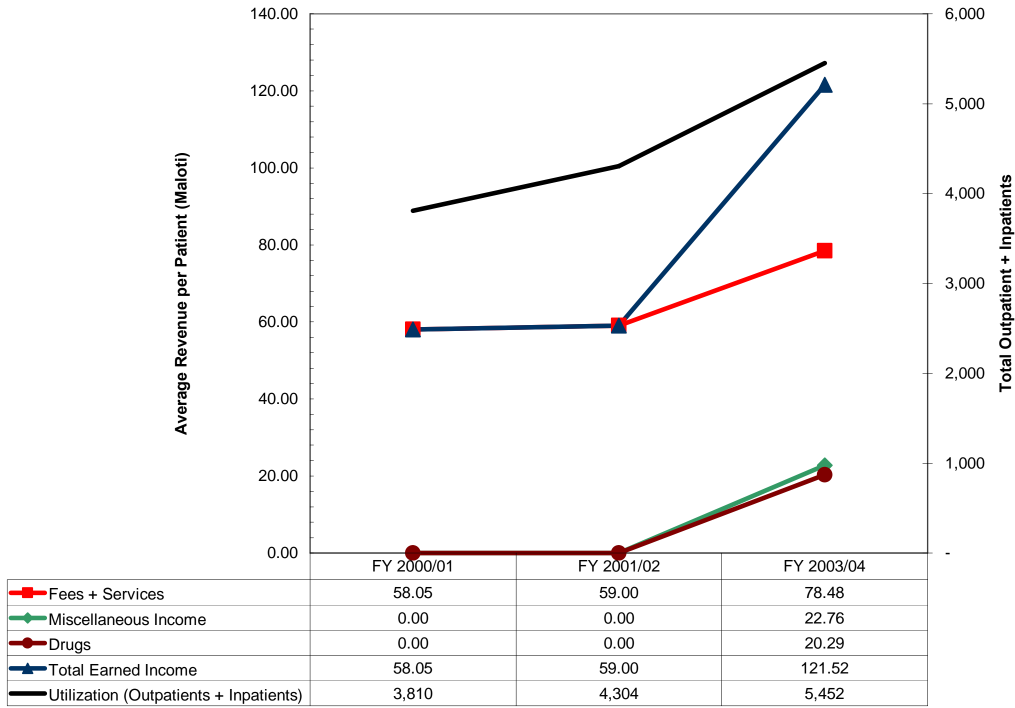
This analysis reveals how important it will be to update the subvention calculation on an annual basis and to base it on the most recent possible financial data. The fact that it was not possible to calculate the revised SEFF in July 2004 for the FY 2003/04 – some three months after the end of the fiscal year – is problematic and will need to be addressed in the future.

3.5.3.1.2.2 Impact of freeze on Fees

The freeze on fees appears to have had a varying impact on earned income revenue performance of the CHAL hospitals. In the case of **Mamohau** hospital (see Figure 6), though fee revenues increased at a rate commensurate with the increase in demand, total earned income increased at a greater rate than demand because of the effort made to raise non-fee revenues.

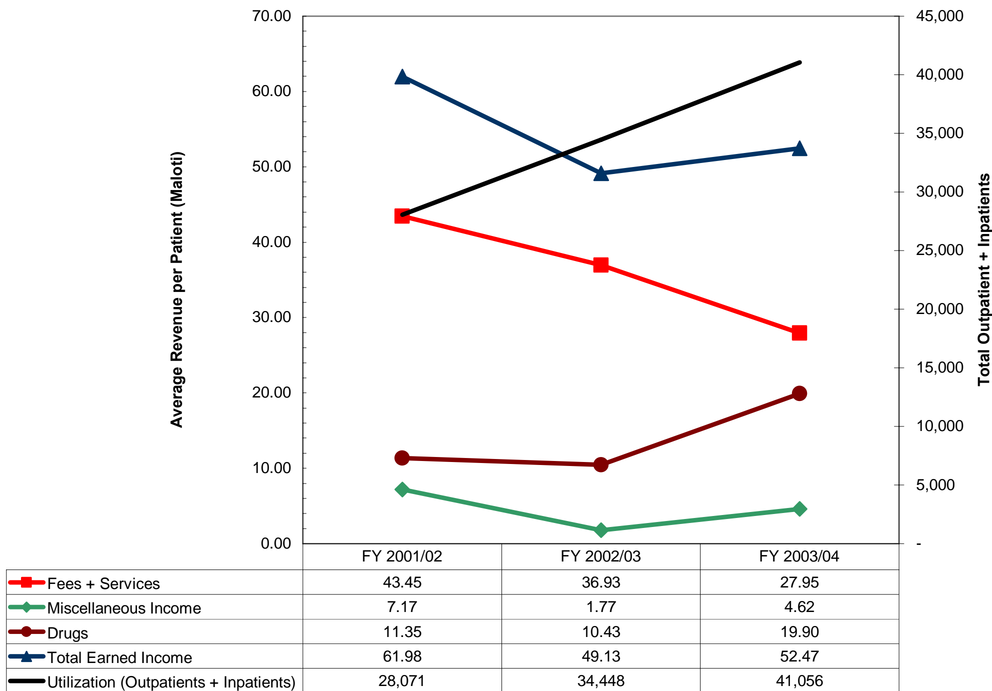
By contrast, as depicted in Figure 7 at **Scott** both fee revenues and total earned income declined while demand increased. The large decline in fee revenues should be investigated further since it either reflects a fundamental change in the service/patient mix or signals potential leakage problems. As in the case of Mamohau, Scott relied on increased drug sales revenues to partially compensate for the loss in fee revenues. This too is something that should be evaluated further since rising drug costs can have the same adverse equity implications that the Government is seeking to avoid by freezing fee rates.

Figure 6: Average (per Patient) Revenues from Fees and Other Sources of Earned Income – Mamohau (FY 1998/1999 – FY 2002/2003)



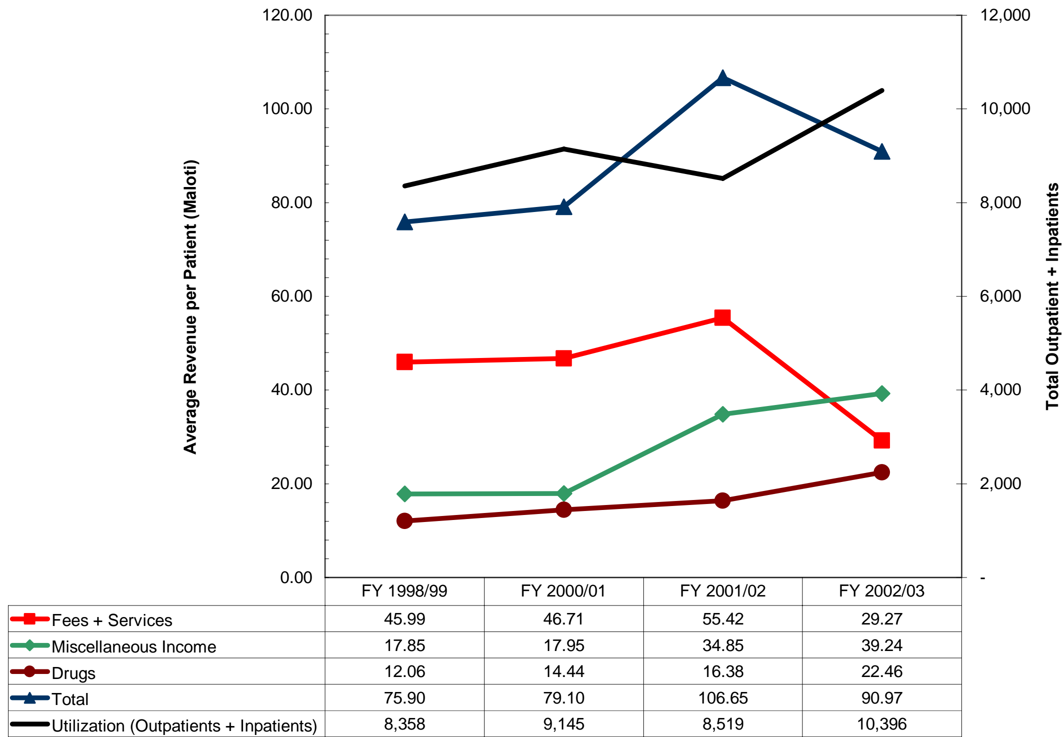
	FY 2000/01	FY 2001/02	FY 2003/04
Fees + Services	58.05	59.00	78.48
Miscellaneous Income	0.00	0.00	22.76
Drugs	0.00	0.00	20.29
Total Earned Income	58.05	59.00	121.52
Utilization (Outpatients + Inpatients)	3,810	4,304	5,452

Figure 7: Average (per Patient) Revenues from Fees and Other Sources of Earned Income – Scott (FY 1998/1999 – FY 2002/2003)



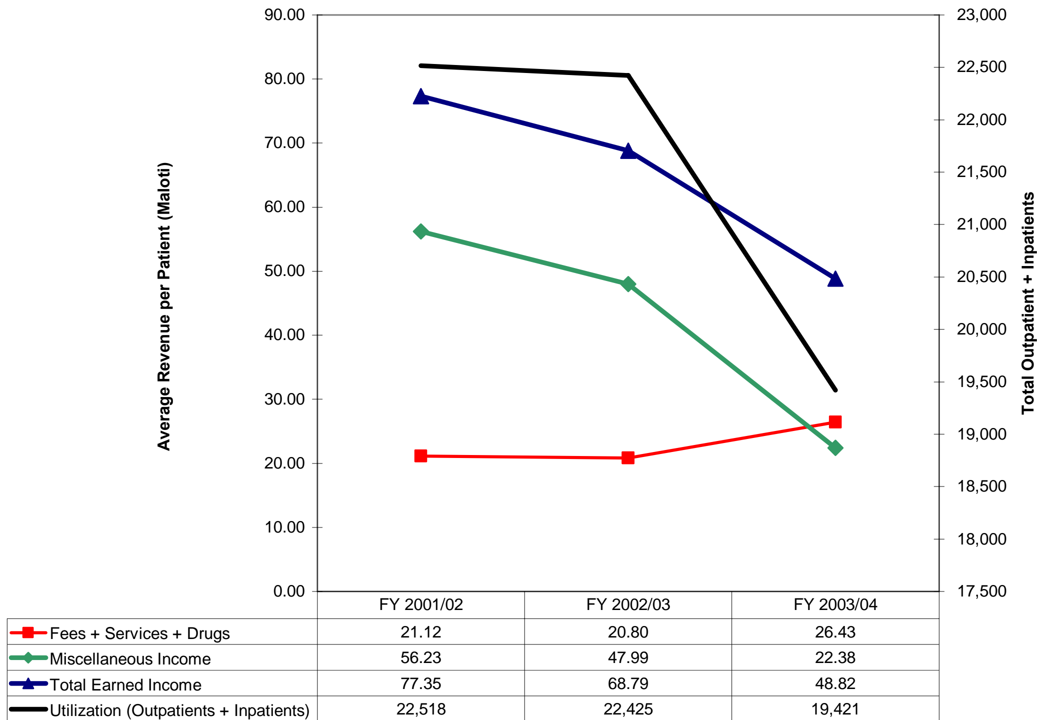
	FY 2001/02	FY 2002/03	FY 2003/04
Fees + Services	43.45	36.93	27.95
Miscellaneous Income	7.17	1.77	4.62
Drugs	11.35	10.43	19.90
Total Earned Income	61.98	49.13	52.47
Utilization (Outpatients + Inpatients)	28,071	34,448	41,056

Figure 8: Average (per Patient) Revenues from Fees and Other Sources of Earned Income – Seboche (FY 1998/1999 – FY 2002/2003)



