NATIONAL HEALTH STRATEGIC PLAN

NHSP 2017- 2022

(Final draft)

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LIST OF ABBREVIATIONS

AfSBT	African Society for Blood Transfusion
AIDS	Acquired Immune Deficiency Syndrome
AJR	Annual Joint Review
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
BCG	Bacillus Calmette-Guérin
BSIS	Blood Safety Information System
CA CX	Cervical Cancer
CDC	Centres for Disease Control and Prevention
CHAL	Christian Health Association of Lesotho
CHE	Council for Higher Education
DHIS	District Health Information System
DHMT	District Health Management Team
DHT	District Health Team
DHS	Demographic and Health Survey
DNA	Deoxyribonucleic Acid
EHP	Essential Health Package
EHSP	Essential Heath Services Package
EML	Essential Medicines List
EMR	Electronic Medical Records
EPI	Expanded Programme on Immunisation
FCTC	Framework Convention on Tobacco Control
FP	Family Planning
FSW	Female Sex Worker
FTE	Full-Time Equivalent
FY	Financial Year
GAVI	Global Alliance for Vaccines and Immunization
GoL	Government of Lesotho
HC	Health Centre
HCC	Health Centre Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
iHRIS	Human Resource Information System
HR	Human Resource
HRH	Human Resources for Health
HTC	HIV Testing and Counselling
ICT	Information and Communication Technology
IFC	International Financial Corporation
IUD	Intrauterine Device
LBTS	Lesotho Blood Transfusion Service
LDHS	Lesotho Demographic and Health Survey
LIS	Laboratory Information System
LPPA	Lesotho Planned Parenthood Association
LRCS	Lesotho Red Cross Society
MCA	Millennium Challenge Account
MDGs	Millennium Development Goals
MDR-TB	Multi Drug Resistant Tuberculosis
MDR	Multi Drug Resistant
MEAs	Multi-lateral Environmental Agreements
MoH	Ministry of Health
MPS	Ministry of Public Service
MSM	Men Sleeping with Men

MTCT	Mother to Child Transmission
M&E	Monitoring and Evaluation
NCDs	Non-Communicable Diseases
NDSO	National Drug Supply Organisation
NEPI	Nursing Education Partnership Initiative
NGOs	Non-Governmental Organisations
NHA	National Health Accounts
NHP	National Health Policy
NHSP	National Health Strategic Plan
NIP	National Immunisation Programme
NSDP	National Strategic Development Plan
NTHC	National Health Training College
NTP	National Tuberculosis Programme
OOP	Out-of-Pocket
OP	Outpatient
OPD	Outpatient Department
PCR	Polymerase Chain Reaction
PEPFAR	President's Emergency Plan For AIDS Relief
PHC	Primary Health Care
PIH	Partners In Health
PMTCT	Prevention of Mother to Child Transmission
PNC	Postnatal Care
PPP	Public-Private Partnership
QMH	Queen Memorial Hospital
REC/RED	Reach Every Child/Reach Every District
SABS	South Africa Blood Service
SDGs	Sustainable Development Goals
SDP	Service Delivery Point
SOP	Standard Operating Procedure
SI-TWG	Strategic Information Technical Working Group
STEPS	STEPwise Approach to Surveillance
STI	Sexually Transmitted Infection
SWOC	Strengths, Weaknesses Opportunities and Challenges
TAT	Turn-around-time
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
VHW	Village Health Worker
VNRD	Voluntary Non-Remunerated Donors
WHO	World Health Organisation

CHAPTER ONE: INTRODUCTION

1.1 CONTEXT OF THE NATIONAL HEALTH STRATEGIC PLAN

The National Health Strategic Plan extends the contents of the policy and explain in more details on how the objectives in the National Health Policy will be implemented, the priorities, expected results and how the results will be measured. The National Health Policy (NHP 2016) and the National Health Strategic Plan (NHSP 2017-22) must be implemented together. The National Health Strategy provide the basis for stakeholder discussion and dialogue on the priorities of the health sector and the basis for partners (both inter and intra sectoral) to prioritise their programmes and funding plans in the health sector.

1.2 GLOBAL AND REGIONAL POLICY ENVIRONMENT

The shared vision of this strategy is a global vision that seeks to achieve Universal Health Coverage for all people of all ages. This strategy was developed within the context of global health. It is informed by the Sustainable Development Goals (Goal 3) and has internalised the goals and targets of the SDGs for health. This strategy also reflects and has adopted other global and regional strategies and frameworks such as the Paris Agreement on climate change (2015), Global Health Security, building a resilient health system, Global Strategy on Human Resources for Health (Workforce 2030), Engagement with non-state actors, Global Strategy for Women's, Children's and Adolescents' Health (2016-2030), Reducing HIV transmission by 2020, Elimination of Mother-to-Child transmission of HIV and syphilis, End TB Strategy, WHO Framework Convention on Tobacco Control and Global plan of action on violence.

1.3 NATIONAL CONTEXT

The Constitution promotes health gain as a social gain. Health Gain is concerned with health status, both in terms of increase in life expectancy and in terms of improvements in the quality of life through the cure or alleviation of an illness or disability or through any other general improvement in the health of the individual or the population at whom the service is directed. The constitution, the vision 2020 and the National Development Strategic Plan (NDSP) are all reflected in this strategy. With a vision to achieve Universal Health Coverage, this strategy will contribute to the vision of the NDSP of having a healthy nation with a well-developed human resource.

1.4 DEVELOPMENT OF THE NATIONAL HEALTH STRATEGIC PLAN

The development of the National Health Strategic Plan (NHSP) was done alongside the development of the National Health Policy (NHP). Both the NHP and the NHSP were developed to continue from previous versions. The process of developing the two documents, including consultations and feedback, lasted for approximately four months.

The process started with a review of the implementation of the previous NHP and NHSP. Situational analyses were conducted using face to face interviews, literature review and the administration of standard questionnaires.

A detailed situational analysis was conducted using review of annual reports, studies, reviews, evaluation and surveys conducted over the period 2012 to 2015. The National Health Policy and National Health Strategic Plans were also reviewed. Face to face interviews using structured questionnaire and group discussions were held with directors, programme managers and heads of units at MoH, focal persons in the United Nation family, CHAL, NTHC, Ministries of Finance, Local Government and Chieftaincy, Public Service and Social Welfare. Meetings were also held with five District Health Management Teams, a District Administrator and a District Council Secretary. The draft National Health Policy and National Health Strategic Plan were developed through a consultative process culminating with a stakeholder meeting of all key stakeholders to present the finding of the situational analysis. The revised zero draft of the National Health Strategy was circulated to MoH for comments for two weeks. Based on the comments received, the first draft (draft 1) was circulated for review. The first draft was presented to the technical team during the costing workshop with further face to face discussions with individual programme managers and staff to address areas of concern during the workshop.

1.5 DEFINITION OF HEALTH

This Strategy adopts the definition of 'health' used by the World Health Organisation: “a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity.”

This Strategy is centred on a whole-system approach to tackling health in Lesotho. It goes beyond the traditional concept of 'health services'. It is about developing a system in which health and social well-being are valued and supported. The context of the health system includes both public and private providers of health services. It also includes every person and institution with an influence on, or a role to play in, the health of individuals, groups, communities and society at large. In describing the strategic direction for the future, this Strategy incorporates a shared vision in order to deliver a healthier wealthier population.

The shared vision of this strategy is a global vision; a global vision that seeks to guarantee Universal Health Coverage for all people of all ages. The global agenda for the Sustainable Development Goals (SDGs), Paris Agreement on climate change (2015), Global Health Security, resilient health system, Global Strategy on Human Resources for Health: Workforce 2030, Engagement with non-state actors, Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030), Reducing HIV transmission by 2020, Elimination of Mother-to-Child transmission of HIV and syphilis, End TB Strategy, WHO Framework Convention on Tobacco Control and Global plan of action on violence are all expressed in the constitution which provides protection to health, equality and justice for all, regardless of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

The Constitution promotes health gain as a social gain. Health Gain is concerned with health status, both in terms of increase in life expectancy and in terms of improvements in the quality of life through the cure or alleviation of an illness or disability or through any other general improvement in the health of the individual or the population at whom the service is directed. Social Gain is concerned with broader aspects of the quality of life. It includes, for example, the quality added to the lives of vulnerable people and their care givers as a result of the provision of support services, or the benefit to a child living in an environment free from physical and psychological abuse. This is what this strategy seeks to achieve for Basotho.

1.5.1 LINKING THE FACTORS THAT DETERMINE HEALTH

To develop an effective health system, the determinants of health, that is the social, economic, environmental and cultural factors which influence health, will be taken into account. People’s age, sex, and hereditary characteristics inherited from parents are the basic determinants of health status. These are factors over which individuals have no control.

Social and community networks, including families and households, have a considerable role to play in the health of individuals.

It is often through local structures that services are delivered or that individuals and communities get information about health and health services and get the support they need to take an active role in improving their own health.

Other determinants of health include education, employment, housing, work environment, agriculture, food production, water and sanitation, and health services. These factors are described as socio-economic, cultural and environmental conditions and they affect an individual's social and educational pathway through life.

1.5.2 MAKING THE RIGHT CHOICES

People's lifestyles, and the conditions in which they live and work, influence their health and how long they live. The individual's ability to pursue good health is influenced by his or her skills, information and economic means. Most people have a basic understanding of the positive and negative effects which lifestyles can have on their health. With the proper information and support, they can control many factors which influence their health and take greater personal responsibility for their own health and well-being.

The health system will focus on providing individuals with the information and support they need to make informed health choices.

Gaining people's trust in a health system is about guaranteeing quality. People want to know that the services they are receiving are based on best-practices, are evidence-based and meet approved and certified standards. Improving quality within the health system requires implementation of internationally-recognized evidence-based guidelines and protocols, as well as on-going education and commitment from health care professionals. Setting and meeting standards is not enough. The development of a quality culture will ensure the provision of homogeneous, high-quality, integrated health services at community, district, and national levels.

Addressing quality of life issues is central to the National Health Strategic Plan

1.5.3 HEALTH EXPENDITURE AS AN INVESTMENT

This Strategy recognises the value of investment in health, the linkage to overall economic development and the potential to contribute to societal well-being by focusing on people's ability and willingness to work together.
Much of the public debate about health services is focused on the increased cost involved and its resultant poor services. While there are valid concerns about the growth in health spending, both national and international, the proper context for this debate is one which views health spending as an investment delivering benefits as well as accruing costs.

The debate on health financing is about Universal Health Coverage. This strategy recognises the social and economic value which accrues from investment focusing on how resources are mobilised, distributed and used.

CHAPTER TWO: BACKGROUND

2.1 ECONOMY OF LESOTHO

Lesotho gained independence from the United Kingdom on 4th October, 1966. It is a mountainous, landlocked country surrounded by the Republic of South Africa. The population is just over 2 million[1] people. About 61% of the population is between the ages of 15-46 years whilst 34% are under the age of 15 years. The government is a parliamentary constitutional monarchy. The king serves as head of state in a largely ceremonial role, while the prime minister serves as head of government. Executive powers are vested in an elected prime minister.

The governance system comprises two houses of parliament, the National Assembly and the Senate. Members of the National Assembly are elected whilst Senate members are appointed by the executive branch. The High Court is the superior court of record. Lesotho has ten districts. The District and Local Councils are composed of elected representatives, as provided for in the Local Government Act of 1997, which was last amended in 2004. The country has four ecological zones (the lowlands, foothills, mountains and the Senqu River valley). Lesotho has cold temperature with winter temperatures reaching as low as minus 18°C in the highlands. The mountainous topography and harsh winters negatively affect access to basic services, including health care services.

Lesotho is classified as a lower middle income country with a per capita income of US$1879 and ranks 161 out of 187 countries on the UN Human Development ranking. High unemployment and widening inequalities (with a Gini Index of 0.52) have excluded most of the population from participation in economic development. The rural areas are home to the majority of the poor and income distribution remains skewed in favour of the urban areas. Three quarters of the unemployed live in rural areas and include mostly the youth. Lesotho's economy is projected to grow at the rate of 2.6%[2], with growth mainly limited to urban areas, while rural communities remain impoverished. The main drivers of growth are the mining, construction and textile industries, as well as government services. Lesotho has one of the highest public spending rates at 63%[3]. The nation's high poverty and unemployment rate poses additional challenges to the economy.

2.1.1 ORGANIZATION OF THE HEALTH SECTOR

The delivery of health services in Lesotho is done at three levels namely primary, secondary and tertiary levels. There are 372 health facilities in Lesotho consisting of 1 referral hospital, 2 specialised hospitals, 18 district hospitals, 3 filter clinics, 188 health centres, 48 private surgeries, 66 nurse clinics and 46 pharmacies. Health centres are the first point of care and this is aimed at making the patient load at district and referral hospitals lighter.

1 Lesotho Factsheet of Health Statistics, Africa health Observatory, WHO (Regional Office for Africa), 2016
2 World Development Indicators, Washington, DC: World Bank. World Bank. 2015, http://data.worldbank.org
3 Lesotho: Overview." Washington, DC: World Bank. http://www.worldbank.org/en/country/lesotho/overview

Forty-two percent (42%) of the health centres and 58% of the hospitals are owned by the MoH. Thirty-eight percent (38%) of the health centres and the same proportion (38%) of the hospitals are owned by CHAL. The remaining facilities are privately owned. About 90% of the private for profit health facilities are situated in the four large districts of Maseru, Berea, Mafeteng, and Leribe[4].There are non- governmental organizations (NGOs) which provide health services. These include (i) Lesotho Planned Parenthood Association which has nine clinics located in urban centers around Lesotho; (ii) Lesotho Red Cross Society (LRCS) which operates four clinics; and (iii) Population Services International (PSI) operates five voluntary counseling and testing (VCT) centers[5].

Primary or community level

The primary level of health care includes health centres, health posts and all community level initiatives including all staff working at this level. There is a network of more than 6,000 village health workers (VHWs) who work at the health posts. A Village Health Worker (VHW) serves about 40 households. There are also other categories of community-based health workers such as traditional birth attendants, community based condom distribution agents and water minders[6]. VHWs are volunteers and receive an incentive from the GoL. They mainly provide promotive, preventive and rehabilitative care. VHWs also organize health education gatherings and immunization efforts within the communities they serve. The link between community and health centres provided by VHWs has remained informal despite their huge contribution. VHWs refer cases to health centres. Health centres are the first point of professional care. Nurses at health centres supervise and train VHWs. Health centres offer curative and preventative services, including immunizations, family planning, HIV/AIDS and TB treatment and deliveries. There is a health centre committee made up of representatives from the communities they serve (including chiefs and opinion leaders) with the head of the health centre being a member. Each of the Local Community Councils has a Social Services' Committee.

District or secondary level of care

In each district there is a district hospital which is a referral facility for all health centres in the district. In Maseru, however, there is no district hospital hence the National Referral Hospital also acts as a district hospital and congestion of clients is inevitable. Clients who go to the district hospitals to access services pay user fees. All the district hospitals, instead of offering specialized services, are still offering primary health care (PHC) services which are supposed to be offered by health centres and health posts. This is partly because those people living in towns do not have access to free primary level health services and they are accessing hospital services and hence they are paying. District hospitals refer cases to the National Referral Hospital for further management.

At the district level, the National Decentralisation Policy and Strategy requires devolution of services, with the MoH as one of the initial pilot ministries. Working with the Ministry of Local Government and Chieftaincy, the MoH is approaching the devolution in phases. Currently the MoH has aligned the district level structures with

[4] Ministry of Health and Social Welfare. (2010). Lesotho health system assessment 2010. Maseru: Ministry of Health and Social Welfare

[5] Ministry of Health. (2009). National Reproductive Health Commodity Security Strategic Plan 2008-2012 for Lesotho. Maseru: Ministry of Health

[6] Ministry of Health. (2012), National Tuberculosis and Leprosy strategic plan 2013-2017. Maseru: Ministry of Health

the Local Government structures and has defined the first phase of services that are to be decentralised. These services have been gazetted. According to the interim arrangement, the District Health Management Teams (DHMTs) will work under the offices of the District Administrators to provide district level services. The DHMTs will continue supporting the health centres and provide services as specified in the gazette (Government Gazette, Vol. 60, No. 71). District hospitals are not part of the decentralised structures in the proposed first phase being piloted in four districts. Health centres deliver services in the community through the health posts. Health posts are established in hard-to-reach areas where the populations are very sparse.

Tertiary level of health care

At tertiary level there is only one National Referral Hospital and two specialized hospitals namely Mohlomi Mental Hospital and Bots'abello Leprosy Hospital. Patients are also referred to South Africa for quaternary care through the national tertiary referral hospital. There are other specialized health care facilities like Senkatana for HIV and AIDS Management, Botšabelo for MDR TB and Baylor's Paediatric Centre of Excellence[7].

The Government of Lesotho through the Ministry of Health (MoH) provides about 42 percent of the health centres and 58 percent of the hospitals. Thirty-eight percent of all hospitals and health centres are owned by the Christian Health Association of Lesotho (CHAL). The remaining facilities are either privately owned or operated by the Lesotho Red Cross Society. In addition, there is an extensive network of private surgeries, nurse clinics and pharmacies providing health care including the dispensing of medicines.

The Ministry of Health, through a public-private partnership arrangement, has a memorandum of understanding with CHAL and the Lesotho Red Cross Society (LRCS) for the provision of a defined Essential Health Service Package (EHP) to the population through their network of health centres and hospitals. The Ministry of Health also has a public-private partnership arrangement (build, equip and operate) with a private firm for the construction of the national referral hospital and three filter clinics. The Ministry of Health works together with Development Partners (Donors) (Irish Aid, Global Fund, the United State Government, CDC/PEPFAR, Millennium Challenge Account, European Union, Gates Foundation, Gavi Vaccine Alliance, UNDP, UNAIDS, UNFPA, UNICEF, World Health Organization, World Bank and World Food Program) in the design, financing and delivery of health care services.

The Christian Health Association of Lesotho is the second largest provider of health services and the largest private-not-for-profit public health provider. CHAL plays a crucial role in providing health care services to at least 40 percent of the population, most of whom live in remote areas where coverage by government-owned facilities is relatively poor. In addition to CHAL, there are a number of NGOs and private-for-profit health care providers (Lesotho Planned Parenthood Association-LPPA, Red Cross Society, Partners in Health-PIH, Lesotho Flying Doctors, Irish Aid, Mission Aviation Fellowship) who are involved in health care service delivery both in urban and rural areas.

7 Ministry of Health. (2009). National Reproductive Health Commodity Security Strategic Plan 2008-2012 for Lesotho. Maseru: Ministry of Health.

CHAPTER THREE: SITUATIONAL ANALYSIS

The Ministry of Health has adopted the Ouagadougou framework for health systems and Primary Health Care (PHC). The National Health Policy 2016 (revised) and the National Health Strategic Plan (NHSP 2017-22) were both developed under the principles of the Ouagadougou framework for PHC. The Annual Joint Reviews are also conducted around the Ouagadougou framework for PHC and health systems. The situational analysis assesses the performance of the previous NHSP 2012-7 to identify the health system's strengths and opportunities as well as its weaknesses and challenges. This section concludes with key outstanding issues and priorities for the next five years.

3.1 REVIEW OF THE NATIONAL VISION DOCUMENT (VISION 2020) – HEALTH COMPONENT

The National Vision Document (Vision 2020) set out a vision of a healthy and well developed human resource base with priority to address the critical issues of HIV and AIDS and education. One of the strategies to reverse the trend of HIV is to expand the number of health facilities to more deprived areas and strengthen health institutions as well as the policy framework.

The HIV prevalence increased over the five years between 2009 and 2014 from 23% to 25%. In 2015, HIV and AIDS was the fourth cause of admission in females (3%) and 7%in males. Knowledge of HIV and AIDS has increased significantly (99% of women and 98% of men) in the last four years. Similarly, 97% of women and 92% of men between the ages of 15-49 years knew where to get HIV test.
In the period 2012 to 2015, the government embarked on the refurbishment of 154 existing health centres. This has been completed. A further 164 health facilities were equipped with modern ICT infrastructure. The government of Lesotho has established a medical school within the National Health Training College (NHTC) as part of its strategy to strengthen institutions and improve its human resource base. However, the project was faced with some challenges and has been suspended due to its failure to meet some of the requirements of the Council for Higher Education (CHE).

3.2 HEALTH OUTCOME PERFORMANCE

3.2.1 HEALTH STATUS

Table 1: Impact and Health Outcome Indicators

#	Indicators	Baseline 2011	Targets 2013	Actual 2015	Targets 2017
1	Life expectancy			47	
2	Maternal Mortality Ratio	1,155 (LDHS 2009)	1,144	1,024 (LDHS 2014)	915
3	Adult Mortality Rate (per 1000 Population)			12.8-Females, 14-Males (LDHS 2014)	
4	Child Mortality Rate				

5	Under-five Mortality (per 1,000 live births)	117	111	85	84
6	Neonatal Mortality Rate			34	
7	Mortality rates due to non-communicable diseases (NCDs) – cardiovascular diseases, diabetes, accidents/injuries and cancers				
8	TB Treatment Success Rate	72%	73%	70%[8] (2014)	74%
9	HIV Prevalence			25%	
10	Percentage of children aged 13-24 months who are fully immunized	60% (LDHS 2009)	65%	68% (LDHS 2014)	70%
11	Proportion of Stunted Children 0-59 months	39.2%%	39.20%	33%	39.20%
12	Proportion of Wasted Children 0-59 months	4% (DHS 2004)	3%	3%	2%

HEALTH SECTOR INDICATORS

Table 2: Performance of Health Sector Indicators

#	Indicators	Baseline 2011	Targets 2013	Actual 2015	Targets 2017
1	Percentage of districts supported/supervised quarterly		25%		50%
2	Percentage of women (15 – 24 years) who are HIV infected	15% (DHS 2004)	10% (DHS 2009)	26.9% (LDHS, 2014)	7%
3	Percentage of women (15 – 49 years) who are HIV infected	27% (DHS 2004)	27% (DHS 2009)	30% (LDHS, 2014)	27%
4	Percentage of men (15 – 24 years) who are HIV infected	4% (DHS 2004)	4% (DHS 2009)	12.3% (LDHS, 2014)	4%
5	Percentage of men (15 – 59 years) who are HIV infected	19% (DHS 2004)	18% (DHS 2009)	19% (LDHS, 2014)	18%
6	Percentage of HIV positive pregnant women who received complete course of ART	31%	35%		40%
7	Proportion of eligible women, men and children that are receiving ARV in line with national guidelines	26%	35%		40%
8	Percentage of people still alive 12 months after initiation of ARV	74%	75%		80%
9	Percentage of deliveries that are supervised by a skilled attendant	60% (LDHS 2009)	65%	77% (LDHS, 2014)	70%
10	Percentage of pregnant women provided ANC by health professionals	90%	90%	95% (LDHS, 2014)	95%
11	Percentage of women provided PNC within 48 hours	47%		62% (LDHS, 2014)	
12	Percentage of women accessing FP method mix				
13	Percentage of women provided CA CX Screening				

[8] AJR 2015

#	Indicators	Baseline 2011	Targets 2013	Actual 2015	Targets 2017
14	Percentage of health centres (H/Cs) with Full Time Equivalent (FTE) staff for the level	1%	20%		30%
15	Proportion of GoL Budget allocated to the Health Sector	11.4% (2007/08 FY)	11.30%	11%	11.50%
16	Percentage of Health Sector Budget allocated to PHC (district health services)	24% (2007/08 FY)	30%		40%
17	Percentage of Sector Recurrent Budget expended	84% (2007/08 FY)	92%	92%	94%
18	Percentage of Sector Capital Budget expended	48% (2007/08 FY)	94%	39%	96%
19	Percentage of budget allocated to maintenance	0.8% (2007/08 FY)	1%		5%
20	Percentage of hospitals reporting one month 'stock-out' for any of the medicines in the EML for the level	6% (Medicines Access Survey 2007)	6%		5%
21	Percentage of H/Cs reporting one month 'stock-out' for any of the medicines in the EML for the level	14% (Medicines Access Survey 2007)	10%		5%
22	Proportion of DHMTs conducting quarterly monitoring of their Operational Plan and organizing reflection meetings	0% (AJR -2008)	30%		100%
23	Percentage of clients satisfied with services offered at hospitals and health centres	66% (exit survey AJR)	70%	92%	73%
24	Percentage of health centres providing a defined minimum package of services	0%	10%		50%
25	Percentage of hospitals with functional medical waste disposal systems in line with national guidelines (functional incinerator as proxy)	8%	30%		50%
26	Percentage of H/Cs with functional medical waste disposal systems in line with national guidelines. (functional incinerator as proxy)	0%	5%		5%

3.3 HEALTH SYSTEM PERFORMANCE

This section is organised along the six health system blocks, taking into consideration the Ouagadougou framework for PHC, community ownership and participation which constitute the cornerstone of the Government Decentralisation Agenda.

LEADERSHIP AND GOVERNANCE

Leadership and governance in health is a function of the Ministry of Health which has the legal mandate to ensure equity in access to health care services. Governance for health includes formulation of national health policy and strategic plans; exerting of influence through regulation and advocacy; gathering and using information and accountability for achieving health outcomes. The MoH provides direction through the National Health Policy (NHP) and National Health Strategic Plan (NHSP) to ensure a functional, accountable, transparent and equitable health system. Building a functional health system requires a strong policy and regulatory environment,

transparent and accountable system of planning, resource allocation, monitoring and evaluation (including research) for better health outcomes. Key elements of leadership and governance in the health sector include functional organisational structures and human resource base with the skills and capacity to implement the NHP and NHSP.

The Ministry of Health in the last decade has had several challenges with the development, revision and approval of policies as well as passage of legislations. There are been several health bills that have taken some time to develop (or revise) and have still not been passed into law. Whilst the planned organisational restructuring of the MoH has delayed, the existing institutional structures are challenged in enforcing laws, regulations, policies and standards. The 2015 and 2016 Annual Joint Review (AJR) reports indicate that the current organisational structure is contributing to the slow pace of achievement of health outcomes. Whilst there are some managerial positions without job responsibilities, other positions need to be developed to address service gaps. The performance management system is not as functional as expected. The proportion of health centres with costed annual operational plans was 16% in 2013, 55% in 2014 and 46% in 2015. The percentage of health centres who know their budget has remained at 46% in the last three years. The proportion of VHWs who submitted their reports on a monthly basis to the health centres reduced from 59% in 2015 to 38% in 2016.

The MoH has a Public-Private Partnership (PPP) arrangement that covers service delivery, supply chain and hospitality services. In 2012, the Government of Lesotho (GoL), with support from International Financial Corporation (IFC), started a PPP project to strengthen health care waste management in 15 health centres and 2 district hospitals. The project was to pilot the collection, transportation and disposal of health care waste from the selected health facilities. The GoL, with funding from the Millennium Challenge Account (MCA), started a project to refurbish 154 health facilities. With support from IFC, a PPP project was initiated to address facility management, Information, Technology and Communication (ICT) including connectivity in 165 health centres. The MoH has a memorandum of understanding with Christian Health Association of Lesotho (CHAL) and selected private health facilities to provide health services. There is also a PPP arrangement to design, build and operate the Queen Memorial Hospital (QMH) for 15 years.

There are currently about 23 memoranda of understanding signed with different organisations. Twenty-three (23) of these were signed in 2015. All the signed PPP contracts (23) are related to HIV and AIDS.

The MoH is one of the pilot ministries implementing the decentralisation policy. There has been considerable engagement with the Ministry of Local Government and Chieftaincy on the structures and functions for decentralised health units at the district level. Selected functions to be decentralized have been gazetted. The District Health Management Teams (DHMTs) have been formed and are operational in pilot districts. The health centre committee meetings improved from 60% to 69% between 2013 and 2014 and fell to 58% in 2015. The percentage of health centres with at least 80% of planned monthly meetings fell from 21% to 20% between 2014 and 2015. Service coverage has increased with the use of the VHW and the Health Centre Committees; more health services are accessible and closer to the community.

Functions, responsibilities and reporting relationships between the decentralised health units and the central MoH have not been defined. Job positions and establishments are yet to be formally agreed. The Health Centre Committees (HCCs) formed to oversee the activities of the health centres and Village Health Workers (VHWs) have not been functional in all the districts. Village Health Worker (VHW) motivation and transport were also considered to be inadequate. In addition, there are policy gaps in the VHW programme and the role of the HCCs in areas where there are no health centres or more than one health centre. In the MoH PCH revitalization programmes (2011-2017), emphasis was placed on promoting accountability, ownership and community involvement. During the period, an assessment of the VHW programme was conducted to provide guidance on better ways to improve community involvement. The community health committees were revived in all the districts.

Some of the current challenges include maintaining morale of the VHWs and providing transport for their work. More health posts need to be constructed or provided for areas where there are no health centres so as to increase community outreach services. There is the need to develop an exit strategy for the VHWs within a longer term plan of how to finance the Village Health Worker programme with the decentralized system. Guidelines on HCC meeting and frequency of payment of the VHWs should be rationalized by GoL and CHAL facilities.

HUMAN RESOURCE FOR HEALTH

The Ministry of Health is responsible for the recruitment, training and development, management and distribution of the health workforce. The human resource function includes training, skill development, development of policies, strategies and systems including a human resource information system. It is also responsible for developing human resource policies and strategies.

The NHSP 2012-17, set out to undertake a functional review of the MoH, an HR audit, establish the Health Service Commission, develop and implement a career development programme for health workers, develop and implement a retention strategy for all health workers, improve the capacity of professional associations and strengthen collaboration with professional associations.

The overall establishment list of the Ministry of Health as at the beginning of the year 2015 was 4,610. This represents 50% of required staff needs. At the end of 2015 financial year, 23% of all vacancies were filled. This was an improvement from 43% in 2014. The processes for recruitment take a long time to complete within the MoH before submission to Public Service Commission for consideration. The Ministry of Public Service has also introduced a new policy that requires MPS to approve all recruitments before ministries start the recruitment process. A request submitted to the MPS since 2014 is yet to be approved. The current government staff establishment does not take care of health cadres that are needed as a result of the use of modern health technologies (equipment, devices and protocols).

The MoH continued to invest in building the capacity of Human Resources for Health (HRH) in an effort to improve quality and efficiency in health service delivery. At the end of the reporting period, there were 53 members of staff within the health sector

who were pursuing their studies in and outside Lesotho. Most of these health personnel (51) were attending school in Lesotho and enrolled in health-related programmes. The highest proportion was enrolled on nursing programmes (50%) followed by allied health workers at 24%.

The Government of Lesotho has introduced medicine as one of the programmes at the NHTC. Due to the severe shortage of health professionals in Lesotho, the Ministry of Health in collaboration with the International Organization for Migration embarked on engaging Basotho health professionals in the diaspora through the sequenced short term return programme. A Technical Working Group (TWG) was established to mobilize health professionals from the South Africa, UK and US with the assistance of Lesotho's missions in those countries.