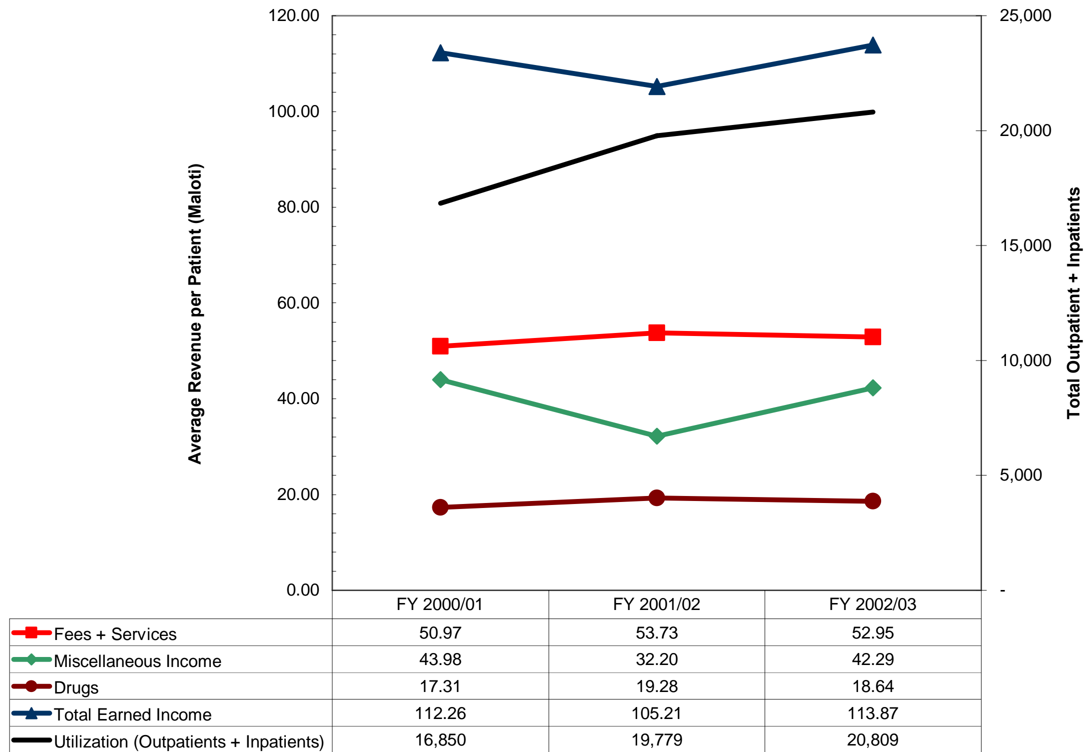
	FY 1998/99	FY 2000/01	FY 2001/02	FY 2002/03
Fees + Services	45.99	46.71	55.42	29.27
Miscellaneous Income	17.85	17.95	34.85	39.24
Drugs	12.06	14.44	16.38	22.46
Total	75.90	79.10	106.65	90.97
Utilization (Outpatients + Inpatients)	8,358	9,145	8,519	10,396

Figure 9: Average (per Patient) Revenues from Fees and Other Sources of Earned Income – St James (FY 1998/1999 – FY 2002/2003)



	FY 2001/02	FY 2002/03	FY 2003/04
Fees + Services + Drugs	21.12	20.80	26.43
Miscellaneous Income	56.23	47.99	22.38
Total Earned Income	77.35	68.79	48.82
Utilization (Outpatients + Inpatients)	22,518	22,425	19,421

Figure 10: Average (per Patient) Revenues from Fees and Other Sources of Earned Income – St Josephs (FY 1998/1999 – FY 2002/2003)



	FY 2000/01	FY 2001/02	FY 2002/03
Fees + Services	50.97	53.73	52.95
Miscellaneous Income	43.98	32.20	42.29
Drugs	17.31	19.28	18.64
Total Earned Income	112.26	105.21	113.87
Utilization (Outpatients + Inpatients)	16,850	19,779	20,809

Figure 8 reveals that **Seboche** compensated for the freeze on fee revenues through a fairly aggressive effort to increase non-fee miscellaneous other sources of earned income. This increase in non-fee revenues included the introduction in FY 2002/03 of roughly M 250,000 in income from "Nursing, Boarding and Lodging" as well as an addition of M 100,000 from vehicle hires, taxi charges and gas sales. Revenues from the sale of drugs also increased, but in manner commensurate with the increase in utilization, suggesting that Seboche did not increase the price of drugs during the pre-SEFF period.

The reported decline in hospital fee revenues in FY 2002/2003 is something that needs to be looked into since it would not have been anticipated given the increase in reported utilization. This reported decline can only be explained if fees were actually reduced, the composition of demand changed appreciably in favor of low-revenue-yielding services, or there were errors in bookkeeping. Either way, the decline in fee revenues should in the presence of increased utilization and a policy of enforced rate stability should be of concern both to Seboche and to the Government.

The situation at **St James** is difficult to discern completely since the Income Statement does not distinguish between fee revenues and revenues derived from the sale of drugs and other medical supplies. This is a limitation that will need to be addressed in the revised financial reporting system. What is evident is that St James has experienced a fairly substantial decline in utilization that has resulted in a decline in total earned income.

Figure 10 reveals that the revenues from earned income at **St Joseph** have remained fairly flat while utilization has increased slightly.

3.5.3.1.2.3 TB and Malnutrition Subvention

Table 20 reveals that the subventions for TB and Malnutrition are small relative to the salary + SEFF subvention. It was not possible to evaluate the adequacy of these grants. CHAL Institutions reported that they have experience problems with delays in being reimbursed under these two grants, though it was not possible to determine how much is currently owed.

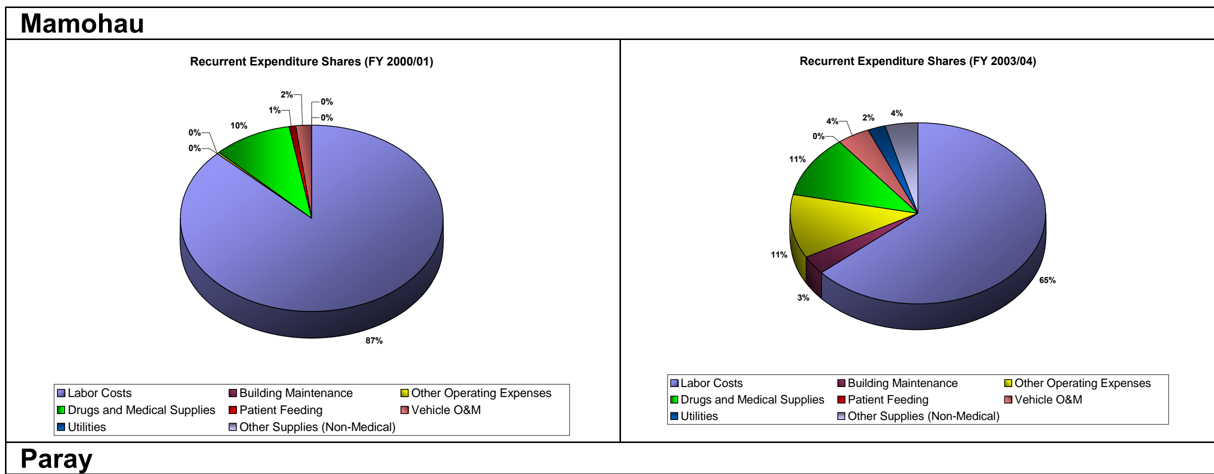
Table 20: TB and Malnutrition Subventions as Percentage of Total GOL Subvention

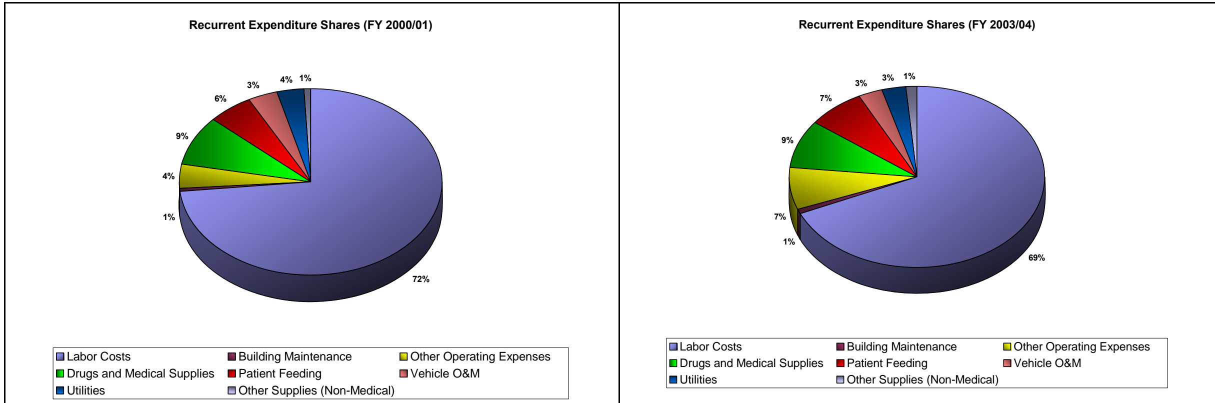
	St James	Mamohau	Paray	Scott	Seboche
TB	2.7%	2.5%	0.0%	3.8%	2.6%
Malnutrition	0.4%	0.1%	0.0%	0.0%	0.4%
GOL + SEFF	96.9%	97.4%	100.0%	96.2%	95.9%
EPI	0.0%	0.0%	0.0%	0.0%	1.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

3.5.3.2 Efficiency

Figure 11 contrasts recurrent expenditure shares before and after the allocation of the SEFF. It reveals that the SEFF has led to substantial efficiency improvements as reflected in the fact that all hospitals have been able to reduce the share of total expenditures allocated to labor to less than 70%, and increase the share of expenditures on drugs, building and vehicle maintenance.