The Nursing Education Partnership Initiative (NEPI) programme was established with the primary goal of scaling up nursing and midwifery education to address shortage of nurses and midwives. As at the end of the reporting period, 77 students had been enrolled in Nursing Education and Training in Lesotho. The MoH also developed the face-to-face midwifery competency-based curriculum, approved by the Lesotho Nursing Council and implemented in 2014, with five diploma offering schools (Maluti, NHTC, Roma and Scott SON) offering the midwifery competency-based curriculum.

In view of the growing cancer burden, there are inadequate facilities and specialists to respond to the actual demand for cancer diagnosis and treatment in Lesotho. The government, with support from IAEA, plans to establish a national cancer treatment centre in order to accommodate the required health technologies and specialized HRH to provide quality cancer care to Basotho cancer patients. At the end of 2014 financial year, seven (7) Basotho nationals were admitted to study Physics, Radiology, and Cytology at the University of Free State.

In 2014, performance management training for thirty (30) human resource practitioners were organised. The concept of performance management was planned to be introduced in all aspects of management to improve performance at all levels within the sector. A payroll audit was conducted with the Ministry of Public Service, Ministry of Development Planning and Ministry of Finance.

The Human Resources Information Management System (iHRIS) is an important tool used to manage staff data. However, it has been observed that staff information in the iHRIS database needs to be updated. There is high attrition among the HR staff and that has resulted in the loss of skills of members who have been trained to use the iHRIS. Unavailability of internet connectivity is also affecting regular update of the HR database.

The Ministry of Health reviewed its recruitment protocol in response to recruitment delays and bottlenecks at the Ministry of Public Service. The protocol is still in the draft form and is yet to be verified by stakeholders. The MoH restructuring is yet to take place and is expected to create a number of positions. Meanwhile, a request has been sent to the Ministry of Public Service (MPS) for establishing directorates for Quality Assurance, Supply Chain, Pharmacy, Cancer, Laboratory Services, Blood Transfusion and Bio-Medical Engineering. Coordination of short term trainings is weak in the Ministry of Health. The analysis of the training plans that were submitted

during the period under review revealed that most of the training requests do not address the ministry's priority HR needs.

3.3.3 Health Financing

The government is committed to the Abuja Declaration of allocating at least 15% of government budget to the health sector. The objective of health financing is to ensure that people are protected from catastrophic health expenditure as a result of using health services and also to make sure that services are equitably allocated and used efficiently.

To achieve this, the MoH sought to develop health policies and strategies, institutionalise National Health Accounts, strengthen financial management skills at all levels (PFM) and establish a social health insurance scheme as well as revive the sector-wide approach within the health sector. By 2012, the MoH had abolished user fees at the primary level (HC) and introduced standardized fees at secondary level.

Out-of-pocket (OOP) expenditure, as a percentage of total health expenditure has been reducing since 2011. OOP for 2011 was 15.6% and reduced to 14.4% in 2013. In 2015, government expenditure on health as a percentage of total government expenditure was 11% from 14.4% in 2013. Similarly, per capita expenditure on health in US dollars reduced from $113 in 2011 to $98 in 2013.

Though total government share of total health expenditure has increased, its share of the health capital budget remained very low at 26% in 2015. The decline in government allocation to health and the low contribution to the capital budget are challenges that need to be addressed. It has not yet introduced a social health insurance scheme and has also not yet produced its first National Health Account.

Health Financing Indicators – 2011-2013

Health Financing Indicators	2011	2012	2013
External resources for health as a percentage of total expenditure on health	26.3	30.2	35.1
General government expenditure on health as % of gross domestic product (GDP)	9.2	9.5	9.1
General government expenditure on health as a percentage of total expenditure on health	77.5	78.6	79.1
General government expenditure on health as a percentage of total government expenditure	14.5	14.5	14.5
Out-of-pocket expenditure as a percentage of total expenditure on health	15.6	14.8	14.4
Per capita government expenditure on health (US$)	113	108	98
Per capita total expenditure on health (US$)	146	138	123
Total expenditure on health as a percentage of GDP	11.9	12.1	11.5

Source: Lesotho Statistical Factsheet, Africa Health Observatory, WHO Africa Region, WHO, Geneva, 2016

3.3.4 Health Service Delivery

Health service delivery at the district level involves the implementation of the Lesotho Essential Health Service Package (ESP). It also involves the implementation of activities to strengthen the health system to deliver on the essential health service package.

Outpatient Attendance

Outpatient attendance reflects availability, access to and use of health services. Outpatient (OP) consultation may be old or new. Access to outpatient services by the population is measured as the total attendance over the population. Outpatient attendance reduced between 2012 and 2016. The per capita OP utilisation dropped from 0.7 in 2012 to 0.3 in 2015. The most common causes of OP attendance in the general population over the period were cough and cold. Pneumonia and Sexually Transmitted Infections (STIs) were the next two reasons for OP attendance.

Table 3: Trends in Top Ten Causes of Outpatient Attendance, 2013-2015

Disease	**2013**	**2014**	**2015**
Cough and Colds	21.8%	22.9%	6.9%
Hypertension	9.5%	10.6%	6.0%
STIs	7.7%	7.8%	2.4%
Other Skin and Subcutaneous Tissue Disorders	7.1%	6.9%	1.7%
Other Disorders of Musculoskeletal and Connective Tissue System	5.8%	5.4%	1.1%
Diarrhoea and Gastroenteritis	3.9%	5.0%	1.3%
Other Respiratory Tract Disease	4.4%	4.2%	1.1%
Conjunctivitis	1.5%	1.5%	1.0%
Other Diseases of the Digestive System	2.3%	2.3%	0.4%
Tonsillitis	2.2%	2.1%	0.6%
All Other Diseases	33.8%	31.4%	77.5%
	100%	100%	100%

The top four causes of OP attendance did not change much over the period. The trend of new OP cases remained the same during the period. The main cause of the reduction in the total OP attendance reported was due to incomplete reporting from districts and national hospitals. Some instances of the low reporting rates were due to the implementation of the Electronic Medical Records (EMR) software and shortage of human resources in most of the health facilities.

Hospital Admissions

The top four most common causes of admission among children aged 0-12 years were pneumonia (12%), diarrhoea (9%), trauma (8%) and malnutrition (7%). The main cause of admission in 2015 was trauma (23%) followed by TB and HIV and AIDS (7%), diabetes (3%), hypertension (3%) in 2015. The top five causes of admission in females were abortion (8%), diabetes (5%), hypertension (5%), HIV and AIDS (3%) and pulmonary tuberculosis (3%).

Causes of Adult and Child Deaths

In 2013, HIV and AIDS was the leading cause of hospital deaths in adults aged 13 years and above. HIV and AIDS has remained the main cause of deaths in the last five years. There is a similar pattern in the cause of hospital deaths in both male and females. Over the period of 2013-2016, HIV and AIDS, TB, Pneumonia, Anaemia and Diabetes were the top five causes of hospital deaths in adults. There has not been much difference between cause of hospital deaths in males and females. Over the four-year period being assessed, HIV and AIDS, TB, Pneumonia, Meningitis and Stroke rank among the top three causes of hospital deaths in males. Similarly, HIV

and AIDS, TB, Anaemia, Meningitis and Stroke were among the top three causes of female deaths in hospitals in the last five years. The situation is however slightly different with children 13 years and below. Malnutrition, Pneumonia and diarrhoea have been the top three causes of hospital deaths in children below the age of thirteen years. Though HIV and AIDS was among the top three causes of deaths in children below thirteen years in 2013, it has not been in the top five causes of deaths between 2014 and 2016. There has been a reduction in hospital deaths since 2014, with 4271 deaths reducing to 2639 in 2016. There was an increase in the number of hospital deaths in 2015 (5257).

Table 4: Top Ten Cause of Death in adult Males and Females - 2015

Male		Female	
Disease	No. of Deaths	Disease	No. of Deaths
HIV and AIDS	237	HIV and AIDS	223
TB (Excl. Extra Pulmonary TB)	191	TB (Excl. Extra Pulmonary TB)	117
Pneumonia	82	Anaemia	99
Diarrhoea	76	Stroke	72
Meningitis	65	Pneumonia	69
Anaemia	55	Diarrhoea	63
Heart Failure	53	Heart Failure	55
Trauma	46	Diabetes	50
Respiratory Tract Infection	42	Hypertension	45
Hypertension	34	Meningitis	35

Communicable Diseases

Communicable diseases are transmitted from one person to the other by direct contact with the infected person or through discharges by the infected person as well as by indirect means. The spread often happens via airborne viruses or bacteria, but also through blood or other bodily fluids. The most common communicable diseases include preventable diseases such as infections and viral haemorrhagic fevers.

HIV and AIDS

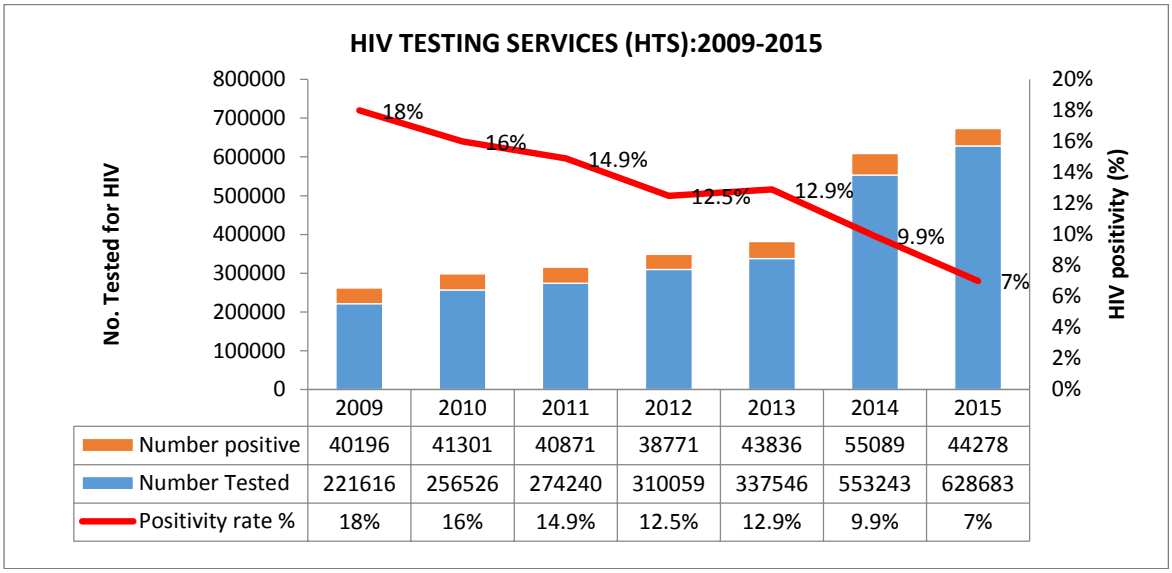
The overarching goal of the HIV and AIDS programme is to achieve universal access to prevention, treatment and care for HIV and AIDS services for the people of Lesotho. In line with the UNAIDS strategy, the MoH strategy targets zero new infection and zero AIDS-related deaths. The previous strategy had four main targets aimed at reducing by 50 percent the percentage of young people aged 15-24 years who are infected, reduce new HIV infections in children by 90 percent and reduce HIV-related deaths by 25 percent (all compared with a 2009 baseline).

Lesotho is said to have a generalised HIV epidemic with 25% of adults aged between 15-49 years being HIV positive. About 310,000 persons (adults and children) are living with HIV and AIDS in Lesotho. The prevalence rate is higher in

women (30%) than in men (23%). HIV prevalence in women is highest between the ages of 35 and 39 years at 45.5% and in men at 43.5%[9] between 40 and 44 years. Key populations with high HIV prevalence include female sex workers (FSWs), men sleeping with men (MSM), migrant and factory workers and transgender persons. HIV prevalence in key populations is higher than in the general population with prevalence of 72% among FSW, 43% among factory workers and 33% among MSM. HIV incidence is less in women than in men. It is estimated that there are 18000 new HIV infections and about 9900 HIV and AIDS related deaths each year.

The 2014 LDHS reported that 63% of men and 84% of women who had ever tested for HIV received their results. The MoH is currently providing HIV testing and counselling in 284 sites in Lesotho. The number of people tested for HIV increased from 310,059 in 2012 to 628,683 in 2015 with testing in health facilities almost doubling over the same period. The number of HIV positive clients increased between 2012 and 2014 and decreased in 2015. The proportion of persons who tested positive for HIV decreased from 12.9% in 2013 to 7% in 2015. Knowledge of HIV and AIDS has increased significantly (99% of women and 98% of men) in the last four years. According to the 2014 LDHS, 97% of women and 92% of men between the ages of 15-49 years knew where to get tested for HIV. More people repeated their HIV testing in 2015 compared to 2014. There were also more people testing positive for HIV among those who repeated their HIV test than those who were testing for the first time.

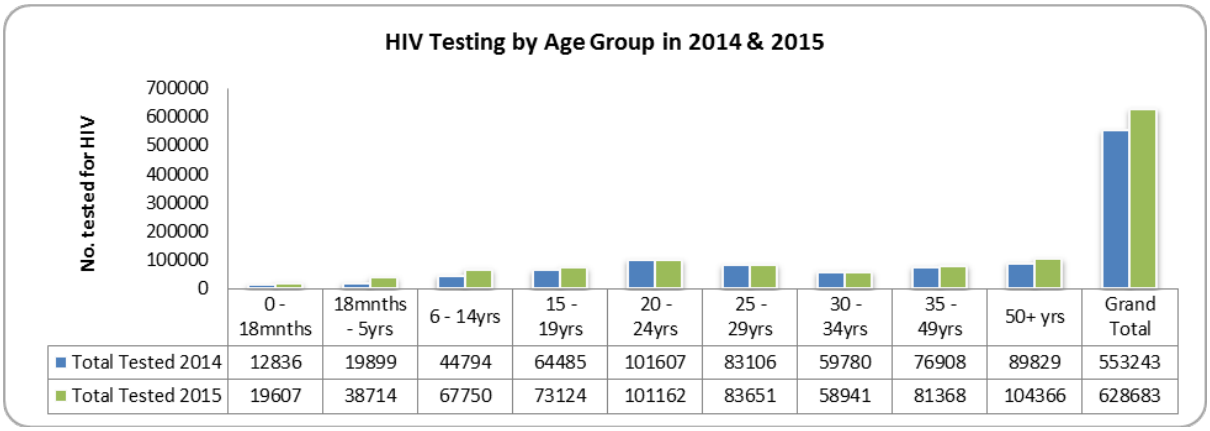
Graph 1: Trends in HIV Testing Services, 2009 - 2015



	2009	2010	2011	2012	2013	2014	2015
Number positive	40196	41301	40871	38771	43836	55089	44278
Number Tested	221616	256526	274240	310059	337546	553243	628683
Positivity rate %	18%	16%	14.9%	12.5%	12.9%	9.9%	7%

Graph 2: HIV Testing by Age group, 2014 and 2014

[9] 2014 LDHS



	0 - 18mnths	18mnths - 5yrs	6 - 14yrs	15 - 19yrs	20 - 24yrs	25 - 29yrs	30 - 34yrs	35 - 49yrs	50+ yrs	Grand Total
Total Tested 2014	12836	19899	44794	64485	101607	83106	59780	76908	89829	553243
Total Tested 2015	19607	38714	67750	73124	101162	83651	58941	81368	104366	628683

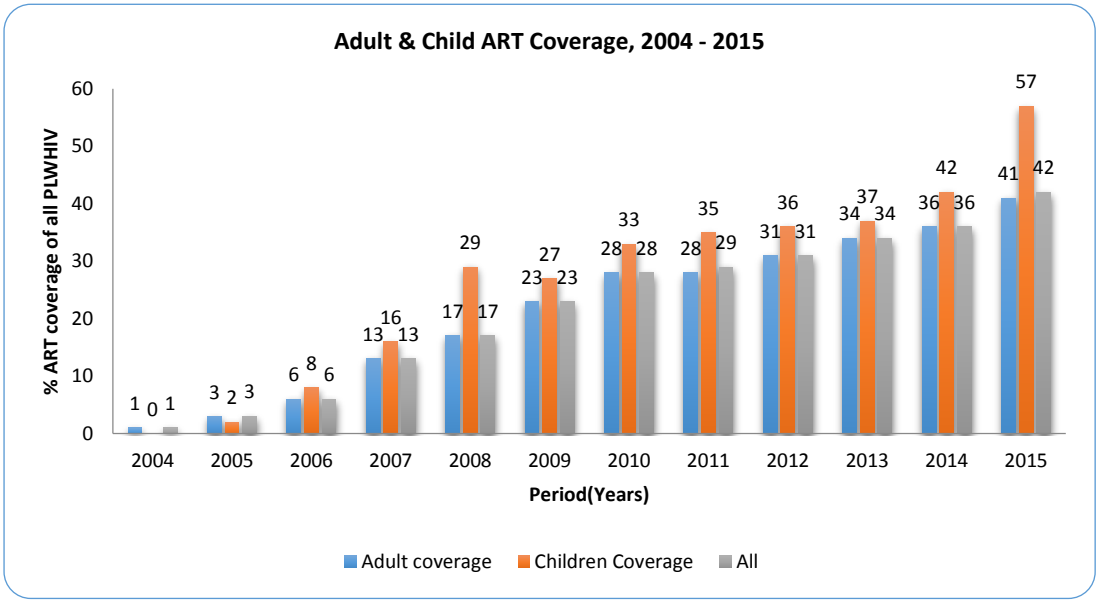
Voluntary Medical Male Circumcision (VMMC)

In 2012, VMMC was adopted as one of the preventive strategies for HIV and AIDS. In 2012, about 110,000 males were circumcised. Males aged between 10-15 years represented 33.5% of those circumcised. About 99% of males circumcised were in the age group of 10-49 years. Seventy-two percent (72%) of those circumcised were tested for HIV.

Coverage of Antiretroviral Therapy (ART)

The current estimated HIV population in need of ART includes about 297,000 adults and 13,000 children. National coverage of ART in 2015 was 42%. There has been a gradual increase in ART coverage among adults and children since 2012.

Graph 3: Trends in ART Coverage for Adults and Children, 2012 – 2015



The global policy for scaling up ARV, 90 90 90, test and start was launched in 2015. The national target is to reach ART coverage of 80% in adults and 85% in children by 2020. This policy will support efforts at increasing ART coverage and contribute to reducing new infections. The test and start strategy will address current challenges of loss to follow-up, low yield of HIV positive clients, high dropout rate and poor

record keeping. Loss to follow up increased from 10.4% at six months to 16% at 36 months.

Between 2014 and 2015, new HIV clients enrolled on ART reduced from 29,920 to 27,330, an 8% reduction. In 2014, 76% (29,920) of clients enrolled into care were enrolled on ART. The total number of new enrolments on ART in 2015 was 27,330, an 8% decline compared to the 2014 enrolments of 29,920. More people need to be enrolled on ART in line with the 90-90-90 strategy that states that at least 90% of clients diagnosed should be enrolled on ART.

In 2015, 67% of HIV positive clients enrolled on ART received services at the health centre and 32% at the hospital level. The 2016 AJR report documented that 49% of HIV positive clients enrolled on ART are receiving services in urban districts as against 24% in rural districts. Mortality among HIV positive clients enrolled on ART is highest at six months of enrolment in all districts compared to other retention periods. National mortality rates for retention periods of 12, 24 and 36 months for HIV positive clients enrolled on ART are 8%, 2% and 2% respectively.

Data quality, timeliness and completeness remains a challenge especially with regard to data collected by private health facilities.

Prevention of Mother to Child Transmission (PMTCT)

The primary goal for implementing PMTCT is to reduce new childhood HIV infections and reduce HIV related deaths in infants and mothers.

In 2015, the coverage of effective antiretroviral treatment for preventing mother to child transmission of HIV was sustained at 74%. In the same year, 8,098 pregnant women living with HIV received ART for preventing mother-to-child-transmission. PMTCT coverage declined from 95% in 2011 to 91% in 2012, 75% in 2013 and 74% in 2014[10]. The estimated MTCT rate at 6 weeks was 5.9%. New HIV infections averted by PMTCT increased from 1,671 in 2012 to 2,013 in 2015.

There are currently (2016) 180 facilities offering PMTCT services in Lesotho. Coverage of ART for HIV infected pregnant women is 74% in 2016. Whilst PMTCT sites increased between 2013 and 2016, coverage declined from 91% in 2013 to 74% in 2016. The estimated MTCT transmission rate at six weeks has remained about the same in the last three years to 2015.

Tuberculosis

The National Tuberculosis Programme (NTP) strategic plan is aligned to the World Health Organisation Stop TB strategy and addresses the social determinants of health. Key components of the 2012-2017 strategy include advocacy for increased resources to NTP, improved infection control and prevention of transmission of TB at workplaces, increased coverage of TB/HIV activities and engagement with all care

[10] In 2015, UNAIDS revised the HIV and AIDS estimates for children. The downward revision is due to changes in the methods of how the number of children living with HIV is calculated and the adjustment has also been applied to estimates for earlier years. There are two primary changes in the calculations that have led to the downward revision: a) new research on the probability of a mother transmitting to her child and b) - newly-available data on the age at which children initiated ART.

providers and stakeholders, community empowerment and promotion of TB research.

Tuberculosis is among the ten leading causes of morbidity and mortality and a major public health problem in Lesotho. The Government of the Kingdom of Lesotho has prioritised TB and has consistently increased resources to the health sector to support the NTP. The main goal of the NTP strategy is to contribute to the reduction of the global TB burden with the objectives to achieve universal access to high quality of care for all people with TB, reduce the suffering and socioeconomic burden associated with TB, protect vulnerable populations from TB and protect and promote human rights in TB prevention, care and control.

There had been a steady decline in TB prevalence rate since 2012. However, in 2015, the TB prevalence rate increased slightly from 648 to 671. In 2012 and 2013, deaths due to TB (excluding HIV) per 100,000 population remained at 55 and increased to 64 in 2014. Mortality rate for HIV/TB per 100,000 population was 273 in 2012 and 231 in 2014. Case notification for all cases of TB declined between 2012 and 2015. TB case detection rate (CDR) declined from 52% in 2012 to 49% in 2014. TB incidence was 852 per 100,000 population in 2014 and case detection rate was 49%. In the same year, TB treatment success rate was 70%.

Family Planning (FP) Services

Family planning is a fundamental right and the National Health Policy of Lesotho requires access to family planning services for all those who need it. Family planning services are provided by all health facilities at all levels of care except for facilities owned by the Roman Catholic Church. Provision of FP services has been integrated into sexual and reproductive health and HIV and AIDS services. The main FP methods most utilised by the population are the pill, IUD, condom (male and female), depo vera, injectables and implants. Among the main challenges faced by the Family Planning programme are funding and frequent stock-outs of FP commodities.

In 2014, a survey was conducted to assess availability of modern conceptive methods and lifesaving medicines. The survey reported that condoms (both male and females), oral contraceptives, injectables, and emergency contraceptives were available in 80% of health facilities. This study also identified stock-out of at least one modern contraceptive at primary level service delivery points (SDPs).

Sexual, Reproductive and Adolescent Health

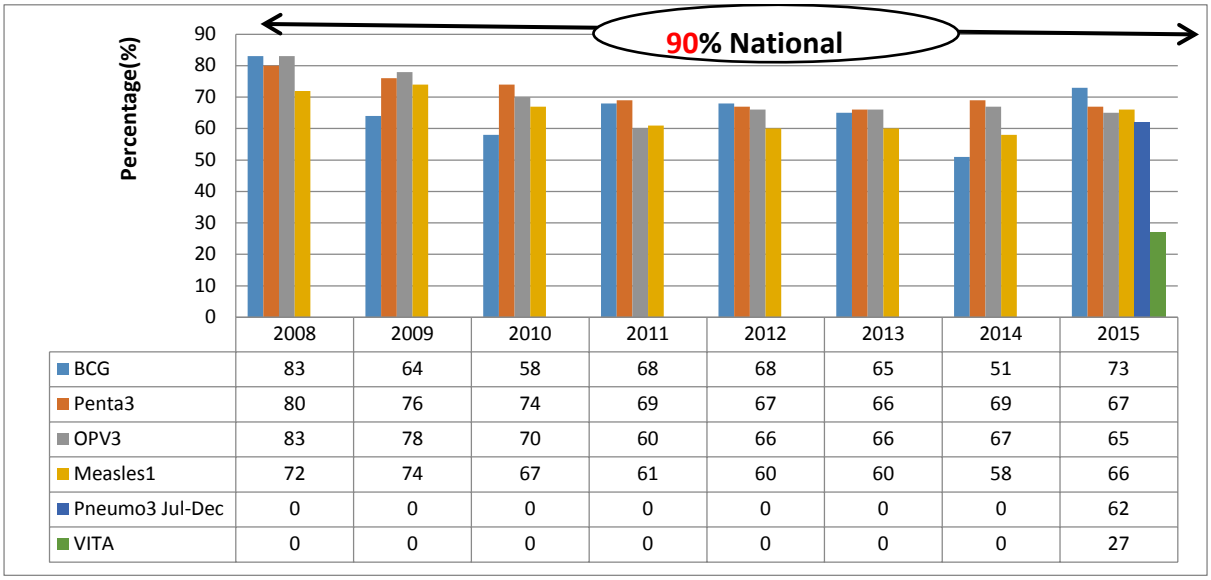
According to the latest LDHS, one out of thirty women in Lesotho is likely to die from childbirth or a related condition. Maternal mortality rate in 2014 was 1024 per 100,000 live births. This is a reduction from 1155 as captured in the 2009 LDHS. According to the LDHS 2014 report, antenatal visits for the first trimester and supervised deliveries (at facility and by skilled personnel) increased from levels the contained in the 2009 LDHS report.

In 2013, institutional deaths recorded were 74. The 2016 AJR reported an increase in institutional deaths from 36 in 2015 to 71 in 2016. More deaths occurred in government health facilities than in CHAL and private facilities. One of the challenging issues outstanding is the quality of data reported.

Expanded Programme on Immunization (EPI)

Immunisation is globally known as one of the most cost effective lifesaving interventions. The national EPI programme has five antigens in its current EPI programme. These are BCG, pentavalent, Polio, first dose of measles, pneumococcal and tetanus toxoid. The 2014 LDHS reported a 68% coverage of full immunization for children. In 2012, coverage of third dose of pentavalent vaccine was 67%. Pentavalent coverage increased from 67% in 2013 to 69% in 2015 and reduced to 67% in 2015. Measles coverage was 60% in 2013 and by 2016 had increased to 66%. Pneumococcal vaccine was introduced in the second half of 2015. At the end of the December 2015, the coverage was 62%.

Table 4: Trends in National Immunisation Coverage Performance, 2008-2015



	2008	2009	2010	2011	2012	2013	2014	2015
BCG	83	64	58	68	68	65	51	73
Penta3	80	76	74	69	67	66	69	67
OPV3	83	78	70	60	66	66	67	65
Measles1	72	74	67	61	60	60	58	66
Pneumo3 Jul-Dec	0	0	0	0	0	0	0	62
VITA	0	0	0	0	0	0	0	27

Dropout rate for pentavalent was 3% as at the end of 2015. Dropout rate for measles increased from 12% in 2013 to 17% in 2014 and then dropped to 4% in 2015. Completeness of data reporting on immunisation services improved during the period 2013 to 2015. However, timeliness of reporting reduced from 93% to 61% between 2014 and 2015.

Stock-out of EPI commodities including vaccines is a major issue affecting the National Immunisation Programme (NIP). Other challenges include capacities in vaccine management, data recording and reporting. Strengthening staff capacity at the district level to rollout the Reach Every Child/Reach Every District (REC/RED) strategy will also address the missed opportunities due to scheduling of immunisation services by some communities.

Nutrition

In 2012, the vulnerability assessment report estimated that about 36% of the population will face food insecurity. The 2012 AJR also identified poor linkage between nutrition partners, as well as between nutrition partners and the community,

shortage of nutrition staff, stock-out of therapeutic commodities and the quality and completeness of nutrition data and reports.

Non-Communicable Diseases

The four main diseases of concern contributing to the non-communicable disease burden are cardiovascular diseases, respiratory diseases, diabetes and cancer. According to WHO Global Burden of Disease Estimates, cancer accounts for 17% of all global NCD deaths and 4% of all deaths in Lesotho. Lesotho had no cancer surveillance system and registry in 2012. Data recording tools for cancer had not been standardised and data on cancer cases were not readily available. The most common types of cancer cases seen at outpatient departments were cancer of the cervix, breast cancer, cancer of the blood and blood from tissues.

Systems for cancer surveillance, recording and reporting have improved in the period 2013 to 2016. The percentage of district hospitals with functional cancer screening equipment increased from 6% in 2013 to 72% in 2016. The number of hospitals with functional cryotherapy machines also increased from one (1) in 2014 to twelve (12) in 2016.

Mental Health

Mental health services are provided in all health facilities and at the community level. The Government of Lesotho seeks to ensure universal access to mental health services by all who need it. The most common mental health illnesses seen at outpatient departments in 2012 were epilepsy, schizophrenia, mood disorders, neurotic disorders, stress, psychometric and HIV and AIDS neuropsychiatry disorders.

Shortages of psychiatric doctors and nurses, social workers and psychologists were the major priority gaps needed to be addressed under mental health in the NHSP 2012/17.

In 2016, the five main causes of mental illness seen at outpatient departments were neurotic stress, mood affecting disorders, epilepsy, schizophrenia and mental and behavioural disorders.

Tobacco

The Government of Lesotho has ratified the Framework Convention on Tobacco Control (FCTC). Though smoking is prohibited in all public places and government offices and premises, there is no legal basis for enforcement. As at 2012, there was no national legal framework to enforce WHO FCTC.

During the period of the NHSP 2012/17, the National Tobacco Bill was drafted and has gone through several stages of review. The Tobacco Bill has received approval from cabinet and will soon be presented to parliament. During the same period, the National Tobacco Policy and Strategy was prepared in draft and is yet to be approved.

Alcohol

The Government of Lesotho has adopted the WHO global strategy for reducing the harmful use of alcohol, and in 2012 drafted the National Alcohol Policy. The main interventions for reducing the harmful use of alcohol is health promotion, counselling

and treatment. The STEP survey reported alcohol prevalence at 31%. The same study estimated those in higher episodes of drinking to be 31% in males and 9% in females. Between 2013 and 2015, alcohol was the most abused substance, followed by dagga and cocaine. The absence of a regulatory framework and policy on alcohol negatively affect the efforts to reduce the harmful use of alcohol. Lack of financial resource is also one of the current challenges facing the MoH.

Diabetes

The main interventions are prevention and treatment. The focus has been on prevention with health promotion and education and campaigns on awareness and adopting healthy lifestyles.

In 2012, diabetes was among the top four causes of new outpatient visits, among the top ten causes of admission (7^{th} in males and 4^{th} in females) and in the top ten causes of deaths in adults. According to the STEP survey conducted in 2012, diabetes prevalence was 4%. This is an increase from the prevalence reported by the diabetes population survey conducted in 2001, in which diabetes prevalence was 1%. The AJR 2016 reported diabetes as the 7^{th} and 3^{rd} main cause of admissions in adult males and females respectively.