Figure 11: Seboche Recurrent Expenditures Shares – FY 2000/01 vs FY 2003/04





Scott

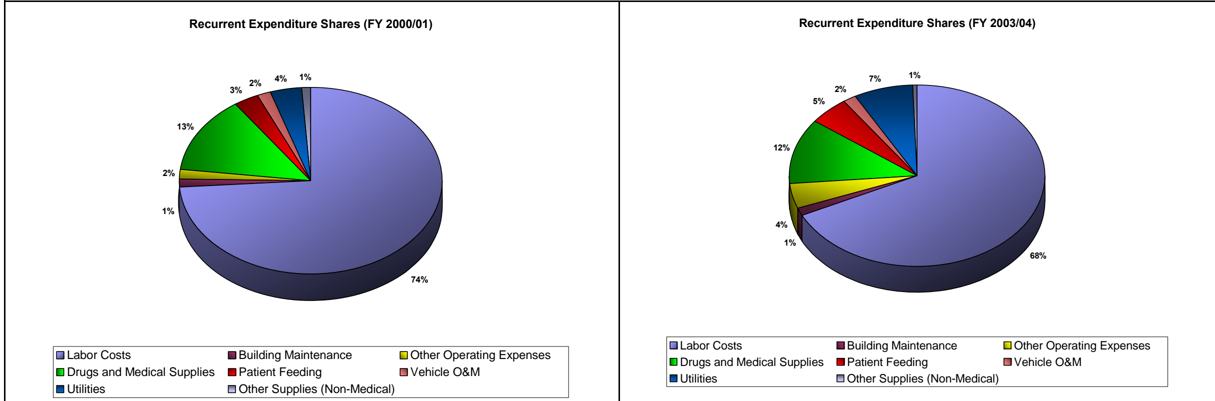
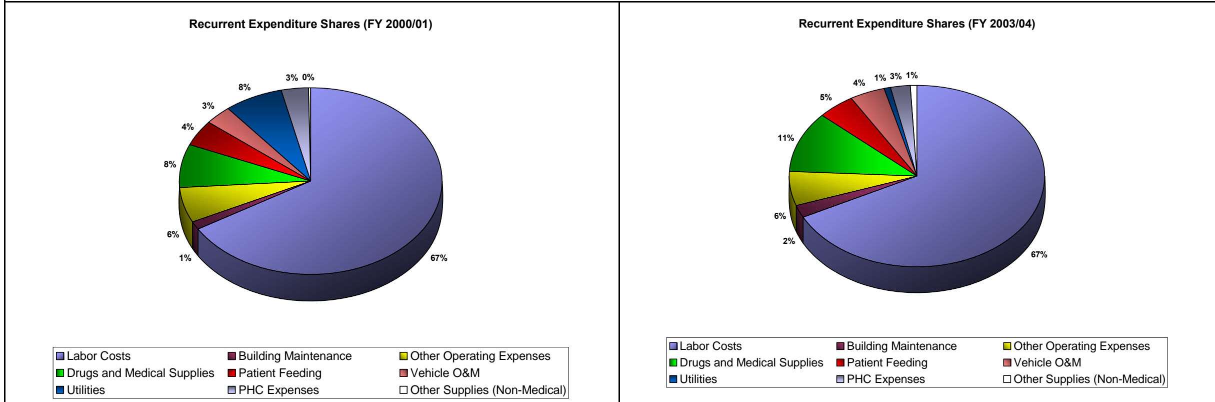
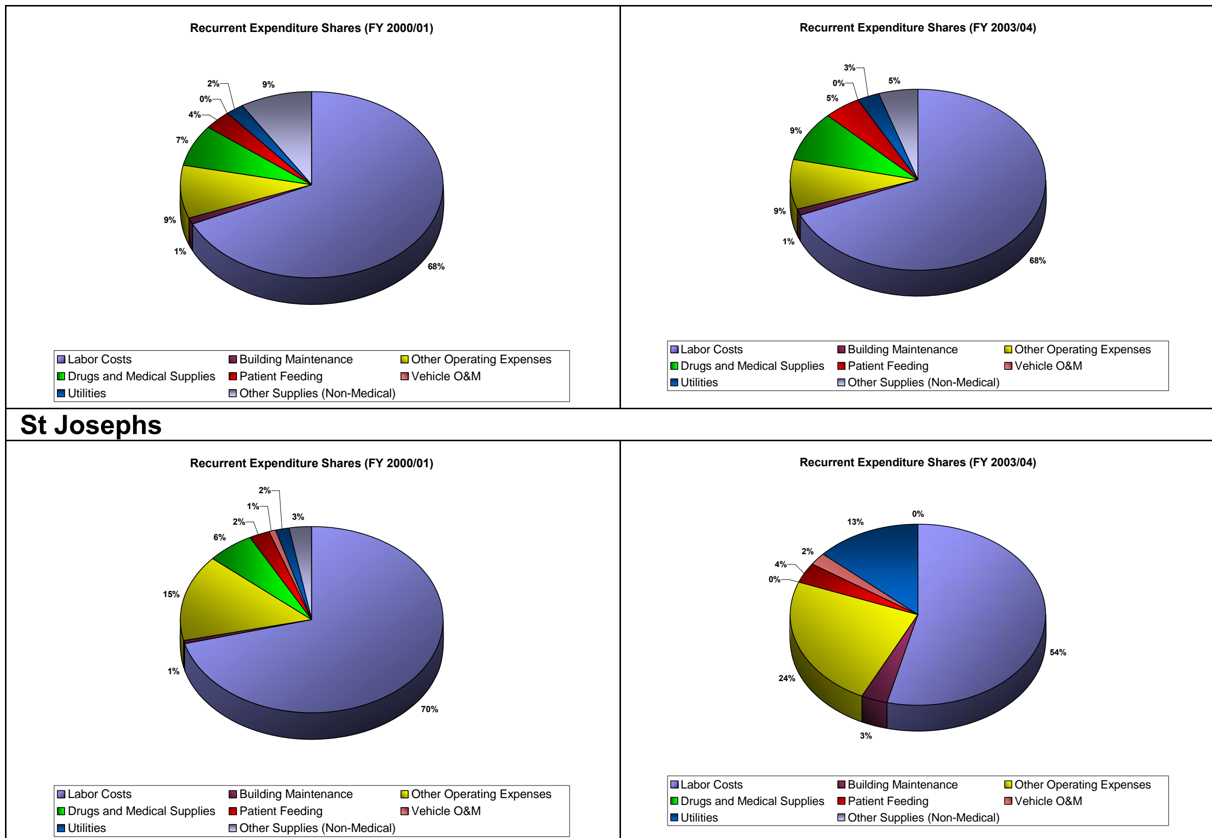


Figure 11 Continued…

Seboche



St James



3.5.3.3 Administrative Feasibility

3.5.3.3.1 CHAL

3.5.3.3.1.1 Ability of CHAL Institutions to produce requisite financial management information

All hospital accounts departments are equipped with competent staff which ensures completeness of their financial reports. However, health centers accounting is handled by Nurses with little or no accounting background. There is therefore a need for frequent follow up on their training on bookkeeping. The high staff turnover at health center level without handover also poses a challenge for the financial reports at this level.

The production and submission of financial reports remains a challenge especially with the health centers.

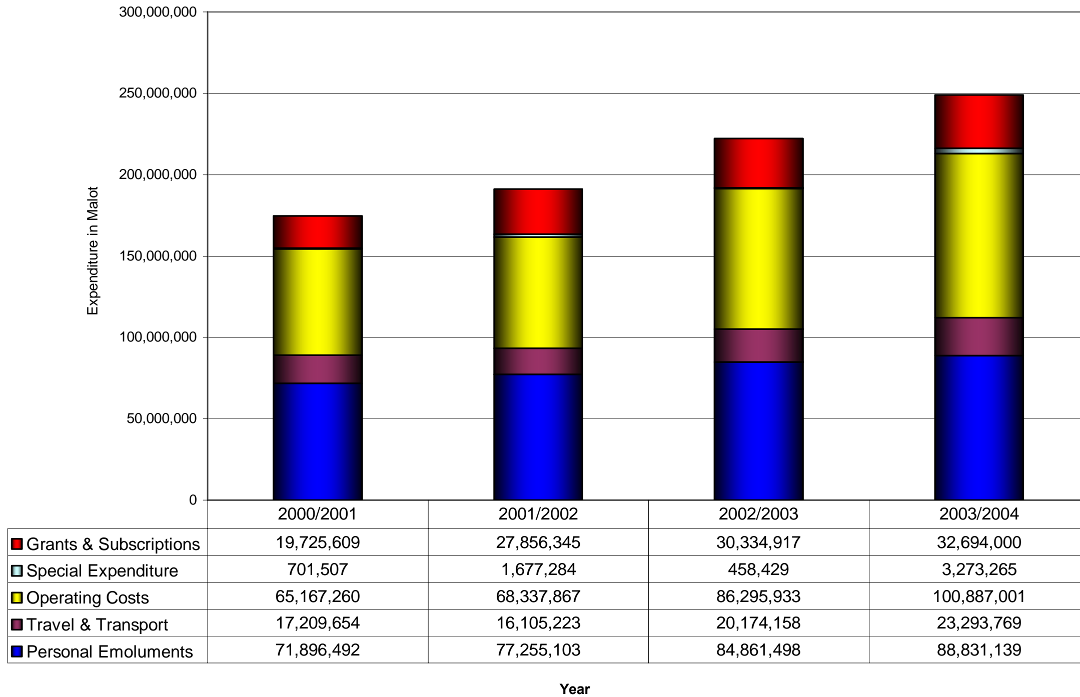
The role of the Secretariat is to monitor the production of reports and ensure adherence to the reporting requirements as a whole. However, there is not enough capacity within the Secretariat to follow up where needs be.

3.5.4 Impact of SEFF on MOHSW Expenditures

Figure 12 reveals that the introduction of the SEFF increased the total grant outlays by the MOHSW by roughly Maloti 2.36 million, but that this increase was the smallest of all expenditure categories listed. Though grant outlays increased by 5% between FY 2002/03

and FY 2003/04, total MOHSW recurrent expenditures increased by 12%. Evidently, services provided by CHAL remain a relatively cost efficient substitute for publicly produced health care.

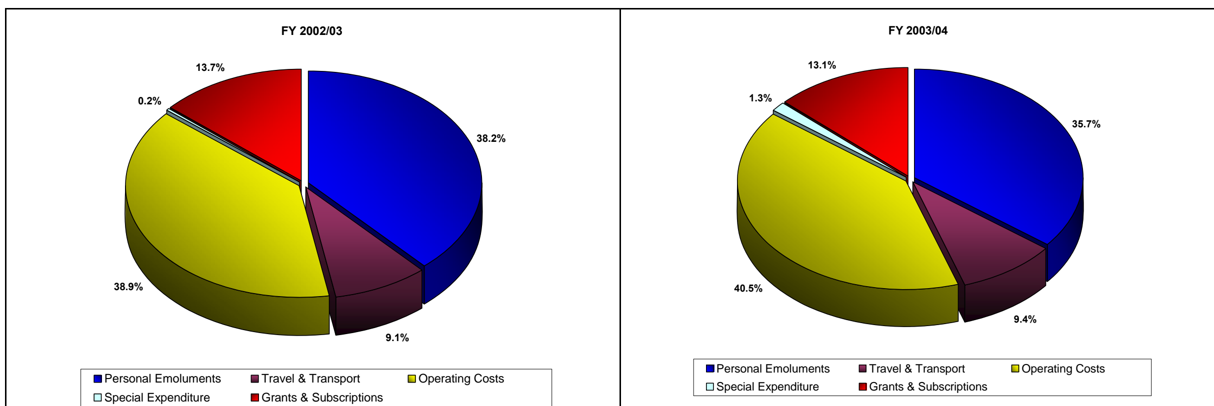
Figure 12: MOHSW Expenditures FY 2000/01 – FY 2003/04



	2000/2001	2001/2002	2002/2003	2003/2004
Grants & Subscriptions	19,725,609	27,856,345	30,334,917	32,694,000
Special Expenditure	701,507	1,677,284	458,429	3,273,265
Operating Costs	65,167,260	68,337,867	86,295,933	100,887,001
Travel & Transport	17,209,654	16,105,223	20,174,158	23,293,769
Personal Emoluments	71,896,492	77,255,103	84,861,498	88,831,139

Figure 13 contrasts the MOHSW expenditure shares between FY 2000/01 and FY 2003/04. It reveals that grant outlays decreased slightly as a share of total MOHSW expenditures from 13.7% to 13.1% of total expenditures. This indicates that there is added expenditure capacity to fund the CHAL subvention without appreciably increasing the share of total recurrent expenditures allocated to the purchase of services from CHAL sector.

Figure 13: MOHSW Expenditure Shares FY 2002/03 and FY 2003/04



3.5.5 Lessons Learned

1. The overall perception of the stakeholders interviewed during the mid-term Review is that the SEFF had a favorable impact on restoring the financial position of the CHAL Institutions.
2. This perception is confirmed by an analysis of current financial data, which reveals that the total subvention received from the MOHSW increased at all CHAL facilities. In the few cases where total revenues decreased (Paray, St James) it was due to a decrease in earned income from fees and other charges and/or a decrease in non-governmental grants. Without the SEFF, these institutions would have faced an even greater decrease in total revenues.
3. Overall, the Government financing share under the SEFF ranges from a low of 55% of total revenues at St James to a high of 69% at Seboche with a median level of 66%. Thus, with the SEFF included, the Government is currently providing approximately 2/3rds of the total financing for the CHAL hospitals.
4. The net result of the increase in the Government subvention provided under the SEFF has been positive on the overall financial position of the CHAL hospitals for which complete financial data were available for FY 2003/04: Mamohau, St James and St Josephs. In spite of their improved financial status, however, there is still need for considerable further improvement. For those hospitals that only provided complete financial data through FY 2002/03 (Paray, Scott, and Seboche) performance was mixed. On one extreme is Seboche whose financial position improved substantially through FY 2002/03 and in the process achieved the recommended operating margin as a percentage of operating expenditures. On the other extreme is Paray which experienced a significant worsening of its financial position and remained with a negative operating margin at the end of FY 2002/03. In the middle is Scott which experienced a substantial improvement in its financial position but still faces a negative operating margin as result of accrued liabilities which it is in the process of clearing.
5. The net impact of the SEFF on the health centers sampled in the mid-term Review has been positive.
6. The four-year lag between the calculation of the SEFF based on FY 1999/2000 financial audits and its disbursement in FY 2003/04 has had a variable impact on the hospitals. Had the SEFF been recalculated for the hospitals it would have been increased for all but Scott and Seboche and thus would have helped strengthen the financial position of most of the hospitals even further. The total SEFF for 6 of the 7 CHAL Hospitals would have been 23% higher than the amount based on the 1999/00 audit and it would have increased five fold for St James and Paray while being virtually eliminated for Seboche.