Oral Health

The oral health programme seeks to ensure access to high quality, preventive, curative and rehabilitative oral health care services to all people living in Lesotho. Oral health care is provided as an integrated service in accordance with the principles of Primary Health Care.

Due to shortage of oral health personnel and challenges in infrastructure, oral health services in Lesotho are currently provided at national and district levels only. There are no services at the health centre level where majority of the people in need of oral health services reside.

Dental caries is the most common dental problem seen in all facilities followed by periodontal diseases, oral cancer, dental fluorosis and oro-facial trauma. There is no national baseline data to inform decision-making and policies. Many hospitals are currently in need of dental equipment and instruments. Lack of continuous maintenance of dental equipment and periodic stock-outs of oral health commodities are some of the priority challenges to be addressed to ensure continuous service delivery.

To address the human resource challenges, a three-year programme in dental therapy was started at the National Health Training College with an initial intake of ten (10) students in July 2016.

Environmental Health

The mandate of the environmental health division is to provide technical and administrative support to ensure safe a physical environment. The scope and functions include water, sanitation and hygiene, health care waste management, safe housing, occupational health and safety, food safety, pollution control and port health. At the beginning of the current strategic plan period, there were challenges with availability of food testing equipment, transport for supervising and monitoring

as well as low funding for environmental health in the national health budget. There was also the need for the establishment of a call centre.

The proportion of water sources that were safe for drinking increased from 31% in 2013 to 80% in 2016. The percentage of health facilities with appropriate and functional waste disposal systems was 84% in 2016. Sixty –three percent (63%) of all ports of entry had safe drinking water for travellers in 2016.

Trauma and Injuries

Road accidents constitute the main direct cause associated with trauma and injuries. The main strategy being used to address the high levels of road accident is road safety campaigns.

In 2012, trauma was the 1st (16%) and 5th (6%) cause of admission in adult males and females respectively. Cause of admission in males increased to 25% in 2013 and reduced to 23% in 2014. In 2015, trauma remained the main cause of admission in adult males with 46 deaths (3.6%). Trauma as a cause of admission in adult females aged 13 years and above remained at 4% between 2012 and 2014. In 2015, trauma was not in the top ten causes of admission in adult females aged 13 years and above. With regard to the top ten causes of admission in children 12 years and below, trauma was 4% in 2014 and has remained at 4% in 2015.

3.3.5 ACCESS TO MEDICINES, MEDICAL DEVICES AND HEALTH TECHNOLOGIES

Access the medicines and health technologies involve the application of organised technologies in the form of devices, equipment, vaccines, procedures and systems to solve and improve the quality of health services. Improving access to medicines and health technologies is to ensure access to quality health care services. The NHSP 2015/16 set out to improve legislation, regulation and the policy environment, strengthen supply chain, procurement, laboratory and blood services and improve access to quality health care data.

Laboratory services are conducted in health facilities, district laboratories and national reference laboratories. Prior to 2013, some of the main challenges affecting access to laboratory services were the lack of equipment and human resource. The need for laboratory services was high, especially for TB and HIV and the equipment available at the time were inadequate and some too obsolete to cope with the volume and type of laboratory services required.

Laboratory Services

To improve the medical records system, the Electronic Medical Records (EMR) and Laboratory Information Systems (LIS) were initiated and piloted and then scaled up in a number of hospitals and laboratories. Currently the Laboratory Information System has been installed and is functioning in 17 laboratories. A tracking tool has been deployed to interface with the LIS system, to track samples from health facilities to district and national reference laboratories and provide feedback to the health facilities.

Between 2013 and 2016, eight (8) GeneXpert machines, twenty-seven (27) PMIA analysers and two (2) viral load machines were procured and installed in health

facilities, district laboratories and two national reference laboratories. The equipment has helped improve monitoring of CD4 count for clients, early detection for HIV positive clients on ART, reduced TAT to five (5) days for viral load and seven (7) days for DNA-PCR test.

Drafting of the Medicines and Medical Devices Bill started in 2013 and the final draft has been submitted to the Attorney General's office, awaiting certification before sending it for cabinet approval.

Procurement

The procurement function includes strengthening capacity at national and district levels to manage procurement issues. The National Drug Supply Organisation (NDSO) has been mandated by the MoH to procure, store and distribute health sector goods[11]. The main challenges in procurement before 2013 were the absence of a regulatory framework and shortages of procurement officers and managers. In the absence of a regulatory framework, it was difficult to regulate pharmaceuticals that were imported and used as well as retail pharmacy shops and herbal medicine producers. The MoH set out in 2013 to review the Essential Medicines List, build capacity of pharmaceutical personnel in forecasting and quantification of drugs, strengthen management of pharmaceutical services at all levels, review and implement guidelines for dugs donations and national standard treatment guidelines and establish a Medicine Regulatory Authority.

The average order fill rate for all commodities procured and distributed by NDSO was 90% over the period 2013 to 2016. The average order fill rate was 92% in 2013 and reduced to 90% in 2014 and 88% in 2015. During this period, NDSO had to increase the volume of warehouse due to increase in the volume of goods as a result of an increase in the number of districts they covered.

There are still challenges with stock-outs at health facilities for health commodities supplied by NDSO. In 2015, 25% of all facilities nationwide experienced some form of stock-out for ARVs and test kits. The stock-outs have partly been attributed to the length of time the MoH takes to complete an order and partly to the time it takes for the NDSO to complete a tender. In 2015, the average number of days it took for the NDSO to complete six tenders was 67 days and it varied from 49 days to 77 days depending on the type of items in the tender.

Blood Services

The mandate of the Lesotho Blood Transfusion Service (LBTS) is to ensure the availability of quality blood and blood products to all health facilities. The functions of the LBTS include recruiting blood donors, collecting, screening and storing blood, as well as distributing blood and blood products to all health facilities. The performance of the LBTS is measured by the availability of blood and blood products. Most of the staff providing services at the LBTS are temporary and contract staff. Availability of transport was one of the main challenges facing the LBTS in 2012.

In the year 2013, the number of blood donation clinics was 220. This has increased to 339 in 2014 and 406 in 2016. Most of the blood is donated by voluntary non-

[11] Pharmaceuticals, medical consumables, laboratory reagents, dental and other consumables used at health facilities.

remunerated donors (VNRD). In 2013, voluntary non-remunerated donors donated 99% of the total blood collected.

There has been an improvement in the LBTS data reporting with the installation and implementation of the Blood Safety Information System (BSIS). During the period, the LBTS worked with a number of quality assurance firms including Thistle QA, South Africa Blood Service (SABS) and the National Health Laboratory Service of South Africa to improve the quality of blood and blood services. The MoH is working with the Africa Society for Blood Transfusion (AfSBT) for the accreditation of the LBTS. Currently the accreditation process is in the final stage (stage 3) where a strong national regulatory environment is required for blood services.

There are no established positions for key management and technical personnel in the MoH to enable the recruitment of staff for the LBTS. This is a major challenge now and for the future, as most of the contracted staff have ended their contracts and left. Another important issue that requires attention is the communication between the LBTS, the blood transfusion clinics (centres) and health facilities. Poor communication has often resulted in the cancellation of blood donation campaigns.

3.3.6 HEALTH INFORMATION AND RESEARCH

The objectives of the HMIS as well as Monitoring and Evaluation (M&E) are to ensure: availability of timely health information; management of information through better analysis and interpretation of data; availability of relevant, ethical and timely research evidence; use of evidence by policy-makers and decision-makers; improvement of dissemination and sharing, evidence and knowledge; access to global health information and; the use of information and communication technology.

The four key functions of health information systems are data generation, compilation, synthesis and analysis, and communication and use. Timely and reliable information is necessary for decision-making in all the areas of health. Quarterly reviews are to ensure continuous accountability and reporting of performance. It is also a way of accounting to all stakeholders on their stewardship. Districts conduct quarterly reviews with all the health centres and hospitals with all providers accounting for their performance. During the review process, 16 indicators are reported by the district, 68 by hospitals and 34 by health centres. These are a set of standardised indicators to assess the performance of institutions and state of health services delivery.

In the last four years, the percentage of districts conducting at least two quarterly reviews annually has reduced from 90% in 2012 to about 20% in 2015. The percentage of planned SI-TWG meetings held at central level also reduced from 50% to 25% between 2012 and 2015. In the period 2012 to 2015, no SI-TWG meetings were held in any of the districts. None of the ten districts conducted more than two quality assessment visits in the same period.

Currently, there is no standardised set of indicators for management and administrative functions towards assessing their performance. There has been effort to integrate data from various sources into the DHIS2 platform.

3.3.7 ANALYSIS OF EXTERNAL AND INTERNAL ENVIRONMENT

External Environment

In 2015, the Millennium Development Goals (MDGs) come to an end and the post-2015 agenda, the Sustainable Development Goals (SDGs), began. The SDGs, with the theme "The 2030 Agenda, Transforming the World" have the goal of ensuring healthy lives and promoting well-being for all at all ages. They include 17 goals with Goal Three devoted to health. The SDGs also significantly broaden the scope of action, covering a wide range of human activity across three sustainable development dimensions (economic, social and environmental). All countries have adopted and signed on to the SDGs, Agenda 2030.

Beyond the SDGs, there are a number of global strategies and frameworks that have been adopted by the Government of Lesotho. Among the key global strategies and frameworks are the:

- Global Health Security and having a resilient health system
- Engagement with non-state actors
- Global Strategy for Women's, Children's and Adolescents' Health (2016-2030)
- Elimination of Mother-to-Child Transmission of HIV and Syphilis
- WHO Framework Convention on Tobacco Control
- WHO Stop TB Strategy
- Global Strategy on Human Resources for Health: Workforce 2030
- Global Plan of Action on Violence
- Paris Agreement on Climate Change (2015)

The government's Vision 2020 set out to ensure that by the year 2020 Lesotho shall be a stable democracy, a united and prosperous nation at peace with itself and its neighbours. It shall have a healthy and well-developed human resource base. The government has made efforts to revise policies and strategies to respond to the emerging global issues and implement them to improve the health of the people living in Lesotho. These include national guidance documents such as the National Vision 2020 and the National Strategic Development Plan (NSDP 2013-17). The Ministry of Health takes its mandate from the national vision document (Vision 2020 and the National Health Strategic Plan (2012-17) to provide a healthy environment for achieving Universal Health Coverage for all at all ages.

3.2.1 Internal Environment

The world is now a global village and national health systems have to respond to emerging challenges including the effects of climate change and disease outbreaks. The Government of Lesotho is therefore committed to building a resilient health system. A resilient health system will require global and national efforts, mobilising all health actors (state and non-state), having a strong regulatory and policy framework to guide actions and accountability and maintain a dedicated and committed health workforce.

These are all major challenges that the health sector is facing. The MoH will work with all relevant actors in the health sector to provide the environment for the health system to function and respond to the health needs of the people.

3.3.8 STRENGTHS, WEAKNESSES, OPPORTUNITIES AND CHALLENGES (SWOC)

Table 6: Strength Weaknesses Opportunities and Challenges

STRENGTHS	WEAKNESSES
• Systems for joint review and accountability • Committed health workforce • Commitment to government policy on decentralisation • Health information, monitoring and evaluation systems • Planning systems	• Slow pace of approving amendments to obsolete policies, frameworks and protocols • Capacity to implement health system reforms • Ability to influence other sectors (e.g. MPS) to accelerate approval of HR requests to fill established positions, create new staff establishment and organisational reforms • Performance management system • Coordination of donor support • Use of information for decision-making • Capacity for research and use for decision-making • Management and leadership capacity at all levels • Supervision and monitoring • Limited health staff with knowledge in eHealth and health informatics
OPPORTUNITIES	**CHALLENGES**
• Availability of global support to improve health • Support from the donor community • Government commitment to the health budget • Availability of national ICT platform • Government commitment to Public-Private Partnership • Government decentralisation policy and strategy • Impact of rapid demographic change with a large labour force and reducing dependency ratio[12] • Strong financial commitment for GoL domestic financing of the health budget • Health as a priority for government	• Slow pace of approval and passage of health bills • Recruitment process for trained health staff • Inadequate staff establishment for health • Increasing new HIV incidence and prevalence rate • Increasing burden of communicable and non-communicable diseases • Low productivity as a result of poor health mainly linked to high HIV and AIDS prevalence[13] • Sustainability of some proprietary ICT solutions • Low levels of eHealth awareness • Lack of eHealth strategy to govern the management of eHealth

[12] NSDP 2012-17

[13] NSDP 2012-17

• Commitment to national policy and strategy	

3.4 KEY ISSUES AND HEALTH SECTOR PRIORITIES

KEY ISSUES

Leadership and Governance

- Delayed organisational restructuring of the MoH
- It takes a long time to review and update protocols and standards for programmes
- Slow process of reviewing and getting bills to be passed into law
- Non availability of job descriptions and specifications for decentralised health staff positions
- The organisational structure and functions of the decentralised health departments are not clear
- Standard Operating Procedure (SOP) for management of Public-Private Partnerships (PPP)
- Capacity at MoH to negotiate, manage and evaluate PPP proposals and projects
- Absence of a partnership framework to manage MoH relationships with its stakeholders (Development Partners, NGOs and Private sector)
- Clear procedures and processes for the management of Village Health Workers in relation to incentives and exiting (exit strategy) from the programme
- Most of the Health Centre Committees (HCC) are not functional

Human Resource

- Delays in approving new staff establishment for the MoH
- The need to appoint substantive managers for key positions in the MoH
- Weak performance management system
- Resources to expand the National Health Training College (NHTC) to introduce more courses to address current and future HR capacity gaps
- High attrition rate in the health sector
- Absence of a functional system for coordinating in-service training programmes by department

Health Financing

- Tracking financial flows and linking them to interventions and disease burdens
- Proportion of government budget allocated to the health sector has been reducing
- Donors fund a higher proportion of the investment budget of the MoH
- Resource allocation criteria need to be revised and used

Health Service Delivery
- High disease burden due to communicable and non-communicable diseases
- High new HIV infections
- High prevalence of HIV and AIDS
- High institutional deaths especially from GoL health facilities
- The need to increase funding to address high prevalence of alcohol and substance abuse
- High TB burden
- Increase in prevalence of diabetes
- Equipment for the oral health programme
- Increasing number of admissions and deaths due to trauma and injuries

Access to Medicines, Medical Devices and Health Technology
- Frequent stock out of essential medicines
- The lengthy time that the National Drug Supply Organisation (NDSO) takes to process tenders
- Delays in the processing of orders within the MoH

Health Information and Research
- Timeliness, completeness and quality of health data reported
- The use of health research for evidence-based decision-making
- Weak national health system structures
- Capacity for routine analysis and use of health information for decision-making at all levels
- Low funding for research and eHealth

3.4.2 HEALTH SECTOR PRIORITIES

Service Delivery
- Ensure universal access to HIV preventive services (e.g. commodities, IE&C, PMTCT), testing and counselling and ART services
- Reduce incidence of HIV, TB and NCDs (cancer, cardiovascular diseases, diabetes)
- Strengthen supervision and quality assurance
- Strengthen outreach services
- Improve quality of ANC, delivery, PNC and family planning services
- Increase access to mental health services
- Increase access to health services in hard to reach areas
- Increase and prioritise services for the elderly
- Improve the quality of new born care services

- Improve the capacity of health personnel to deliver Integrated Management of Childhood Illness (IMCI) at the community level

Health Workforce

- Address the human resource gap
- Expand on the cadres of human resource training available at the National Health Training College (NHTC)
- Address restructuring of the MoH
- Address gaps in appointments to managerial positions at all levels
- Reduce attrition rate
- Establish workplace programmes

Health Information and Research

- Strengthen capacity in monitoring, surveillance, evaluation and research
- Build capacity in the use of data for decision-making
- Observe standards for interoperability
- Ensure standardization and integration of data systems
- Align eHealth and health ICT solutions to eGovernment policies
- Strengthen standards for interoperability

Medical Products, Vaccines and Health Technologies

- Uphold timely procurement, processing and distribution of medicines to the last mile
- Strengthen the capacity and skills of DHMTs and hospitals in procurement and supply chain management
- Strengthen regulation of medicines to tackle the problem of substandard and counterfeit medicines
- Reduce stock-out of health commodities
- Improve supply chain and last mile delivery to health facilities

Health Financing

- Development of a health financing policy and strategy that will ensure the attainment of financial risk protection and sustainability.
- Strengthen health financing monitoring through institutionalization of National Health Accounts (NHA)
- Finalize and adopt a resource allocation formula for allocating funds to districts.
- Explore a pro poor health insurance scheme

Leadership and Governance

- The passage of the health bills
- Reorganization of the MoH
- Recruitment and appointment of directors and managers
- Strengthening of intra-sectoral and inter-sectoral partnerships
- Guideline and tools for managers at the district level
- Capacity building for district staff
- Job description and functions for District Health Management Teams

- Increase community involvement and participation
- Alignment with local structures
- Selection of village health workers in line with local structures
- Fully functional health facilities
- Deployment of Community Health Workers in every community

CHAPTER FOUR: HEALTH SECTOR STRATEGIC DIRECTION

4.1 OVERVIEW OF NATIONAL HEALTH POLICY (NHP 2016)

The National Health Policy 2011 has been reviewed. The new National Health Policy (NHP 2016) took into consideration the Sustainable Development Goals and all other global, regional and national strategies, policies and framework. Its goal is to achieve Universal Health Coverage with a vision of a health population living a quality and productive life. The goals of the NHP are that of the SDGs and is targeted to achieve the SDGs for Lesotho by 2030.The NHP 2016, covers all aspects of health and provides broad direction for the development of health and the determinants of health. It has fifteen (15) objectives and seventy-five (75) policy measures. A framework has been provided in the NHP 2016, to guide implementation, with responsibility for policy oversight, coordination and responsibility. This framework also provides policy stakeholders and beneficiaries to help in the communication of the policy.

4.2 MISSION, VISION AND GOALS

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

4.2.1 MISSION

Its mission is to enhance a system that will deliver quality health services efficiently, effectively, and equitably to all Basotho.

4.2.2 VISION OF THE HEALTH SECTOR

The vision of the health sector is to have a healthy nation, living a quality and productive life.

4.2.3 GOAL OF THE HEALTH SECTOR

To achieve Universal Health Coverage, including financial risk protection, access to quality essential health-care services, safe, effective, quality and affordable essential medicines and vaccines for all Basotho by 2030.

4.3 GUIDING PRINCIPLES AND CORE VALUES

4.3.1 GUIDING PRINCIPLES

Primary Health Care Approach

In accordance with Alma Ata declaration of 1978 and the Ouagadougou Declaration 2008, the Government of Lesotho shall provide essential health care services that are universally accessible and affordable to all Basotho. Emphasis will continue to be placed on effective application of its principles and elements as well as Health Systems Strengthening.

Political Commitment

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

Community Involvement

The way health services are delivered must be personalized. Individuals differ in many ways, including their knowledge of and ability to understand the health system as well as their own health status. Individuals have different needs and preferences. Services must adapt to these differences rather than the individual having to adapt to the system. Services will be designed and delivered taking into consideration individual and community needs. Communities shall be actively encouraged and supported to participate in decision-making and planning for health services. Through empowering communities to assume ownership of community projects, communities will be managers of sustainable primary health care programmes in their own areas.

Equity

Everyone should have a fair opportunity to attain full health potential and, more pragmatically, no-one should be disadvantaged from achieving this potential, if it can be avoided. Inequity refers to differences in health delivery/access to basic health facilities which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust (Health 2001, WHO).

This strategy recognizes that the Constitution of Lesotho provides equal access to basic quality health care services for all Basotho. Particular attention shall be paid to resource distribution patterns in Lesotho to identify and accelerate the correction of any disparities. Special attention shall be given to the disadvantaged regions and underserved communities in the country. Services shall be community-based, taking into consideration special socio-cultural circumstances.

Affordability

People from the lower socio-economic groups suffer from a disproportionately high burden of ill-health. Social, environmental and economic factors including

deprivation, education, housing and nutrition affect both an individual's health status and his or her ability to access services. Improving equity of access will improve health by ensuring that people know what services they are entitled to and how to get those services and that there are no barriers, financial or otherwise, to receiving the services they need.

The Essential Health Package shall be free of charge or highly subsidized. Other services shall be obtained for nominal but affordable fee. The fee structures for such services shall take into consideration wealth differentials of Basotho and provide alternative options.

Gender Sensitivity and Responsiveness

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

Ethical consideration

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

Evidence-Based Decision-Making

The development and implementation of health intervention programmes shall be based on research evidence, cost-effectiveness and where appropriate, international best practices.

Decentralization

In line with the Local Government Act, health services shall be delivered to the people of Lesotho using a decentralized approach where local governments shall be responsible for service delivery at the district and lower levels.

4.3.2 CORE VALUES

Ethics and Human Rights

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

Accountability

Measuring the costs and quality of services, managing capital resources, co-ordinating services and managing human resources, have become increasingly complex at all levels. Health professionals now work in a more demanding environment. Evidence-based guidelines, tighter professional standards, the requirements of health-care organisations, and patient rights and expectations all add to these demands. Better planning and evaluation models will be used to ensure that available resources are used as efficiently and effectively as possible. As much as possible, resources shall be allocated to the greatest benefit of the population. Cost-effective interventions will be prioritized.

Quality

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

4.4 GOAL OF THE NATIONAL HEALTH STRATEGIC PLAN

To achieve Universal Health Coverage, including financial risk protection, access to quality essential health care services, safe, effective, quality and affordable essential medicines and vaccines for all people living in Lesotho by 2030.

4.4.1 INDICATORS

1. Reduction in the maternal mortality ratio
2. Increase in the proportion of births attended by skilled health personnel
3. Reduction in under-five mortality rate
4. Reduction in infant mortality rate
5. Reduction in under-five mortality rate
6. Reduction in neonatal mortality rate
7. Reduction in the number of new HIV infections
8. Reduction in tuberculosis incidence
9. Reduction in tuberculosis deaths
10. Increase in access to interventions against neglected tropical diseases
11. Reduction in mortality attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease
12. Increase in coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders
13. Reduction in deaths due to trauma and road traffic injuries
14. Increase in the proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods
15. Reduction in adolescent birth rate
16. Reduction in mortality rate attributed to household and ambient air pollution
17. Reduction in the mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)

18. Increase in the proportion of the population with access to affordable medicines and vaccines on a sustainable basis
19. Increase health worker density
20. Increase in capacity for International Health Regulations (IHR) and health emergency preparedness

4.5 STRATEGIC OBJECTIVES AND ACTIONS

4.5.1 STRATEGIC OBJECTIVES

The National Health Strategic Plan has six objectives based on an integration of the nine priority areas contained in the Ouagadougou framework for Primary Health Care and the six WHO Health system blocks. The final number of objectives for the health sector are six, covering health service delivery, human resource, health information and research, access to medicines, medical devices and health technologies, health financing and leadership, governance, partnerships, community ownership and participation.

Objectives

1. To ensure equity in access to health services, infrastructure, equipment and technologies for quality primary and secondary health services for all Basotho
2. To ensure a well-trained and motivated health workforce to deliver effective health services
3. To improve ICT and eGovernance systems and infrastructure for timely, relevant, accurate and complete health information and health research development
4. To Increase access to quality and safe health technologies, including medical devices, laboratories, medicines, and vaccines while improving procedures and systems
5. To ensure an equitable, efficient and sustainable health financing system that protects people from financial catastrophe and impoverishment as a result of using health services
6. To strengthen the national health system's leadership and governance, improve harmonization and alignment towards government-led policy

4.5.2 STRATEGIES

Objective 1: To ensure equity in access to health services, infrastructure, equipment and technologies for quality primary and secondary health services for all Basotho

Strategies

1.1. Coordinate and ensure linkages between sexual and reproductive health (SRH), HIV, gender-based violence, nutrition and non-communicable diseases
1.2. Ensure access to safe, effective, affordable and acceptable reproductive health services including family planning services to youth, women and men

1.3. Ensure free universal access to HIV and AIDs information, prevention, treatment, care and support to all the population
1.4. Improve access to quality child health services
1.5. Ensure universal access to TB, HIV and AIDS, information, prevention, treatment care and support
1.6. Strengthen the prevention of mother to child transmission of HIV and STIs
1.7. Improve immunization services for vulnerable groups such as infants, mothers, adolescents, elderly people, people in congregate settings, PLHIV and migrant populations
1.8. Provide micronutrient supplementation to mothers, children and families
1.9. Promote behavioural change in people's social behaviour and lifestyle
1.10. Promote fortification of locally available foods for consumption by households, especially children and mothers
1.11. Ensure elimination and eradication of vaccine preventable diseases
1.12. Strengthen the implementation of pre-hospital emergency medical services
1.13. Institute environmental surveillance mechanisms in collaboration with relevant stakeholders
1.14. Coordinate and ensure the links between childhood diseases, environment, hygiene and nutrition
1.15. Strengthen enforcement of legislations on environmental health
1.16. Integrate physical, mental and social rehabilitation activities into epidemic control measures
1.17. Strengthen adherence to Infection Prevention and Control measures in all health care facilities
1.18. Monitor and enforce relevant legislation on occupational health and safety
1.19. Strengthen documentation and regulation of traditional and complimentary medicines
1.20. Adopt social marketing for health strategies
1.21. Promote occupational health and safety, port health services and appropriate water supply and sanitation
1.22. Promote documentation of available traditional medicines to inform future studies on efficacy and safety
1.23. Promote healthy lifestyles and behaviour change
1.24. Promote healthy environment, safe food and water, personal hygiene, adequate sanitation, shelter and ventilation
1.25. Promote quality SRH services amongst adolescents, mothers and men
1.26. Promote and preserve indigenous knowledge of traditional medicine
1.27. Promote fortification of locally available foods for consumption by households, especially children and mothers
1.28. Promote healthy lifestyles and behaviour change communication (BCC) that lead to good health
1.29. Promote and contribute to healthy environment, which includes safe food water personal hygiene adequate sanitation, shelter and ventilation
1.30. Protect susceptible community members through immunization, education and other appropriate interventions including quality assured medicines for management of diseases like HIV infection, TB, MDR/XDR-TB
1.31. Provide comprehensive services for victims/survivors of abuse/violence and promote reduction of all forms of gender-based violence
1.32. Provide early childhood development services including guardian education and counselling

1.33. Improve facility and community based nutritional care and support to vulnerable children and women
1.34. Strengthen emergency preparedness and response
1.35. Provide technical guidance to attain community and institutional ante-natal, post-natal and child nutrition screening, counselling and support and promotion of breastfeeding
1.36. Conduct epidemiological investigation of disease outbreaks
1.37. Undertake regular surveillance on and implement interventions against all diseases including local vector borne and zoonotic diseases and those affecting neighbouring countries
1.38. To strengthen coordination in response to emergencies in collaboration with other stakeholders
1.39. Strengthen interventions to reduce risk factors for non-communicable diseases (tobacco use, alcohol, poor dietary practices, physical inactivity, increased salt intake, obesity)
1.40. Scale up comprehensive screening and early treatment of cervical cancer in women of child bearing age
1.41. Enforce the communication strategy at all levels
1.42. Strengthen community, district and national level preparedness and response to health emergencies and disasters
1.43. Strengthen integration of physical, mental and social rehabilitation activities into epidemic control measures
1.44. Protect susceptible community members though immunizations, education and other appropriate interventions
1.45. Integrate oral health into PHC programmes

Objective 2: To ensure a well-trained and motivated health workforce to deliver effective health services

Strategies

2.1. Develop and implement appropriate curriculum for Dental Assistants at the National Health Training College
2.2. Increase output of Dental Therapists and Dental Assistants for deployment to health facilities
2.3. Develop and implement appropriate curriculum for Dental Assistants
2.4. Ensure absorption of currently trained Dental Therapists
2.5. Improve teaching and learning resources and environment within the health sector
2.6. Improve training opportunities for effective career development and continuing education
2.7. Strengthen the capacity of existing health institutions to organise training programmes according to national needs
2.8. Strengthen capacity to deliver comprehensive occupational health and safety services across the country
2.9. Revise the establishment list for the health sector
2.10. Strengthen health care workers' capacity in emergency preparedness and response
2.11. Develop an appropriate manpower plan to maintain adequate human resource supply for health
2.12. Strengthen the capacity of health professionals to provide evidence-based clinical and nursing care

2.13. Strengthen collaboration with health professional bodies on ethical conduct and professionalism
2.14. Rationalize health personnel in accordance with recommended FTE
2.15. Strengthen capacity for laboratory and radiology investigations at all levels of care
2.16. Adopt strategies for retention of skilled health professionals in the health sector
2.17. Recruitment of health professionals with specialised skills (expatriates and nationals) in the diaspora
2.18. Strengthen capacity for laboratory investigation at all levels in response to emergencies
2.19. Strengthen radiology investigation capacity in response to emergencies
2.20. Advocate for uniform benefits and rewards to CHWs
2.21. Promote provision of incentives and professional pathways for mental health staff
2.22. Harmonize national professional and legal frameworks that regulate education and training for health professionals
2.23. Establish a regulatory body for professional and allied bodies
2.24. Regulate the scope of professional practices in the health sector

Objective 3: To improve ICT and eGovernance systems and infrastructure for timely, relevant, accurate and complete health information and health research development

Strategies

3.1 Integrate oral health data into HMIS
3.2 Conduct a national oral health survey
3.3 Adopt open source solutions as a preferred platform for the health sector
3.4 Support the provision of synchronous (for places where real time linkages can be established between the locations participation) and asynchronous telemedicine (store and forward techniques for places where real time connectivity is not possible)
3.5 Support both offline and online eLearning services with the objective of increasing the number of qualified health workforce
3.6 Support the interaction of information systems (EMR, BIS, eLMIS and LAB IS) with patients
3.7 Support mLearning activities
3.8 Support health system services with mobile platforms and mLearning activities
3.9 Support the use of websites and social media applications in health promotion, education and campaigns
3.10 Build business intelligence solutions for collation, analysis and publication of health information
3.11 Strengthen central coordination of the ICT support functions
3.12 Conduct periodic data collection and surveys to gain a better understanding of the health status of the country
3.13 Develop partnerships with international, regional and local stakeholders to promote the National Health Research agenda
3.14 Document, copyright and protect all the ICT programmes and products
3.15 Establish safe storage and observe confidentiality of patients' records

3.16 Include monitoring and evaluation in the design and implementation of all projects
3.17 Link key functionaries in the health system and relevant government focal points through Local Area Networks and Wider Area Networks
3.18 Promote data use for health systems strengthening and evidence-based planning.
3.19 Selectively engage partners to develop required ICT systems, including sustainability measures and handover of source code
3.20 Standardize ICT hardware and software, including interoperability with existing systems
3.21 Support secondary data analysis on existing data sets, in line with ethical requirements
3.22 Ensure sustainability of the independent Research Ethics Committee

Objective 4: To Increase access to quality and safe health technologies, including medical devices, laboratories, medicines, and vaccines while improving procedures and systems

Strategies

4.1 Improve the use of ICT in Supply Chain Communication for increased information sharing and integration of systems
4.2 Promote national and regional collaboration on pooled procurement and other procurement mechanisms
4.3 Strengthen Supply Chain Management for all health products
4.4 Strengthen the Technical Working Group on Supply Chain
4.5 Strengthen Supply Chain Management systems of all health products at all levels
4.6 Strengthen Pharmaceutical Services and structures (Centre for Pharmacovillance, National Pharmaco-Therapeutic Committee, Pharmacy Structure, narcotic bureau)
4.7 Promote Good Manufacturing Practices (GMP) in line with local, regional and international standards
4.8 Promote integrated HCWM systems nationally
4.9 Establish internal coordination mechanism on HCWM
4.10 Strengthen inter-sectoral collaboration in HCWM
4.11 Strengthen inter-sectoral collaboration in HCWM
4.12 Maintain a capacity building programme around HCWM within the health care structures
4.13 Maintain regulatory control of private HCWM service contractors
4.14 Strengthen capacity on HCWM within the health care structures
4.15 Improve compliance with HCWM standards
4.16 strengthen surveillance of identified environmental pollutants
4.17 Provide appropriate information and education on environmental pollution, and related diseases/conditions and hazards/risks
4.18 Promote and support operational research on pollution and associated effects
4.19 Maintain an updated inventory of sources and types of pollution in the country
4.20 Strengthen monitoring and surveillance systems at workplaces
4.21 Strengthen capacity of national and districts levels on occupational health and safety
4.22 Promote and support research on occupational health and safety
4.23 Provide information and education on occupational health and safety

4.24 Strengthen compliance with food safety standards
4.25 Prevent and control transmission of food-borne and food-related diseases
4.26 Promote and support food quality and safety research
4.27 Strengthen public awareness on food quality, safety and food-borne diseases.