7. TB and malnutrition subventions are relatively small compared to the Salary + SEFF grant. It is reported that there are delays in receiving reimbursement under these subventions.
8. The SEFF has led to substantial efficiency improvements as reflected in the fact that all hospitals have been able to reduce the share of total expenditures allocated to labor to less than 70%, and increase the share of expenditures on drugs, building and vehicle maintenance.
9. The introduction of the SEFF has increased the total grant outlays by the MOHSW by roughly Maloti 2.36 million. Though grant outlays increased by 5% between FY 2002/03 and FY 2003/04, total MOHSW recurrent expenditures increased by 12%. Evidently, services provided by CHAL remain a relatively cost efficient substitute for publicly produced health care.

3.5.6 Way Forward

1. It will be important to recalculate the SEFF based on updated financials. This should be undertaken as a matter of priority for the upcoming budget submission based on the FY 2003/04 audited statements. This will require CHAL to expedite the completion of the audits for the hospitals and health centers and to submit these in the shortest possible delay to the Auditor General for review.
2. It will be necessary to further evaluate the performance of the TB and Malnutrition subventions. This should include the adequacy of these grants as well as the reason for the delays in obtaining reimbursement under them. This latter is important given that the new funding formula under the MOU is envisaged to include financing for carved-out services.

3.6 Adequacy of Monitoring and Supervision Conditions

3.6.1 Monitoring and Supervising Implementation of SEFF and Development of MOU

3.6.1.1 Description of Supervision and Monitoring Provisions of SEFF

Progress of the implementation of SEFF and development of the MOU is monitored by the JTF though regular meetings for presentation of progress, problems and way forward. However, the Partnership working committee is charged with the responsibility of ensuring progress and implementation of the recommendations by the JTF. Both bodies represent CHAL and the GOL. The GOL- CHAL Coordinating Unit facilities compliance of agreement conditions by both parties, while the secretariat ensures fulfillment of the requirements of the partnership by the institutions.

3.6.1.2 Knowledge & perceptions by stakeholders of Supervision & Monitoring Provisions of SEFF

3.6.1.2.1 Joint Task Force

The JTF confirmed that the non-functioning of the JTF Sub Committees has really been an impediment in terms of the monitoring the process. They also reported that the process has been more confined to the developments towards the MOU and compromised the monitoring of the SEFF. The meeting also reiterated the importance of the CHAL facilities to be audited with the authority of the Auditor General since the financial support from GOL is well above 50% of the overall CHAL facilities income.

3.6.1.2.2 GOL-CHAL Coordination Unit

The Unit reiterates the non-functioning of the sub committees as an impediment especially in light of the fact that they are responsible for setting the benchmarks and developing all necessary indicators for monitoring the process. However it had been anticipated that the actual monitoring would start during implementation of the MOU. The Unit feels that the Secretariat has played a significant role in monitoring and supervising the process and indeed in capacitating and ensuring compliance of the Institutions.

3.6.1.2.3 CHAL Board

The board feels the need to accelerate activation of the proposed sub-committees of the JTF for development of the needed procedures. It also realizes the need to demand for more information on the process and be more proactive with regards to the SEFF implementation. Secondly, the proprietors should give the board the statutory authority to negotiate and oversee the MOU process. Again, they felt that a senior person within the MOHSW should be appointed to have oversight responsibility for partnership process where the Coordinating unit would report.

3.6.1.2.4 CHAL Secretariat

According to the secretariat, effective communication should be ensured between CHAL representatives in the JTF and proprietors to ensure involvement of heads of churches in the MOU process.

3.6.1.2.5 CHAL Institutions

Not all institutions are well informed of the bodies in place for monitoring the SEFF, especially the existence and function of the JTF. They voiced the need for enhanced information flow.

3.6.1.3 Adequacy of Supervision and Monitoring

3.6.1.3.1 Joint Task Force

In view of the fact that the JTF sub committees have not been functional the JTF has not had any role to play in the monitoring of the SEFF, except in receiving the quarterly reports.

3.6.1.3.2 GOL-CHAL Coordination Unit

The role of the Coordinating Office in monitoring the SEFF has also been very limited, especially in light of the fact that the one officer is engaged more in spearheading the development process towards the MOU. The office has ensured the inclusion of the budget CHAL in the overall MOHSW. The office does not play any supervision role to the CHAL facilities, this mandate is vested to the CHAL Secretariat.

3.6.1.3.3 CHAL Board

The role of the Board as a whole in monitoring the process is not apparent, but a number of its members are in the JTF and therefore assume a monitoring role via this means.

3.6.1.3.4 CHAL Secretariat

The secretariat has managed to participate actively in the developments of the MOU. Since it is vested with the accounting responsibility for the SEFF it has ensured production of financial reports by institutions to monitor SEFF utilization.

3.6.1.3.5 CHAL Institutions

The participation of Institutions has been on production of reports as requested and the problems encountered at the beginning o the process were later overcome. However communication channels have to be enhanced to and within the Institutions to enhance the monitoring process.

3.6.1.4 Lessons Learned

Information dissemination is essential to ensure active participation by all parties in the MOU process.

3.6.2 Financial Monitoring

3.6.2.1 Description of Financial Monitoring Provisions of SEFF

A financial reporting format was designed for institutions to report on SEFF utilization. It also provides a comprehensive picture of income and expenditure of each institution and the sources of income. The secretariat assists in proper entry of information and before consolidation and submission of the report to the MOHSW. It also ensures timely submission of budgets for consolidation and submission to the MOHSW.

A format for quarterly financial reports for the SEFF were designed and introduced to all CHAL facilities. The format was subsequently revised end of 2003, and the new format was used since FY 2004/05. CHAL submits the quarterly reports to the office of the GOL/CHAL Coordinator at the end of each quarter and the reports are then distributed to all members of the JTF and MOHSW management however they have only been discussed once by the JTF.

3.6.2.2 Knowledge and perceptions by stakeholders of Financial Monitoring Provisions of SEFF

3.6.2.2.1 Joint Task Force

Both the first and the revised financial reporting formats were discussed at the JTF meetings and they endorsed the revised version.

3.6.2.2.2 GOL-CHAL Coordination Unit

The office has been facilitated the process of designing the reports.

3.6.2.2.2.1 Monitoring of Financial Position of Institutions and Impact of SEFF

This has not been done prior to this performance review.

3.6.2.2.2.2 Monitoring of Use of Funds

The reports have been used to monitor the use of funds, since the first audits on the SEFF are currently being undertaken.

3.6.2.2.3 CHAL Board

The budgets and financial reports get submitted to the board for comments. However, the board is not actively involved in the financial monitoring of SEFF.

3.6.2.2.4 CHAL Secretariat

3.6.2.2.4.1 Monitoring of Financial Position of Institutions and Impact of SEFF

The secretariat receives audited financial statements from the hospitals, which give a picture of the financial position of the institutions. It normally assists the health centers with the auditing process, which includes identification and forwarding of the financial records to the auditors. But since SEFF implementation year has just been completed, most institutions are still in the auditing process or preparing for the audit for the year 2003/04, which will show the impact of SEFF on the financial position to facilitate budget preparation for the coming year.

3.6.2.2.4.2 Monitoring of Use of Funds

The secretariat finds the reporting format designed for SEFF adequate in providing required information as it reflects sources of income and detailed expenditure items. The use of SEFF for health centers is administered by the secretariat by paying their drug bills and per invoices submitted by the health centers every month. Health centers get informed of the total amount of SEFF allocated to them to give them an idea of how much of their bills will have be taken care of from their other sources of income. The secretariat therefore took the responsibility of compiling the health centers reports on the utilization of SEFF.

3.6.2.2.5 CHAL Institutions

All institutions find the revised reporting format easy to follow and adequate for provision of information required to monitor the MOU process. However, one hospital felt that the items direct to the schools of nursing should be deleted and a separate format

be designed for the schools. They encounter no problems in extracting information from their financial records to the report format.

3.6.2.3 Adequacy of Financial Monitoring

3.6.2.3.1 Joint Task Force

This has not been adequate since the Finance Management Committee would have been responsible for the monitoring had it been formally established and functional.

3.6.2.3.2 GOL-CHAL Coordination Unit

The office has looked at the reports to review the use of funds but the capacity is very limited.

3.6.2.3.3 CHAL Board

The financial monitoring of each Institution is handled by their individual Boards and not by the Board of CHAL.

3.6.2.3.4 CHAL Secretariat

The secretariat has successfully introduced the financial reporting format to the facilities. This process required repeated training sessions for health centers due to staff turnover.

3.6.2.3.5 CHAL Institutions

The day-to-day financial monitoring of facilities is the direct responsibility of management, which reports to the Boards as the overseers. Institutions perceive the financial report to be adequate to effectively monitor the SEFF process.

3.6.2.4 Lessons Learned

Health centers need to get frequent feedback of compiled report on their use of SEFF.

3.6.3 Service Monitoring

3.6.3.1 Description of Service Monitoring Provisions of SEFF

The MOHSW is in the process of defining standards that will be used in monitoring of the service provision. In HMIS, the outpatient and inpatient forms used at facility level have been updated and are now compiled on a monthly not weekly basis. The forms have been put to use starting in July 2004. The inpatient form remains unchanged, while a new mid night census form will be introduced. The Unit is planning to conduct trainings for data clerks for all health facilities. In decentralizing services all data shall be processed at district level. The Health Statistics Unit has also revised the classification of disease reporting to ensure they are using the same standards as other countries, they are now using the International Classification of Diseases (ICD) 10.

No quality assurance programme is in place currently to monitor quality service provision by institutions. The programme together with the certification standards are in the development or finalization stage to pave way for monitoring the purchaser-provider agreement. These include, Essential Service Package, Standard Treatment Guidelines, Standard Equipment List, Essential Drug List and Standard Staffing Pattern. However,

data is submitted to Statistics Unit of the MOHSW on the services provided to provide a picture of the disease burden in the country.

1. Certification

An assessment shall be undertaken but modalities on how the process will be done are still to be deliberated.

2. Quality Assurance

Indicators are yet to be developed.

3. Existence of minimum standards for

4. Human Resources

Report with proposed standards is available and still to be disseminated.

5. Equipment

Standard Equipment available and CHAL involved in discussions but final list still to be disseminated.

6. Drugs and Medical Supplies

An Essential Drug List is currently being edited.

3.6.3.2 Knowledge and perceptions by stakeholders of Service Monitoring Provisions of SEFF

3.6.3.2.1 Joint Task Force

The JTF has vehemently expressed their concern in the MOHSW having been two slow in developing the standards.

3.6.3.2.2 MOHSW

3.6.3.2.2.1 GOL-CHAL Coordination Unit

No benchmarks or indicators were agreed upon during the interim period, therefore there was no service monitoring.

3.6.3.2.2.2 Other Departments in MOHSW

The other departments in the MOHSW (for example HMIS, Monitoring &Evaluation, FMU, Quality Assurance Unit, Human Resource and Primary Health Care) are represented in the JTF sub-committees and will play their roles as soon as the standards are set.

3.6.3.2.3 CHAL Board

The board as a body has not been involved in the service monitoring of institutions except from the fact most of its member are from the institutions and in the capacity of the institutions employees they ensure provision of service at the best of the institutions capacity and provision of data to facilitate monitoring.