Objective 5: To ensure an equitable, efficient and sustainable health financing system that protects people from financial catastrophe and impoverishment as a result of using health services

Strategies

5.1 Institutionalise the development of National Health Accounts (NHA)
5.2 Review user-fee policy regularly to assess affordability, criteria for exemption and access to treatment of diseases
5.3 Strengthen decentralized financial planning, management and accountability systems
5.4 Strengthen financial management systems in the health sector
5.5 Develop strategies to mobilize resources from within and outside the country
5.6 Develop appropriate financing mechanism to engage local health NGOs for GoL subvention
5.7 Encourage private funding through cost recovery and user fees at the tertiary level and through private health insurance
5.8 Put in place resource allocation mechanisms for efficient and equitable distribution of resources
5.9 Adopt a Sector-Wide Approach to allocation and expenditure
5.10 Explore innovative health financing mechanisms to promote sustainability
5.11 Advocate for a higher allocation of the government budget to health service delivery
5.12 Develop appropriate resource allocation criteria for the district health budgets

Objective 6: To strengthen the national health system's leadership and governance, improve harmonization and alignment towards government-led policy

Strategies

6.1 Advocate for legislation on control of breast milk substitutes
6.2 Advocate for legislation on fortified foods with micronutrients
6.3 Establish a regulatory body for medicines' control and practices through an Act of parliament
6.4 Establish standards for maintenance of dental equipment
6.5 Establish clear guidelines and legislation on prevention, control and management of communicable and non-communicable diseases
6.6 Develop and implement legislation related to sensitization and education in respect of sexual and reproductive rights for individuals, families and communities
6.7 Provide guidelines for the partnership with traditional and allopathic practitioners in the context of Basotho culture
6.8 Establish regulation and control on the safety and efficacy of medical devices, as well as therapeutic technological equipment including blood and blood products and monitor their utilization
6.9 Strengthen regulatory framework to guide the partnership

6.10 Provide standard guidelines and protocols on health emergencies to all health facilities
6.11 Promote child health rights and legal protection
6.12 Enforce adherence to jointly agreed Code of Conduct in line with the legal provisions governing development assistance as reviewed or enacted by government from time to time
6.13 Ensure effective quality monitoring mechanisms for subcontractors for service delivery
6.14 Improve accountability for subvention for any subcontractor for service delivery
6.15 Develop Health Sector PPP guidelines and monitoring structure based on the government PPP policy
6.16 Collaborate with other stakeholders on emergency preparedness and response
6.17 Develop partnership framework to facilitate regular dialogue with all development partners and other stakeholders working in the health sector
6.18 Operationalize Health SWAP fully to ensure transparency and accountability for all health resources and improved donor coordination in planning, financing, implementation, monitoring and evaluation within the health sector
6.19 Establish a Health and Environment Strategic Alliance (HESA) for the implementation of Lesotho's obligations under Multi-Sectoral Environmental Agreements (MEAs) on health issues in partnership with stakeholders
6.20 Establish the Health Service Commission
6.21 Establish a national cancer centre
6.22 Establish a comprehensive multi-sectoral, multidisciplinary and participatory approach to occupational health services and hazard management

CHAPTER FIVE: COST AND FINANCING OF THE NHSP

CHAPTER SIX: IMPLEMENTATION ARRANGEMENT

The costed National Health Strategic Plan (NHSP 2017-22) identifies key areas in the NHP 2016 that needs to be targeted and improved to address the vision and goals of the government of Lesotho. It is intended to target priority service areas identified as major challenges and critical to the achievement of the goals and vision of the health sector. Whilst the NHSP 2017-22 targets priority areas, the monitoring framework will be used to measure the performance of the sector as well as the implementation of the NHP 2016. The NHSP 2017-22 has been developed to address the Sustainable Development Goals (SDGs) and all other Global initiatives as well as development partners and stakeholders. The vision, goals and objectives are consistent with the national constitution, Vision 2020 and the National Development Strategic Plan of government. All stakeholders to align their strategies and plans to the NHSP 2017-22

The vision and goals are the same as the NHP 2016 and is consistent with global, regional and national strategies and frameworks. Each objective has a number of strategies that describes how the objective will be achieved. Each strategy has a number of indicators to provide the roadmap towards the achievement of the objective. The NHSP 2017-22 will be used to guide the development of the annual plans. The annual planning process will be guided by the six health sector objectives and their respective strategies. Beyond the strategies, each planning entity will develop activities from the strategies.

This strategy will be used to guide programmes who may be revising or developing their strategic plan. The vision and goals of the NHSP 2017-22 will remain the same for all strategic plans of any national or subnational organisation of the Ministry of Health and its stakeholders. Where it becomes necessary for a new vision, goal or objectives to be developed for any planning document in the health sector, it should make reference to the vision and goal or the NHSP 2017-22 objectives and strategies for which the sub objective contributes to and must be aligned to the NHSP 2017-22.

The starting point for the annual planning process is the use of the objectives and strategies in this document as the guide for their activities. The monitoring and evaluation framework (separate document), describes in details the relationship between the NHSP 2017-22, the Monitoring and evaluation and the annual plans. The planning format will be revised to reflect the objectives and strategies, beyond which activities and budgets will be developed.

It is hoped that when implemented well, will ensure alignment of the NHP 2016, the NHSP 2017-22, the Monitoring and Evaluation Framework and the annual plans. The monitoring and evaluation framework provides more details of how each of these documents will be measured and how each document feeds into the other. A summary of the framework is described in the monitoring and evaluation section of this document.

CHAPTER SEVEN: MONITORING & EVALUATION

This section briefly describes how this strategy will be measured. Annex A is the implementation plan which provides the tool for monitoring the performance of the NHSP 2017-22. Annex B, will be used to monitor the contribution of the NHSP 2017-22 to the national goals and vision of the health sector. It is a set of indicators that respond to the goals of the NHSP.

A section in the Annual Joint Review (AJR) report will be devoted to a narrative report on the performance of the NHSP 2017-22. An update on the result indicators as described in the second column of the Implementation plan in annex A of this strategy.

There are three level of monitoring indicators that has been included in the NHSP. The first, is the high level indicators that will be used to measure the goals of the NHSP. These are the goal targets. The goal targets are measured as percentages as either prevalence or incidence and represents final outcomes as a result of implementing activities. The second level of indicators are the results indicators found in the implementation plan. These are descriptive and are indented to describe the final outcomes. Results indicators will be used to describe the extent of implementation of the strategies. The third level of indicators are the outputs. The outputs are a direct result of implementing the strategies. Outputs will be used to access implementation of the strategies at national level for programmes and directorates level. Most of the data and information required for reporting in the indicators are generated routine in the annual reports. Measuring the outcome indicators will be complemented by periodic surveys and studies such as the Demographic and Health Surveys (DHS), Multiple Indicator Cluster Surveys (MICS), Maternal Mortality Survey. These surveys help evaluate the health status of the population and are conducted between3-5 years intervals. The NHSP will be evaluated at mid-term and end term. The monitoring and evaluation framework describes in details the

ANNEXXES
Annex A: Implementation Plan

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
1. To ensure equity in access to health services, infrastructure, equipment and technologies for quality primary and secondary health services for all Basotho	Access to healthcare services improved	Coordinate and ensure linkages between sexual and reproductive health (SRH), HIV, gender based violence, nutrition and non-communicable diseases	Availability of Standard Operating Procedure		Disease Control
		Ensure access to safe, effective, affordable and acceptable reproductive health services including family planning services to youth, women and men	Number of youth, women and men receiving reproductive and family planning information and education		Family Health
		Ensure free universal access to HIV and AIDs information, prevention, treatment, care and support to all the population	Number of persons aged 15-24 years with comprehensive correct knowledge of HIV/AIDS		Disease Control
		Improve access to quality child health services	Coverage of Fully Immunised Children		Family Health
		Ensure universal access to TB, HIV and AIDS, information, prevention, treatment care and support	Number of new TB and HIV infections		Disease Control
		Strengthen the prevention of mother to child transmission of HIV and STIs	Reduction in the Number pf new HIV infection transmitted from mother to child		Disease Control

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Improve immunization services for vulnerable groups such as infants, mothers, adolescents, elderly people, people in congregate settings, PLHIV and migrant populations	Coverage of children in deprived districts immunised		Disease Control
	Evidence of lifestyle changes	Provide micronutrient supplementation to mothers, children and families	Number of mothers receiving micronutrients supplementation		Family Health
		Promote behavioural change in people's social behaviour and lifestyle.	Number of new cases of NCDs		Disease Control
		Promote fortification of locally available foods for consumption by households, especially children and mothers	Number of locally produced foods fortified		Family Health
	Protection of the environment and reduction in incidence of diseases	Ensure elimination and eradication of vaccine preventable diseases	Fully immunised children		Disease Control
		Strengthen the implementation of pre-hospital emergency medical services	Number of functional ambulance		Nursing Services
		Institute environmental surveillance mechanisms in collaboration with relevant stakeholders	A functional system for surveillance with other stakeholders well documented		Environmental Health Unit
		Coordinate and ensure the links between childhood diseases environment, hygiene and nutrition	Number of wasted children who were enrolled into care		Primary Health Care

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Strengthen enforcement of legislations on environmental health.	Level of enforcement of legislation on Environmental Health		Environmental Health
	Quality of health care services improved	Integrate physical, mental and social rehabilitation activities into epidemic control measures	Evidence of integrated activities		Mental Health
		Strengthen adherence to Infection Prevention and Control measures in all health care facilities	Number of health facilities implementing infection prevention and control activities		Nursing Services
		Monitor and enforce relevant legislation on occupational health and safety	Number of districts who meet standards		Primary Health Care
		Strengthen documentation and regulation of traditional and complimentary medicines	Proportion of traditional medicines documented		Pharmaceutical Services
		Adopt social marketing for health strategies	Availability of social marketing strategy		Health Promotion
	The population is more informed about their health	Promote occupational health and safety, port health services and appropriate water supply and sanitation	Proportion of ports of entry with safe water and sanitation facilities according to standard		Environmental Health
		Promote documentation of available traditional medicines to inform future studies on efficacy and safety	Proportion of traditional medicines documented		Pharmaceutical Services
		Promote healthy lifestyles and behaviour change	Number of new cases of NCDs		Health Promotion

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Promote healthy environment, safe food and water, personal hygiene, adequate sanitation, shelter and ventilation	Number of facilities with safe water and sanitation facilities according to standard		Health Promotion
		Promote quality SRH services amongst adolescents, mothers and men	Number of adolescent, women and men receiving quality SRH information		Health Promotion
		Promote and preserve indigenous knowledge of traditional medicine	Proportion of traditional medicines documented		Pharmaceutical Services
		Promote healthy lifestyles and BCC that leads to good health	Number of BCC messages developed		Health Promotion
		Promote and contribute to healthy environment, which includes safe food water personal hygiene adequate sanitation, shelter and ventilation	Number of households receiving information on environmental pollution and related disease conditions and risk		Health Promotion
	Increased attention to emergency preparedness and response	Protect susceptible community members through immunization, education and other appropriate interventions including quality assured medicines for management of diseases like HIV infection, TB, MDR/XDR-TB	Number of new TB cases detected		Disease Control
		Provide comprehensive services for victims/survivors of abuse/violence and promote reduction of all forms of gender based violence	Number of victims/survivors of abuse and violence who received comprehensive		Family Health

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
			services		
		Provide early childhood development services including guardian education and counselling	Number of guardians who received education and counselling on early childhood development		Family Health
		Improve facility and community based nutritional care and support to vulnerable children and women	Number of vulnerable women receiving nutrition care and support		Nutrition
		Strengthen emergency preparedness and response	Number of districts trained in emergency preparedness and support		Director General
		Provide technical guidance to attain community and institutional ante-natal, post-natal and child nutrition screening, counselling and support and promotion of breastfeeding	Number of pregnant women receiving ante-natal, post-natal and child nutrition screening, counselling and breastfeeding information		Family Health
		Conduct epidemiological investigation of disease against outbreaks.	Number of investigations conducted		Disease Control

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Undertake regular surveillance activities and interventions against all diseases including vector borne and zoonotic diseases and those affecting neighbouring countries	Number of disease outbreaks		Disease Control
		To strengthen coordination in response to emergencies in collaboration with other stakeholders.	Number of coordination meetings held		Director General
	Reduce risk factors due to NCDs	Strengthen interventions to reduce risk factors for Non-communicable diseases (tobacco use, alcohol, poor dietary practices, physical inactivity, increased salt intake, obesity)	Number of NCD cases seen a OPD		Disease Control
		Scale up comprehensive screening and early treatment of cervical cancer in women of child bearing age	Number of women screened		Disease Control
		Enforce the communication strategy at all levels	Number of health facilities with copy of communication strategy		Health Promotion
		Strengthen community, district and national level preparedness and response to health emergencies and disasters	Number of district teams trained in emergency preparedness		Director General
		Strengthen integration of physical, mental and social rehabilitation activities into epidemic control measures	Availability of Standard Operating procedures to guide integration		Mental Health

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Protect susceptible community members through immunizations education and other appropriate interventions.	Number of children immunised (penta III as proxy)		Family Health
		Integrate oral health into PHC programmes	Availability of guidelines or SOP to guide integration		Disease Control
2. To ensure a well-trained and motivated health workforce to deliver effective health services	New health cadre courses introduced in Health Training Institutions	Develop and implement appropriate curriculum for Dental Assistants at the National Health Training College	Availability of curriculum		Disease Control
		Integrate oral health into PHC programmes	Availability of guidelines or SOP to guide integration		Disease Control
		Increase output of Dental Therapists and Dental Assistants for deployment to health facilities	Number of Dental Therapist enrolled		NTHC
		Develop and implement appropriate curriculum for Dental Assistants	Availability of Curriculum		Disease Control
		Ensure absorption of currently trained Dental Therapists	Number of trained Dental Therapist employed		Human Resource
		Improve teaching and learning resources and environment within the health sector	Number of Health Training Colleges/School which are fully equipped		NHTC
		Improve training opportunities for effective career development and continuing education	Number of training opportunities available		NHTC