3.6.3.2.4 CHAL Secretariat

The secretariat initially had just the advisory role to the institutions but the agreement furnished it with the role to monitor service provision by the institutions. However with no milestones, it has not been possible to monitor the quality of services. After finalization of the standards, the secretariat will assume the role of dissemination of documents and ensuring understanding and compliance by the institutions.

3.6.3.2.5 CHAL Institutions

Currently, the institutions have no problem in fulfilling the requirement to submit monthly statistical data on the services provided to the MOHSW, with an exception of a few health centers who sometimes run out of the tally sheets. Health centers submit to their supervising HSAs and most of them attend HSA meetings monthly or quarterly for planning ands reporting and also get supervisory visits from the PHC teams of the hospitals.

Quarterly or annual feedback of the submitted data is usually received from the Extended Program of Immunization (EPI). Feedback in a form of comparative statistical tables is received on an irregular basis from Statistics Unit of the MOHSW. The institutions sometimes get contacted only to fill identified gaps in the submitted data.

Some CHAL hospitals got involved in reviewing the standard treatment guidelines that will form part of standards for service provision.

3.6.3.3 Adequacy of Service Monitoring

3.6.3.3.1 Joint Task Force

The sub committees will empower the JTF to do the monitoring.

3.6.3.3.2 GOL-CHAL Coordination Unit

This Unit requires additional personnel to ensure capacity to do the monitoring.

3.6.3.3.3 CHAL Board

There is no clear role for the Board in service monitoring.

3.6.3.3.4 CHAL Secretariat

There is no clear role for service monitoring by the Secretariat. However, the functioning of the JTF sub-committees will enhance the process as the Secretariat is represented in most of them.

3.6.3.3.5 CHAL Institutions

The facilities have collected service delivery data using the HMIS formats with little or no difficulty. However, service monitoring by the Institutions will be through membership in the JTF sub-committees.

3.6.3.4 Lessons Learned

There is need to expedite finalization and dissemination of the standards to facilitate service monitoring

3.6.3.5 Way Forward

3.7 Adequacy of Management Conditions

3.7.1 Financial Management

3.7.1.1 Description of Financial Management Provisions and Procedures

3.7.1.1.1 MOHSW

3.7.1.1.1.1 Calculation of the SEFF

The first calculation of the SEFF was based on the 1999/00 audited financial statements for CHAL facilities. It has to be recalculated each year to inform the budget for the following year. However the 2003/04 SEFF was still based on the 1999/00 audits and it was not revised either for the 2004/05 budget.

Apart from the FMIS Consultant, none of the Finance staff are conversant with the calculation of the SEFF. They include the budget from CHAL based on the submission they receive.

3.7.1.1.1.2 Disbursement of SEFF

The SEFF is disbursed on a quarterly basis. This corresponds to the release of GOL financial warrants to line Ministries by the MOFDP which are availed during the first week of each quarter. In receiving a request for funds from CHAL, the Coordinating Office drafts a Savingram[28] to the Accountant General requesting the transfer of SEFF funds for the quarter to a designated CHAL account. The signed letter is used as a basis for preparing a voucher by the Finance department of MOHSW. The two documents are then submitted to the Treasury department of MOFDP where they check against the Government of Lesotho Financial Information Systems (GOLFIS) that the Grants in Aids vote[29] can accommodate the requested amount. Once clearance is made the office of the Deputy Accountant General will direct the Central Bank to affect the transfer.

3.7.1.1.1.3 Evaluating Financial Position of Institutions and Impact of SEFF

No evaluations have been done prior to this performance review.

3.7.1.1.2 CHAL

3.7.1.1.2.1 CHAL Secretariat

3.7.1.1.2.1.1 Calculation of the SEFF

The total budget submitted to the MOHSW was based on the 1999/00 audited financial statements following the pre-established formulae. In 2003/04 as the SEFF was implemented, institutions had experienced a lot of changes in staff numbers and inflation increase of salaries, which affected the total salary subvention and the SEFF to be disbursed to them. Moreover, some health centers that had been included in the SEFF

[28] Correspondence between GOL Ministries
[29] This is the vote which includes the CHAL subvention and the SEFF.

calculation were no more functional on implementation (Paki and Mount Carmel), while others were not included in the original SEFF calculation because they were not functioning at the time. These are St Francis, Sebedia, St Denis and Bethane health centers. With this in mind, the SEFF for the health centers was redistributed bearing in mind the utilization of the institution, size, staff retainment history[30], and prospects of the results from the recommendations of the rationalization study to ensure that all health centers received the SEFF.

3.7.1.1.2.1.2 Disbursement of SEFF

All hospitals were requested to open separate bank accounts for SEFF disbursement. Therefore, on receiving the funds, the secretariat transfers the amounts due to each hospital to their accounts and informs them how much was disbursed to them as salary subvention and SEFF. The decision on how best to use the SEFF to improve the financial position of the hospital lies with the hospital management and this gets accounted for in a form of a report.

The health centers just get informed about their total allocation but the funds remain with the secretariat for administration. The secretariat therefore accounts by preparing a report on the amount received and utilized on their behalf.

3.7.1.1.2.1.3 Evaluating Financial Position of Institutions and Impact of SEFF

3.7.1.1.2.2 CHAL Institutions

No evaluations have been made by the CHAL prior to the SEFF review.

3.7.1.1.2.2.1 Institutions completeness and reliability of financial records and accounts

The hospitals utilize accounts personnel qualified either as accountants or bookkeepers. This puts them in a better position to have proper accounting. All of them use Pastel accounting system though at different versions, with an exception of Mamohau because the accountant the got trained on Pastel left the hospital. This justified a considerable reliability of their financial records. On the other hand, some hospitals indicated the need for assistance form the secretariat to improve their accounting system especially with proper capturing and handover of financial records form all departments of the hospital. To date, the Financial Manager has been to two hospitals to set up improved accounting systems. It was discovered that most institutions operate on a cash accounting basis, which underestimates their income and expenditure per each time period.

Health centers were introduced to a simplified standard financial bookkeeping and recommendations were made on the type of accounting books to use. The books are, Income and Expenditure analysis book, Cash Book, Debtors and Creditors Ledger and Petty Cash Book. However, a follow up was not made after the training to ensure that the books are correctly used due to limited capacity of the secretariat. The bookkeeping at health center level is handled by the nursing staff.

3.7.1.1.2.2.2 Receipt, use and accounting for SEFF

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[30] Which would determine the service provision.

On receiving the SEFF, hospitals keep funds in the bank accounts separate from the rest of the pull of funds. How the funds are used is entirely depended on the needs of the facility as may be deemed necessary by its management. Health Centers use SEFF on drugs procurement only. The funds are accounted for using an agreed upon standard format designed by the MOHSW.

3.7.1.1.2.2.3 Evaluating Financial Position

The Institutions need to be equipped with the skills to enable them to evaluate their financial positions as brought about by the SEFF.

3.7.1.2 Knowledge and perceptions by stakeholders concerning financial management

3.7.1.2.1 MOHSW

The Financial Controller[31] in MOHSW admitted he did not know much about the SEFF. It appears that no orientation was made nor any handing over from his predecessors concerning the SEFF. Though the Financial Management Unit (FMU) has been working closely with the FMIS Consultant, it is apparent that they have not been any skills transfer, the staff is not at all conversant with the derivation of the SEFF. However they were involved in designing the financial reporting formats for the SEFF.

3.7.1.2.2 CHAL

3.7.1.2.2.1 CHAL Secretariat

The Secretariat is fully conversant with the financial procedures for the SEFF process. It however finds the financial reporting format inadequate for monitoring the system. Another challenge is the continuous late submission by the health centers of their financial reports.

3.7.1.2.2.2 CHAL Institutions

Some hospitals indicated the need for improvement of their financial management skills, while all health centers are in dire need for acquisition of financial management skills.

3.7.1.3 Adequacy of financial management

3.7.1.3.1 MOHSW

The FMU is responsible for the monitoring of the recurrent budget in the MOHSW. It is staffed with a Senior Economic Planner and two Senior Accountants, and while they ideally report to the Financial Controller, due to staff turn over in that office, a temporary arrangement has been made for them to report directly to the Director Health Planning. Though the SEFF reports are copied to the Financial Controller the FMU have not been given any copies, thus they have not had a chance to review them.

A lot of problems have been encountered in the disbursement of SEFF, always emanating in delays in transfers and misappropriation of the SEFF funds by the Finance department.

[31] At the time of the review the acting Financial Controller is hardly two months in the MOHSW.

This can be attributed to a number of reasons; (1) high staff turn-over of the Financial Controller, (2) high turn over in the accounts staff responsible for preparing the vouchers, (3) lack of commitment in this department and hence no follow up etc.

3.7.1.3.2 CHAL

3.7.1.3.2.1 CHAL Secretariat

The creation of the position of the Financial Manager within the Secretariat improved the financial management capacity of the Secretariat. However, the current workload hinders focus of the FM to the intended responsibilities.

3.7.1.3.2.2 CHAL Institutions

There has been an expressed need for improvement of skills in this regard.

3.7.1.4 Lessons Learned

Loss of staff with no proper handover leaves a gap in the financial records of the health centers.

3.7.1.5 Way Forward

1. Bookkeepers could be recruited for a cluster of health centers to take over the bookkeeping duty from the nursing staff.

3.7.2 Service Management

3.7.2.1 Description of Service Management Provisions and Procedures

3.7.2.1.1 MOHSW

Other than the monitoring of the HMIS through submission of monthly out patient and in patient summary reports submitted to the Health Statistics Unit there is no service management of the CHAL facilities by the MOHSW. Formerly there used to be some PHC planning and reporting meetings for all MOHSW and CHAL health facilities but this has ceased to exist.

Through the decentralization process the management of services at the periphery will shift from being HSA based to the DHMTs. The Decentralization Framework stipulates that all health centres irrespective of ownership shall be supervised and monitored directly by the DHMTs, while the hospital will report to the DHMT and provide services only to their immediate catchment area. This approach is currently being introduced in the three pilot districts, and the roll out will follow based on the lessons learnt.

3.7.2.1.2 CHAL

3.7.2.1.2.1 CHAL Secretariat

Planning and reporting sessions are held with facilities on a quarterly basis to monitor progress. This however is limited to PHC donor-funded activates only. No other measures are taken for service monitoring by the Secretariat.

3.7.2.1.2.2 CHAL Institutions

Management currently employs the utilization data to keep track of the services provided by the Institutions. With the current HSA concept, the hospitals bear the responsibility for supervising the health centers within their catchment area and this is achieved through monthly visits by the doctors and more frequent visits by the PHC teams.

4 Recommendations

Strengthening the Partnership Process

1. ***A more realistic time frame needs to be instituted that adequately accommodates the bureaucratic requirements of government processes, and the capacity of all stakeholders (including CHAL). This should be reflected in the new and revised Action Plan for the Partnership Process.***

   This will help avoid unnecessary frustration on the part of stakeholders and misconceptions about the commitment of the other parties involved.

2. ***The process for implementing the full partnership should be adjusted in whatever ways necessary and the partners should commit to ensuring that the full MOU is signed and enacted before the next election cycle in 2007, and that associated Operating Agreements are signed and implemented at least on a provisional basis subject to institutional accreditation.***

   This will avoid having to re-start the process under a new Administration – a situation that could likely undermine the whole partnership process.

3. ***The MOHSW through the GOL/CHAL Coordinating Unit needs to strengthen its internal and external communications systems and procedures pertaining to developments in the partnership process, ensuring that all stakeholders are kept up-to-date on developments, achievements, constraints, expectations etc.***

   This will not only accelerate the implementation of the partnership process but will minimize unnecessary misunderstandings.

4. ***The CHAL Secretariat needs to strengthen its internal and external communications systems and procedures especially with the Proprietors and its Institutions pertaining to developments in the partnership process.***

   This will not only accelerate the implementation of the partnership process but will minimize unnecessary misunderstandings.

5. ***The hospitals that manage health centers directly need to provide briefings to the health center staff on the partnership process and keep them fully and regularly informed of developments.***

This will not only accelerate the implementation of the partnership process but will minimize unnecessary misunderstandings.

6. ***CHAL training institutions need to be more fully and effectively included in the partnership process.***

    This will ensure that the production capacity exists to produce the requisite human resources for the sector.

Enhancing the JTF:

7. ***All the Sub-Committees of the Joint Task Force should be activated with immediate effect work plans developed that ensure that essential tasks necessary to finalize the MOU are accomplished in a timely manner***

    This will speed up the MOU development process and will hold all partners accountable for the development and implementation of the process. It will also ensure that the MOU is in place and signed by the GOL and CHAL prior to the 2007.

8. ***The Government Secretary, in his capacity as the chairperson of the JTF, should ensure routine participation of all relevant GOL Ministries in all meetings of the JTF***

    This will ensure that all Ministries are on board at all stages of the development of the MOU and will speed up processes at the operational level.

9. ***CHAL membership to the JTF/JCC should be reviewed by the CHAL Proprietors***

    This should address internal-to-CHAL concerns over ownership proportionality, and the selection of representatives who can participate adequately in technical discussions.

10. ***The Ministry of Local Government as a member of the JTF should be pro-active in advising the JTF on matters related to the overall government decentralization strategy***

    This will ensure clarity on how the GOL-CHAL MOU will be impacted by decentralization and will ensure in turn that decentralization decision-makers are fully cognizant of the GOL-CHAL partnership process.

11. ***Lines of communication should be strengthened between the JTF and all relevant stakeholders. This is a role that the GOL-CHAL Coordinating Unit should assume as the standing Secretary to the JTF. A list of key stakeholders should be agreed to who will receive summary proceedings of JTF meetings and any special informational circulars etc.***

This will ensure timely and complete dissemination of concerns and/or decisions of the JTF to all relevant stakeholders and will ensure effective feedback from the stakeholders to the JTF.

12. ***The JTF should be disbanded once the MOU is signed and be replaced by a Joint Commission of Cooperation (JCC) as currently envisaged. While chairmanship of the JCC should remain with the office of the Government Secretary the membership of the JCC should no longer be at PS level other than that of MOHSW. Representation from other Ministries or Government institutions critical to the process (e.g. the Office of the Auditor General, the Ministry of Education?) should be assured by suitably senior representation. The PS-MOHSW should be delegated responsibility by the GS to act as the Chairperson of the JCC. Special Executive Sessions of the JCC could be convened as required under the chair of the GS***

    This will ensure regular and active participation of the those members with particular interest in the health sector and the partnership between the GOL and CHAL while retaining the involvement of the Government Secretary in order to ensure that the process has adequate authority and direction.

Strengthening the GOL-CHAL Coordinating Unit

1. ***The GOL/CHAL Coordinating Unit should be expended with recruitment of an Assistant to the Coordinator, and both positions should be formally created/established within the Health Planning & Statistics Department***

   This will ensure continuity in a case where the current Coordinator may leave the Ministry and also sharing responsibilities especially in driving the development process of the MOU as well as monitoring the SEFF. It will also ensure sustainability should donor support phase out.

2. ***The capacity of the GOL/CHAL Coordinating Unit should be enhanced to ensure that it will be able to effectively implement the monitoring and evaluation processes required under the partnership. This should include the provision of intermittent technical support, continuing education and study tours as relevant.***

   This will render the process more effective and help ensure that Lesotho can benefit from similar experiences elsewhere. It should also enhance the capacity of the Unit to identify and solve problems earlier in the process.

3. ***The GOL/CHAL Coordinating Unit should institute procedures for ensuring that the JTF members are adequately prepared for meetings***

   This will facilitate effective participation, focusing on decision-making rather than reporting, while minimizing the time required for the JTF meetings.

4. ***The GOL/CHAL Coordinating Unit should institute mechanisms to ensure follow up on decisions made by the JTF***

   This will ensure that responsibilities for follow-up action are clearly understood by all stakeholders and that the process adheres to the schedule specified in the work plan.

5. ***The GOL/CHAL Coordinating Unit should develop a clear timeline and task definition of for timely preparation and processing of the CHAL subvention and financial reporting within the annual budget cycle.***

   This will ensure timely submission of requisite financial information and disbursement of the SEFF.

6. ***The GOL/CHAL Coordinating Unit in consultation with the DPHC should institute forums to interact with the districts to report them on developments in the MOU process and discuss their concerns. These forums should be instituted with assistance from the DHTMTs and should be integrated if possible within existing meetings at the district level.***

   This will enhance decentralized participation in the partnership process and will provide the Coordinating Unit with a mechanism through which it can obtain regular feedback from the operational level.

The CHAL BOARD

1. ***The CHAL Constitution should be amended to restrict the powers of the AGM to revoke, suspend or amend actions or decisions by the CHAL Board if doing so would contravene the terms and/or conditions of the partnership framework as defined in the MOU.***

   This will protect the terms and conditions of the Partnership framework between CHAL, its Institutions and the GOL as defined in the MOU.

2. ***The statutory authority of the CHAL Board should be strengthened within the CHAL Constitution to accord the Board explicit authority to negotiate on behalf of its members and enter into binding agreements on behalf of the CHAL members with GOL with respect to the partnership framework governing the supply and financing of health and social welfare services.***

   This will eliminate a current impediment to the partnership process which envisages that CHAL will sign an MOU with Government on behalf of its members and that this agreement will have binding legal standing under the laws of Lesotho. It will also enhance the performance of the CHAL Board and

decision-making in general within CHAL and thus will render the partnership process more efficient and accountable.

3. ***The GOL participation in the CHAL Board sessions should be initiated without further delay.***

   This will enhance communications between CHAL and the GOL and will provide Government with a greater appreciation for the concerns and positions of CHAL. It will also help to minimize potential future misunderstandings based on inadequate information and will ensure that the Board is fully informed in a timely manner about policy decisions that could impact the partnership. Finally, it will provide another important mechanism for CHAL to communicate with Government.

4. ***A formal orientation for the newly appointed GOL representatives to the CHAL Board on the GOL-CHAL Partnership process should be organized prior to their first Board meeting.***

   This will ensure more fruitful discussions at the meeting and their role will be more clarified.

CHAL Secretariat

1. ***The CHAL Secretariat should improve the communication infrastructure between the Institutions (including Health Centres), Secretariat and Board***

   This will eliminate the current impediment to timely and effective communications within CHAL and facilitate monitoring and evaluation under the new accreditation and quality assurance programme.

2. ***The CHAL Secretariat should participate in the yearly forums convened by the GOL-CHAL Coordinating Unit at the DHMTs and regularly participate in HSA meetings and quarterly Health Centre meetings***

   This will position the Secretariat to better discern the needs and concerns of the staff at the Institution level and ensure effective dissemination of information pertinent to the partnership process.

3. ***Mechanisms to implement and ensure sustainability of the new Organogram of the CHAL Secretariat should be instituted.***

   This will enhance the capacity of the Secretariat to support the partnership process and in particular the financial management requirements, and render the Secretariat more effective in addressing the needs of the Institutions.

4. ***The CHAL Secretariat should institute a formal orientation for new staff on the partnership framework and processes.***

This will maximize the capacity of new staff to support the partnership and will minimize potential problems caused by a lack of information / orientation.

5. ***The CHAL Secretariat should strengthen its public relations and communication with the Institutions.***

   This will entrust the Secretariat to the Institutions and will ensure smooth working relations.

6. ***The Secretariat should institute procedures for accounting separately for the subvention intended for hospitals, health centers under direct administration of hospitals and schools of nursing, and ensure that these funds are used to defray the costs of the Institutions for which they were allocated.***

   This will improve accountability and ensure effective use of funds in accordance with the intentions of Government.

7. ***In cases where funds for specific expenditure purposes are disbursed directly to the Institutions, the Secretariat should provide clear instructions on how the funds should be employed, as well as information on the source of the funding.***

   This will ensure the effective use of funds and appropriate financial accountability and reporting.

8. ***The CHAL Secretariat should expedite instituting a process of direct salary deposits to employee bank accounts. Institutions should expedite submission of accounts to the Secretariat.***

   This will reduce irregularities in dates of salary disbursements.

Legal Provision for the Partnership Process

Interim Agreement

1. ***The period of validity of the Interim Agreement should be extended through March 31 2006 by signature of the PS-MOHSW and the Chairman of the Board of CHAL.***

   This will ensure that the new MOU and Letters of Intent and associated supporting procedures and documentation can be prepared prior to the interim agreement terminating. It will also ensure that CHAL and its Institutions have an opportunity to enter into the new partnership agreement during the period of the current Government Administration.

2. ***Clause (iv) of Article 4.1 of the Interim Agreement should be amended immediately to allow CHAL Institutions to pay salaries at levels commensurate with those paid by the GOL. The SEFF should be adjusted accordingly based on a salary review to be undertaken jointly by the CHAL Secretariat and the GOL-CHAL Coordinating Unit.***

   This will eliminate the structural labor market inequity that currently exists and that has led to excessive personnel turnover within the CHAL sector and rendered it difficult for the sector to sustain services in manner consistent with the desires of Government.

3. ***Clause (v) of Article 4.1 of the Interim Agreement pertaining to freezing user fees at prevailing levels within CHAL Institutions should be retained so long as clause (iv) is amended as recommended in Recommendation 8 above.***

   This will ensure that barriers to access for consumers in the CHAL health service areas are not increased any further during the interim period.

4. ***The Interim Agreement should be amended to reflect the following:***

   a. ***A CHAL Strengthening Investment Programme should be initiated as soon as possible and no later than March 2006 to pre-position the CHAL Institutions to satisfy Certification Requirements.***

      This will ensure that the CHAL Institutions have the resources and means to strengthen the management systems and service provision capacity sufficiently to adequately pre-position them to satisfying the accreditation requirements of the new MOU and LIs.

   b. ***A valuation of the fixed assets of all CHAL Institutions should be carried out by December 2004 as the basis for deriving the Proprietor's annualized contribution to financing services.***

      This will validate the historical investment made by the Proprietors and the annualized asset stream that these fixed assets represent. It will also ensure that a common methodology is used at all Institutions (including health centres), thus improving comparability between Income Statements and the operating margins of each institution.

   c. ***An Initial Certification Review should be carried out starting in October 2005 and ending with a preliminary determination of certification status by March 2006. This preliminary determination of certification status should include a detailed report identifying all performance deficiencies relative to the accreditation and quality assurance standards and specific recommendations on what steps are necessary for achieving compliance with the certification standards.***

This will ensure that all CHAL Institutions have undergone an initial accreditation review in time to sign the new MOU and LI (either under permanent or provisional certification as discussed in Recommendation 7 below), thus ensuring that the new partnership framework is in place during the current Government Administration.

d. ***All CHAL Institutions should be provided an initial 2-year provisional certification if they fail to satisfy initial certification based on the Initial Certification Review. Two additional certification reviews will be conducted over the course of the next two years. Institutions that fail to meet the certification standards after this third attempt will be de-certified and will receive future GOL funding (if any) in accordance with the needs/wishes of Government based on a separate arrangement with Government outside the purview of the MOU and LI framework.***

This will ensure that all CHAL Institutions have sufficient time to meet the accreditation standards set by Government for sustained future funding under the new MOU and LIs. As such, it will maximize the likelihood that Institutions will satisfy these requirements and thus be positioned to supply the services that Government seeks to purchase.

MOU and Letters of Intent

5. ***A review of supporting legislation and statutes that have a bearing on the MOU or LIs should be undertaken by January 2005.***

This will ensure that the new partnership framework is fully consistent with and supported by the laws and statutes of the Kingdom of Lesotho, and that any conflicts and/or inconsistencies between the MOU and LI and these laws and statutes are addressed prior to the signing of the new MOU and LIs.

6. ***Operating Agreements between the MOHSW and each CHAL Institution should be retained as part of the legal framework for the new partnership between the GOL and CHAL***

This will ensure that the MOU does not need to be renegotiated in the event that the agreement with a single CHAL Institution is terminated and will allow for Institution-specific provisions pertaining to the services to be provided, the terms and conditions of the contract purchase agreement. It will also ensure that the assets of the Institution provide “collateral” for the service agreement and, therefore, that Government can sue to keep an Institution open in the event that it were to unilaterally and suddenly decide to shutdown in contravention to the service continuity provisions of the contract.

7. ***Text and Annexes to the MOU and LI should be finalized by October 2005.***

   This will ensure that there is adequate time to carry out an Initial Certification Review as defined in Recommendation 6 below.

8. ***A number of changes may need to be made to the Zero Draft of the MOU. These include:***

   Article 3.2.2 stipulates that the JCC – GOL/CHAL "shall report to the Sub-Committee of Cabinet Ministers and Heads of Churches, under the chairmanship of the Right Honorable Prime Minister or his delegate, who in turn shall report to the Cabinet." It is not clear why there is need for a Sub-Committee of Cabinet and Heads of Churches to serve as an intermediary between the JCC and Cabinet. In particular, given that the Heads of Church are *de jure* (if not *de facto*) signatories to the MOU via CHAL, it is not clear why they would need to be represented in the aforementioned Sub-Committee. This would bring into question the authority they have reportedly intended to vest in the Board of CHAL.

   Article 3.2.2 could be reformulated as follows: "This Authority shall report to the Cabinet."

   Article 3.2.3 This Article will need to be reviewed again in light of the concerns on the part of some JTF delegates that the JCC should not be chaired by the GS and should not include the PSs of ministries other than the MOHSW. It is also recommended that the text which reads "…the Delegates of the CHAL Proprietors of Anglican Church of Lesotho, Assemblies of God, Bible Covenant, Lesotho Evangelical Church, Roman Catholic Church and The Seventh Day Adventists" be replaced with the following, "…the Delegates of the Board of CHAL."

   Article 3.4.7 should be amended to read: "At an operational level, the relationship between CHAL hospitals, the District Health Management Teams (DMHTs) and other decentralized structures that may be developed will be governed by the policies and procedures established by the Government of Lesotho and the Ministry of Health and Social Welfare and will be specified in amendments to the MOU or Operating Agreements as required." Where the policies and procedures governing decentralized health service provision conflict with the Articles of the MOU and/or LIs, the Legal Sub-Committee of the JCC-GOL/CHAL will need to review them and either recommend appropriate amendments to the MOU or modifications to the Government's policies and/or procedures governing decentralized health service provision.

   Procedures for amending the MOU need to more fully developed as a separate section of the MOU or as an amplification to **Section 9.0** pertaining to "Non-Variation."

Article 3.5.1 should be amended to read

> "CHAL Institutions should have met all requirements of certification within the pre-certification or re-certification period unless otherwise accorded a fixed-term provisional certification by the MOHSW."

Article 3.5.2 should be amended to read

> "The Proprietor of the CHAL Institution has met its financial obligations as stipulated under the MOU and Operating Agreements for each of its Institutions within period of time prescribed within these contracts."

Article 3.5.3 should be deleted. It is superseded by the revised Article 3.5.2

Article 3.5.7 should be amended to read

> "The CHAL Secretariat shall provide the technical oversight and support necessary to ensure that Institutions prepare and submit for audit the following financial statements not later than three months after the close of the Financial Year…"

The requirement to deliver these financial statements within three months after the close of the Financial Year should be added to each of the LIs and should be included in the indicators of Quality Assurance and Re-Certification.

Article 3.5.8 should be amended to read

> "The audited accounts of the CHAL Institutions has been examined and approved by the Auditor General or any other person(s) authorized by him/her. Audited accounts should be submitted to the Auditor General's Office no later than the end of June of each year and should be examined and approved by the end of August of each year."

Article 3.6 should be amended to read

> "The services to be purchased by the GOL from CHAL Institutions shall be based primarily on the Essential Health Package of the MOHSW. The specific package of services and the service mix will be determined within the Operating Agreements in accordance with MOHSW Policy and through an assessment of the health needs of the communities served by the CHAL Institutions. If deemed necessary, the package of services may include supplementary services that are not defined within the Essential Service Package. Both the Essential Health Package and the specific package of services and service mix to be purchased from individual Institutions may be revised by the MOHSW in consultation with CHAL from time to time to reflect changing circumstances."

Article 3.6.3 should be corrected to read:

> "Training services purchased by the MOHSW…. will be designed on a capitated basis to cover the full operating costs of the school, where the capitation is based on the prospective number of nurses enrolled in accordance with the National Human Resources Development Plan."

Article 4.6 should be amended to read:

> "The MOHSW will include CHAL Institutions that are either provisionally certified or certified as required in its annual operating plans and budgets…"

CHAL Constitution

9. ***The CHAL Constitution needs to be amended in order to safeguard the purchase agreement. This will include modifications to the articles governing (i) the timeline for CHAL members (Proprietors) resigning their membership in CHAL, (ii) the authority the AGM has over amending or revoking Board decisions relating to the MOU, and (iii) the timeline for dissolving CHAL will each need to be revised to ensure that they do not abrogate or contravene the MOU and LIs. Final amendments should be enacted by the AGM by March 2005.***

   This will safeguard the partnership process to prevent any CHAL Institution from suddenly quitting CHAL and thus no longer being bound by the terms of the MOU, or for CHAL to be dissolved without honoring the commitment to service continuity stipulated in the MOU.

The SEFF

1. ***The SEFF should be recalculated based on updated financials. This should be undertaken as a matter of priority for the upcoming budget submission based on the FY 2003/04 audited statements. This will require CHAL to expedite the completion of the audits for the hospitals and health centers and to submit these in the shortest possible delay to the Auditor General for review.***

   This will ensure that the SEFF is responsive to the prevailing financial conditions of the CHAL hospitals thus improving their financial status while ensuring effective targeting of the use of public funds.

Financial Monitoring:

1. ***The financial reports produced by Institutions should be discussed on quarterly basis by the Finance Management Sub-Committee of the JTF and a summary report should then pre presented to the JTF.***

   This will ensure that financial trends are analyzed and that financial problems are identified and corrective actions recommended and instituted in a timely manner.

2. ***All Institutions should produce audited reports within three months of the end of the financial year. These should be submitted by the Secretariat to the GOL-CHAL Coordinating Unit which will in turn submit them to the Auditor General's Office.***

   This will ensure that up-to-date financials are used for the calculation of the SEFF or later subvention.

3. ***The GOL-CHAL Coordinating Unit in conjunction with the CHAL Secretariat should produce an Annual Partnership Report that reviews the financial position of the CHAL Institutions as well as service performance and contrasts this to previous years to observe trends.***

   This will ensure that major trends are discerned and that the performance of each Institution can be monitored both in relation to its past performance and in relation to its relative position vis-à-vis other institutions.

4. ***Financial reports should discern between hospitals and health centers, and should report on total expenditures by source of financing.***

   This will ensure that the MOHSW can fully monitor and evaluate the financial position of CHAL Institutions and ascertain that public resources are being used for the purposes that they were intended.

Financial Management:

5. ***Financial Management Unit of the MOHSW should become directly involved in the SEFF and future subvention process to facilitate and reinforce the calculation, disbursement and monitoring of grants to CHAL.***

   This will not only strengthen the process, but will also ensure that the FMU has up-to-date financial data for incorporation of the MTEF and other financial accounting. It will also enhance the sustainability of the process by ensuring that not only the GOL-CHAL Coordinator is familiar with the process and methods.

6. ***Health Centres should get detailed quarterly statements of their SEFF and salary subvention allocation and their expenditures against these funds and other revenue sources.***

   Health centres need to be assisted in using financial information to better manage service production.

7. ***The Accounts Department of the Secretariat needs to be strengthened to provide regular financial management services for the independent health centres and to provide technical assistance to the hospitals as required.***

   This will enable the Secretariat to provide the financial management support needed by the CHAL Institutions.

8. ***Institutions that assume responsibility for their own financial management should be trained to evaluate their financial position.***

   This will enhance the ability of the Institutions to comply with the terms of the new partnership framework and to produce services in a more cost-effective manner.

Service Management and Monitoring:

1. ***Emphasis must be given now to developing the Accreditation process for CHAL Institutions. This will require linkages with the work being undertaken to strengthen the HMIS and to develop a system-wide Quality Assurance Programme for the Health Sector. These latter are necessary but insufficient conditions for the creation of the Accreditation process.***

   The ability of the CHAL Institutions to comply with the terms of the MOU and LIs depends fundamentally on the Accreditation system that is put in place. They must be given sufficient time to learn the system and develop the capacity to comply with it.

2. ***Service data collection at the facility level will need to be enhanced and requisite forms made available.***

   This will ensure that CHAL Institutions can supply the data required for accreditation and re-certification.

3. ***Automation of the HMIS data processing at the central level will be essential for timely availability and use of service data. This will require the development of a computerized data model and associated infrastructure (see de Jong, 2003).***

   The ability of the CHAL Institutions to comply with the terms of the MOU and LIs depends fundamentally on being able to supply up-to-date and accurate data on service production etc.

5 Implementation Plan

ID	Task Name	Duration	Start
1	Review of SEFF Review findings (national workshop)	10 days	Mon 9/13/04
2	CHAL salary review and calculation of the SEFF adjustment required to enable Institutions to pay salaries comensurate with those of the MOHSW	20 days	Mon 9/27/04
3	Extension of Interim Agreement through March 31 2006	1 day	Mon 10/25/04
4	Valuation of CHAL Institutional fixed assets	20 days	Mon 11/1/04
5	Finalization of User Fee recommendations	20 days	Mon 11/1/04
6	Review of TB and Malnutrition subvention reimburse	20 days	Mon 11/1/04
7	Review undertaken of the supporting legislation and statutes that may affect the MOU and LI	40 days	Mon 11/1/04
8	Revision of CHAL Constitution as required	70 days	Mon 11/1/04
9	Review of proposed modifications to CHAL Constitution with JTF	15 days	Mon 2/7/05
10	Final draft to revised CHAL Constitution for submission to AGM	10 days	Mon 2/28/05
11	AGM to amend CHAL Constitution	1 day?	Mon 3/14/05
12	Review by GOL Law Office	60 days	Tue 3/15/05
13	Final review / approval by CHAL AGM	40 days	Tue 6/7/05
14	Finalization of text of MOU and LI (with exception of some Annexes)	70 days	Mon 12/20/04
15	Finalization of Annexes to MOU and LI: Financial formula; Accreditation-related annexes (QA indicators etc)	240 days?	Mon 11/1/04
16	Last financial year of Interim Agreement; 1st year of investment in CHAL Strengthening	261 days?	Fri 4/1/05
17	FY 04/05 Financial Audit	60 days	Mon 4/4/05
18	Approval of FY 04/05 Audits by Auditor General's Office	50 days	Mon 6/27/05
19	FY 06/07 Budget preparation and submission	20 days	Mon 9/5/05
20	Initial Certification Review	105 days	Mon 10/3/05
21	Determination of Certification status	1 day?	Mon 2/27/06
22	Signing of permanent or provisional Letter of Intent	10 days	Tue 2/28/06
23	1st year under new purchase arrangement under permanent and/or provisional LIs	260 days	Mon 4/3/06
24	Second Round Certification Review	105 days	Mon 10/2/06
25	Determination of Certification status	1 day?	Mon 2/26/07
26	2nd year under new purchase arrangement under permanent and/or provisional LIs	260 days	Mon 4/2/07
27	Third and final Certification Review	105 days	Mon 10/1/07
28	Final determination of Certification status	1 day?	Mon 2/25/08

6 Bibliography

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2. Report of Proceedings for the GOL CHAL Partnership Meeting (MCDI, June 2000)
3. Interim Service Provision and Financing Agreement between the GOL and CHAL (GOL and CHAL, December 2002)
4. Draft Post-Certification Service Provision and Financing Agreement
5. Terms of Reference for the Joint Task Force working committees,
6. Minutes of meetings held by these working committees as well as by the Joint Task Force and the CHAL Board
7. Correspondence between CHAL, its institutions and the Government pertaining to the SEFF and MOU process.
8. CHAL Proprietor Study, the User Fee Study (Ntlafalang Consultants, July 2002)
9. Strategy and Action Plan for Decentralization (MOHSW, April 2004)
10. Designing an Essential Service Package for the Lesotho Health Sector (Muhebwa and Tiheli, June 2003)
11. Action Plan for Implementing Quality Management into the Decentralised Health Care in Lesotho (Idanpaan-Keikkila, March, 2004)
12. Proposal for a Quality Assurance Framework for the Lesotho Health Sector (Muhebwa and Tiheli, June 2003)
13. Draft Standard Treatment Guidelines 2003 (Moji and Mothibe-Masoga, 2003).

7 List of People Interviewed

#	NAME	TITLE/DESIGNATION	ORGANIZATION
	JOINT TASK FORCE MEETING:		
1	Mr S. Sekatle	P.S. - MPS & Government Secretary *a.i.*	GOL
2	Mr M. Mapetla	Attorney General's Chambers	GOL
3	Mrs D. Walters	AUDIT	GOL
4	Ms R. Kepa	Cabinet Office	GOL
5	Mr N. Ramaphiri	*for* P.S. - MOET	GOL
	MOHSW WORKING COMMITTEE MEMBERS MEETING:		
6	Dr T. Ramatlapeng	Director General of Health Services	MOHSW
7	Ms M. Tiheli	Director Primary Health Care	MOHSW
8	Ms M. Makhakhe	Director Health Planning & Statistics	MOHSW
9	Ms T. Mohlomi	GOL/CHAL Coordinator	MOHSW
	MOHSW – FINANCIAL MANAGEMENT MEETING:		
10	Mr Maqhama	Financial Controller *a.i.*	MOHSW
11	Ms M. Selikane	Senior Economic Planner – Finance Management Unit	MOHSW
12	Mr H. Mochekoane	Senior Accountant - Finance Management Unit	MOHSW
	CHAL SECRETARIAT MEETING:		
13	Ms G.P. Nchee	Executive Secretary	CHAL Secretariat
14	Ms P. Jankie	Finance Manager	CHAL Secretariat
15	Ms M. Mohapi	Senior Economic Planner	CHAL Secretariat
16	Mr. J. Oehninger	Technical Officer	CHAL Secretariat
17	Ms. E. Ramaisa	Accountant	CHAL Secretariat
	CHAL PROPRIETORS MEETING:		
18	Mr Manyeli	*for* Head of Church	Roman Catholic Church
19	Rev. J. R. Mokhahlane	Head of Church	Lesotho Evangelical Church
20	Rev. J.N. Leodi	*for* Head of Church	Anglican Church of Lesotho
21	Pastor A. Mainoane	Head of Church	Seventh Day Adventist
22	Rev. Moswatsi	*for* Head of Church	Assembly of God
23	Pastor G. Gault	Head of Church	Bible Covenant
	CHAL EXECUTIVE BOARD MEETING :		
24	Mr. Thamae	Board Chairperson	Paray Hospital
25	Mr. Makhetha	Vice Chairperson	
26	Ms M. Mochai-Mafereka	Board Chairperson	St Joseph
27	Mr Lelosa	Board Chairperson	Maluti Hospital
	CHAL HOSPITALS :		
	MALUTI		

28	Mr. Lelosa	Treasurer	Maluti Hospital
29	Mr S. Ramorasata	Accountant	Maluti Hospital
30	Ms. Lebina	Hospital Matron	Maluti Hospital
31	Ms. V. Nteso	Principal Tutor	Maluti Hospital
	SCOTT		
32	Dr. Makakule	Medical Superintendent	Scott Hospital
33	Mr. Makara	Hospital Administrator	Scott Hospital
34	Ms. M. Hoeane		Scott Hospital
35	Ms. M. Hoeane	Principal Tutor	Scott Hospital
	ST JOSEPH		
36	Dr. Makinga	Medical Superintendent	St Joseph Hospital
37	Ms. M. Mochai-Mafereka	Hospital Administrator	St Joseph Hospital
38	Ms. Ts’ola	Hospital Matron	St Joseph Hospital
39	Mr. Phahlane	Assistant Administrator	St Josephs Hospital
40	Ms. Keketsi	Principal Tutor	St Josephs/Roma
	ST JAMES		
41	Dr. S. Olorumfemi	Medical Superintendent	St Joseph Hospital
42	Ms. M. Makhorole	Accountant	St James Hospital
43	Mr. Mahooana	Hospital Administrator	St James Hospital
44	Ms. M. Fusi/ N. Sello	Hospital Matron	St James Hospital
45	Mrs. M. Fusi	Acting Matron	St James Hospital
	PARAY		
46	Dr. Braide	Medical Superintendent	Paray Hospital
47	Mr. Thamae	Hospital Administrator	Paray Hospital
48	Sr. Vitalin Doti	Hospital Accountant	Paray Hospital
	SEBOCHE		
49	Dr. M. Gimmi	Medical Superintendent	Seboche Hospital
50	Sr. E. Keletsane	Hospital Administrator	Seboche Hospital
	MAMOHAU		
51	Dr. Mavu	Medical Superintendent	Mamohau Hospital
52	Sr. Molefe	Hospital Administrator	Mamohau Hospital
	TEBELLONG		
53	Dr. Ziba	Medical Superintendent	Tebellong Hospital
54	S. Ts'epe	Hospital Administrator	Tebellong Hospital
	SAMPLED CHAL HEALTH CENTRES:		
55	**Mohlanapeng H/C**	Ms. I. Thabane	Nurse Assistant
56		Rev. S. M. Pule	Manager
57		Mr. A. Ntsane	H/C Board Member
58	**Matukeng H/C**	Ms. M. Ranooe	Nurse Assistant
59		Pastor G. Gault	Manager/Proprietor
60	**Good Sherpard H/C**	Ms. M. Mopeli	Nursing Sister
61		Sr. L. Majara	Manager/Nurse Clinician
62	**Little Flower**	Sr. F. Tsepo	Manager/Nurse Clinician
63		Sr. M. Botsane	Bookkeeper

64		Ms. A. Motlamelle	Nursing Sister
65		Ms. M. Chochane	Helper
66	**St Gabriel**	Ms. P. Mothobi	Nurse Assitant
67		Ms. B. Baki	General Nurse
68	**Mofumahali oa Rosari**	Sr. J. Mokhele	Manager
69		Ms. T. Mpitso	Nurse in Charge/Nursing Sister.
70	**Mt Tabor**	Ms. M. Kholoane	Secretary for the Mission and H/C
71		Ms. M. Lepelesana	Nurse Assistant
72	**Matelile Health Centre**	Ms. Masentle	Nusre Clinician
73		Ms. Relebohile	Nurse Assistant/Manager
74	**St Francis**	Sr. C. Maphasa	Nurse in charge/Nursing Sister
75	**Holy Cross**	Sr. I. Nkuatsana	Manager/Nurse Clinician
76		Ms. M. Mpasi	Nursing Sister
77	**Motsekoua**	Sr. P. Bosiu	H/C Assistant
78		Sr. E. Lefifi	Manager
79		Ms. M. Moleko	General Nurse
80		Ms. M. Makateng	Trained Nurse Assistant
81	**Fatima**	Ms.H. Lejakane	Nurse Clinician in charge
82		Ms. T. Mothabeng	Nurse Assistant
83		Ms. M. Mohale	Helper
84	**Maputsoe SDA**	Ms M. Kholane	Nurse Clinician in charge
85	**Holy Family/Maqhaka**	Ms. M. Moroka	Nurse Assistant
86		Sir. M. Mbhele	Manager/Nurse Clinician
87	**Mahobong/Holy Trinity**	Sir. M. Biserekwa	Registered nurse/Manager
88		Sir C. Leger	Bookeeper
89	**Louis Gerard**	Sir. A. Tlabaki	Nurse Assistant/Manager
90		Ms. C. Mohapi	Nurse Clinician
91	**St Barnabas**	Ms. M. Fusi	Nurse Clinician in charge
92		Father L. Thaba	Manager

8 List of SEFF PR Workshop Participants

SEFF PERFORMANCE REVIEW STAKEHOLDERS' WORKSHOP

MASERU SUN HOTEL - 15th SEPTMBER 2004

#	NAME	TITLE	ORGANIZATION
1	T. Sekhamane	Government Secretary	GOL
2	T.J. Ramotsoari	Principal Secretary	MOHSW
3	K. Makhakhe	Principal Secretary	CABINET
4	E.T. Nyepetsi	Budget Controller	MOF&DP
5	T.Mohlomi	GOL/CHAL Coordinator	MOHSW
6	M.Mohapi	Senior Economic Planner	CHAL Secretariat
7	C. Schwabe	Consultant	MCDI
8	K. Lerotholi	Consultant	MCDI
9	P. Liba	Medical Superintendent	Tebellong Hospital
10	S. Olorunfemi	Medical Superintendent	St James Hopsital
11	M. Ntaitsane	Registered Nurse	Matukeng HC
12	M.G. Makoae	Director	LCBC
13	K.L. 'Mou	Assistant Auditor General	AUDIT
14	A.M. Ntholi	Deputy Executive Secretary	CHAL Secretariat
15	P. Jankie	Financial Manager	CHAL Secretariat
16	M. Mohale	PHC Coordinator	CHAL Secretariat
17	R. Kepa	Information Officer	CABINET
18	G.P. Nchee	Executive Secretary	CHAL Secretariat
19	D. Makhetha	Chief Executive	LPPA
20	M. Mphana	PD	LPPA
21	W. Hurlow	Medical Superintendent	Maluti Hospital
22	T. Mofolo	Administrator	Maluti Hospital
23	M. Lelosa	Treasurer - CHAL Board	Maluti Hospital
24	J. Mahooana	Administrator	St James Hopsital
26	M. Makhorole	Accountant	St James Hopsital
27	J.N. Leodi	Diocese Secretary	Dioceses of Lesotho
28	M. Makara	Administrator	Scott Hospital
29	M. Tlali	Senior Economic Planner	MOHSW
30	S.O. Sacakey	DPC	WHO
31	P. Hanson	Programme Advisor	DCI
32	E.K. Mpasa	Director	MOLG
33	L. Makakole	Medical Superintendent	Scott Hospital
34	C. 'Mele	Administrator	Mamohau Hospital
35	S.E. Ts'ephe	Administrator	Tebellong Hospital
36	M. Letlola	Director	Blue Cross Thaba Bosiu Centre

37	M. Mokete	Board Member	CHAL (KEL)
38	M. Chabane	Board Member	CHAL (KEL)
39	T. Ramatlapeng	Director General of Health Services	MOHSW
40	M. Tiheli	Director Primary Health Care	MOHSW
41	M. Makhake	Director Health Planning & Statistics	MOHSW
42	M. Khuele	Chief Economic Planner	MOHSW
43	C. Katito	Operations Manager	MOHSW
44	L.M. Moeketse	APO - Nutrition	UNICEF
45	M. Thamae	Administrator	Paray Hospital
46	N. Moalosi	Ass. Human Resource Officer	MOHSW
47	L. Maema	Secretary General *a.i.*	Lesotho Red Cross
48	M. Sebutsoe	Nursing Officer	St Anne HC
49	K. Ntoampe	Chief Health Educator	MOHSW
50	L.M. Makara	Director Mental Health *a.i.*	MOHSW
51	C.M. Ranthimo	Senior Nursing Officer	MOHSW
52	G. Gault	Health Centre Manager	Matukeng HC
53	T. Mahloane	Assistant Economic Planner	MOHSW
54	I. Pooka	Senior Nursing Officer	Seboche Hospital
55	I. Keletsane	Administrator	Seboche Hospital
56	M. Fobo	Board Member	Hermitage HC
57	N. Sefako	Global Fund Coordinator	MOHSW
58	U. Samson-Akpan	Medical Superintendent *a.i.*	St Joseph Hospital
59	J.T. Makakane	Board Member	LEC