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Strengthen the capacity of existing health institutions to organise training programmes according to national needs	Number of training programmes organised		Principal Secretary
	Health workers' capacities strengthened	Strengthen capacity to deliver a comprehensive occupational health and safety services across the country	Number of staff in occupational health receiving training		Human Resource
		Revise the establishment list for the health sector	Availability of updated establishment list		Human Resource Department
		Strengthen health care workers' capacity in emergency preparedness and response	Number of health staff trained in emergency preparedness and response		Human Resource
		Develop appropriate manpower plan to maintain adequate human resource supply for health	Availability of updated manpower plan		Human Resource Department
		Strengthen capacity of health professionals to provide evidence based clinical and nursing care	Number health professionals trained		Human Resource
		Strengthen collaboration with health professional bodies on ethical conduct and professionalism	Number of collaborative meetings held		Office of DG
	Well skilled and motivated workforce	Rationalize health personnel in accordance with recommended FTE	Number of facilities with full complement of staff		Human Resource
		Strengthen capacity for laboratory and radiology investigations at all levels of care	Number of laboratory and radiology staff		Human Resource

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
			receiving training		
		Adopt strategies for retention of skilled health professionals in the health sector	Availability of a strategy for staff retention		Human Resource
		Recruitment of health professionals with specialised skills (expatriates and nationals) in diaspora	Number of Basotho health professionals recruited from the diaspora		Human Resource
		Strengthen capacity for laboratory investigation at all levels in response to emergencies	Number of laboratories with full complement of equipment and staff		Human Resource
		Strengthen radiology investigation capacity in response to emergencies	Number of laboratories with full complement of equipment and staff		Human Resource
		Advocate for uniform benefits and rewards to CHWs	Nuer of advocacy meetings held		Director General
		Promote provision of incentives and professional pathways for mental health staff	Proportion of mental health staff receiving incentives		Director General
	Coordination and regulation of professional bodies	Harmonize national professional and legal frameworks that regulate education and training for health professionals	Availability of document for harmonisation		Director General
		Establish a regulatory body for professional and allied bodies	Establishment of a regulatory body		
		Regulate the scope of professional practices in the health sector	Availability of a regulatory framework		Director General

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
3. To improve ICT and eGovernance systems and infrastructure for timely, relevant, accurate and complete health information and health research development		Integrate oral health data into HMIS	Evidence of oral health data captured and reported in DHIS2		Planning & Statistics
		Conduct a national oral health survey	Availability of survey report		Disease Control
		Adopt open source solutions as a preferred platform for the health sector	Availability of a framework to guide procurement of ICT solutions		General Administration
		Support the provision of synchronous (for planes where real time linkages can be established between the locations participation) and asynchronous telemedicine (store and forward techniques for places where real time connectivity is not possible)	Availability of a framework to guide procurement of ICT solutions		General Administration
		Support both offline and online eLearning services with the objective of increasing the number of qualified health workforce	Availability of a framework to guide procurement of ICT solutions		General Administration
		Support the interaction of information systems (EMR, BIS, eLMIS and LAB IS) with patients	Availability of an integrated solution for interaction of information systems		General Administration
		Support mLearning activities	Number of mLearning activities implemented		General Administration
		Support health system services with mobile platforms and mLearning activities	Number of services supported by mobile platforms		General Administration

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Support the use of websites and social media applications in health promotion, education and campaigns	Number of services promoted using social media applications		General Administration
		Build business intelligence solutions for collation, analysis and publication of health information	Number of business intelligent solutions available		General Administration
		Strengthen central coordination of the ICT support functions	Availability of FTE of staff and equipment at ICT unit		General Administration
		Conduct periodic data collection and surveys to gain a better understanding of the health status of the country	Number of data collection surveys conducted		Planning & Statistics
		Develop partnerships with international, regional and local stakeholders to promote the National Health Research agenda	Availability of partnership framework		Planning & Statistics
		Document, copyright and protect all the ICT programmes and products	Number of software used by MoH documented		General Administration
		Establish safe storage and observe confidentiality of patients' records	Efforts made to ensure confidentiality of patient records		Planning & Statistics
		Include monitoring and evaluation in the design and implementation of all projects	Number of new projects and programmes with M&E design incorporated and		Planning & Statistics

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
			consistent with central M&E system		
		Link to key functionaries in the health system and relevant government focal points through Local Area Networks and Wider Area Networks	Number of links created		General Administration
		Promote data use for health systems strengthening and evidence-based planning.	Number of districts trained in the use of data for research		General Administration
		Selectively engage partners to develop required ICT systems, including sustainability measures and handover of source code	Proportion of partner developed system handed over or fully managed by MoH		General Administration
		Standardize ICT hardware and software, including interoperability with existing systems	Availability of standards for ICT hardware and software		General Administration
		Support secondary data analysis on existing data sets, in line with ethical requirements	Number of districts trained in the use of data for research		General Administration
		Ensure sustainability of the Independent Research Ethics Committee	Functionality of the Independent Research Ethics Committee		Director General
4. To Increase access to quality and safe health technologies, including medical devices, laboratories, medicines and vaccines and while improving procedures and systems	Improved procurement and Supply chain Management System	Improve the use of ICT in Supply Chain communication for increased information sharing and integration of systems	Availability of a supply chain management software integrated with other relevant system		General Administration

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Promote national and regional collaboration on pooled procurement and other procurement mechanisms	Availability of a Standard Operating Procedure for pooled procurement		General Administration
		Strengthen Supply Chain Management for all health products	Number of qualified Supply Chain Practitioners recruited		General Administration
		Strengthen the Technical Working Group on Supply Chain	Functionality of the Supply Chain TWG		General Administration
	Improved regulatory environment for medicines and pharmaceuticals	Strengthen Supply Chain Management systems of all health products at all levels	Additional health products added to the last mile delivery		General Administration
		Strengthen Pharmaceutical Services and structures (Centre for Pharmacovillance, National Pharmaco-Therapeutic Committee, Pharmacy Structure, narcotic bureau)	Creation of relevant organisational structures		Pharmaceutical Services
		Promote Good Manufacturing Practices (GMP) in line with local, regional and international standards	Number of relevant manufacturers educated of GMP		Pharmaceutical Services
	Improved disposal of health care waste	Promote integrated HCWM systems nationally	Number of national hospitals with integrated Health Care Waste management (HCWM) system		Environmental Health
		Establish internal coordination mechanism on HCWM	Coordination mechanism established for		Environmental Health

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
			HCWM		
		Strengthen inter-sectoral collaboration in HCWM	Availability of a functional inter-sectoral collaborative body for HCWM		Environmental Health
		Maintain capacity building program around HCWM within the Health care structures in the	Number of health facilities trained in HCWM programme		Environmental Health
		Maintain regulatory control of private HCWM service contractors	Number of private contractors adhering to HCWM regulations		Environmental Health
		Strengthen surveillance of identified environmental pollutants	Number of environmental pollutants exceeding standard		Environmental Health
	Reduce risk of disease outbreaks	Provide appropriate information and education on environmental pollution, and related diseases/conditions and hazards/risks	Number of districts who have received appropriate information and education on environmental pollutants and hazards		Environmental Health
		Promote and support operational research on pollution and associated effects	Number of research conducted on pollution and associated effects		Planning & Statistics
		Maintain updated inventory of sources and types of pollution in the country	Availability of updated inventory of pollutants		Environmental Health

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Strengthen monitoring and surveillance systems at workplaces	Number of workplaces (health facilities) visited		Environmental Health
		Strengthen capacity of national and districts levels on occupational health and safety	Number of health facilities receiving training in occupational and safety		Environmental Health
		Promote and support research on occupational health and safety	Number of research studies conducted in occupational health and safety		Environmental Health
		Provide information and education on occupational health and safety	Number of health facilities receiving education on occupational health and safety		Environmental Health
		Strengthen compliance with food safety standards	Proportion of food vendors compliant in food safety standards		Environmental Health
		Prevent and control transmission of food-borne and food-related diseases	Number of food-borne and food related disease outbreaks		Environmental Health
		Promote and support food quality and safety research	Number of research in food quality and safety conducted		Environmental Health
		Strengthen public awareness on food quality, safety and food-borne diseases.	The level of awareness of the public on food quality, safety and food-borne diseases		Environmental Health

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
5. To ensure equitable, efficient and sustainable health financing system that protect people from financial catastrophe and impoverishment as a result of using health services	Information available on sources and use of funds	Institutionalise the development of National Health Accounts (NHA)	NHA conducted		Finance
		Review user-fee policy regularly to assess affordability, criteria for exemption and access to treatment of diseases	Availability of updated user fee policy		Finance
		Strengthen decentralized financial planning, management and accountability systems	Proportion of health centres with annual plans		Planning & Statistics
		Strengthen financial management systems in the health sector	Extent of implementation of the Public Financial Management (PFM)		Finance
	Increase in resources available to the health sector	Develop strategies to mobilize resources from within and outside the country	Availability of a resource mobilisation strategy		Planning & Statistics
		Develop appropriate financing mechanism to engage local health NGOs for GoL subvention	Availability of a framework for engaging NGOs		Finance
		Encourage private funding through cost recovery and user fees at the tertiary level and through private health insurance scheme	Availability of a health financing strategy		Finance
		Put in place resource allocation mechanisms for efficient and equitable distribution of resources	Availability of an updated resource allocation criteria		Finance

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Adopt a Sector-Wide Approach to the allocation and distribution of resource	Availability of an updated resource allocation criteria		Finance
		Explore innovative health financing mechanisms to promote sustainability	Availability of a health financing strategy		Director General
	Improved allocation and disbursement of funds	Advocate for a higher allocation of the government budget to health service delivery	Increase in the proportion of Government budget to health to total government budget		Principal Secretary
		Develop appropriate resource allocation criteria for the district health budgets	Availability of an updated resource allocation criteria		Finance
6. To strengthen national health system's leadership and governance, improve harmonization and alignment towards government led policy	Strong regulatory environment	Advocate for legislation on control of breast milk substitutes	Availability of draft bill for control of breast milk substitute		Family Health
		Advocate for legislation on fortified foods with micronutrients	Availability of draft bill for fortification of foods with nutrients		Principal Secretary
		Establish a Rrgulatory body for medicine's control and practices through an Act of parliament.	Availability of a bill for the establishment of a regulatory body for medicine control and practice		Principal Secretary
		Establish clear guidelines and legislation on prevention, control and management of communicable and cancer and non-communicable diseases	Availability of guideline for prevention and control of Communicable and Non-communicable		Principal Secretary

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
			diseases		
		Develop and implement legislation related to sensitization and education in respect of sexual and reproductive rights for individuals, families and communities	Availability of a regulatory framework for SRH rights of individual, families and communities		Principal Secretary
		Provide guidelines for the partnership with traditional and allopathic practitioners in the context of Basotho culture	Availability of guidelines for traditional and allopathic practice		Director General
		Establish regulation and control on the safety and efficacy of medical devices as well as therapeutic technological equipment including blood and blood products and monitor their utilization.	Availability of a regulatory framework for control on safety and efficacy of medical devices, therapeutic technological equipment including blood and blood products		Director General
		Provide standard guidelines and protocols on health emergencies to all health facilities	Number of health facilities with guidelines and protocols for health emergencies		Director General
		Promote child health rights and legal protection			Director General

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
	Improved and efficient PPP system in place	Enforce adherence to jointly agreed Code of Conduct in line with the legal provisions governing development assistance as reviewed or enacted by government from time to time			Director General
		Ensure effective quality monitoring mechanisms for subcontractors for service delivery	Availability of guideline for monitoring and assessing contracted services		Planning & Statistics
		Improve accountability for subvention for any subcontractor for service delivery	Availability of guideline for monitoring and assessing contracted services		Planning & Statistics
		Develop Health Sector PPP guidelines and monitoring structure based on the government PPP policy	Availability of a guideline for Public Private Partnership		Planning & Statistics
	Strong partnership arrangement with all stakeholders	Collaborate with other stakeholders on emergency preparedness and response	Evidence of collaboration		Director General
		Develop partnership framework to facilitate regular dialogue with all development partners and other stakeholders working in the health sector	Availability of a partnership framework for regular dialogue between MoH, Health Partners and other stakeholders		Principal Secretary

Strategic Objective	Results Indicators (RIs)	Strategies	Monitoring Indicators	Target Year	Lead Responsible Department
		Operationalize Health SWAP fully to ensure transparency and accountability for all health resources and improved donor coordination in planning, financing, implementation, monitoring and evaluation in the health sector	Functionality of the partnership framework guiding MoH, Health Partners and other stakeholders		Principal Secretary
	Strong institutional systems and structures	Establish a Health and Environment Strategic Alliance (HESA) for the implementation of Lesotho's obligations under Multi-Sectoral Environmental Agreements (MEAs) on health issues in partnership with stakeholders	HESA established and functional		Principal Secretary
		Establish the Health Service Commission	Health Care Commission Established		Director General
		Establish a National Cancer Centre	National Cancer Registry established and functional		Director General
		Establish a comprehensive multi-sectoral, multidisciplinary and participatory approach to occupational health services and hazard management	Availability of a guideline for operationalising multi-sectoral, multidisciplinary and participatory approach to occupational health prevention and hazard management		Director General

Annex B: Indicators for Measuring the NHSP

	Indicator	2018	2019	2020	2021	2022
1	Reduction in maternal mortality ratio					
2	Increase proportion of births attended by skilled health personnel					
3	Reduction in under-five mortality rate					
4	Reduction in infant mortality rate.					
5	Reduction in under-five mortality rate					
6	Reduction in neonatal mortality rate					
7	Reduction in the number of new HIV infections					
8	Reduction in Tuberculosis incidence					
9	Reduction in Tuberculosis deaths					
10	Increase in access to interventions against neglected tropical diseases					
11	Reduction in mortality attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease					
12	Increase in coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders					
13	Reduction in deaths due to trauma and road traffic injuries					
14	Increase in the proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods					
15	Reduction in adolescent birth rate					

	Indicator	2018	2019	2020	2021	2022
16	Reduction in mortality rate attributed to household and ambient air pollution					
17	Reduce mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)					
18	Increase in the proportion of the population with access to affordable medicines and vaccines on a sustainable basis					
19	Increase health worker density					
20	Increase in capacity for International Health Regulations (IHR) and health emergency preparedness					

Annex C: Health indicators (Menu of health Indicators to be included in the M&E Framework for review)

Programme Area	Description	Result Chain
Child Health	Infant mortality rate.	Impact
Maternal Health	Institutional maternal mortality ratio	Impact
MMR	Maternal mortality ratio (per 100 000 live births)	Impact
Adolescent	Adolescent fertility rate (per 1000 girls aged 15-19 years)	Outcome
adolescent	Percentage of pregnant Adolescent girls (9-13) attending at least four ANC visits	Outcome
Adult Mortality	Adult mortality rate (probability of dying between 15 and 60 years per 1000 population)	Outcome
Child Health	Children aged <5 years with ARI symptoms receiving antibiotics (%)	Outcome
Child Health	Children aged <5 years with ARI symptoms taken to a health facility (%)	Outcome
Child Health	Children aged <5 years with diarrhoea receiving oral rehydration therapy (%)	Outcome
Child Health	Children aged 6-59 months who received vitamin A supplementation (%)	Outcome
Child Health	Children with diarrhoea receiving oral rehydration solution (ORS)	Outcome
Child Health	Deaths in children aged <5 years, by cause	Outcome
Child Health	Deaths in children aged <5 years, by cause (per 1 000 live births)	Outcome
Child Health	Incidence of low birth weight among newborns	Outcome
Child Health	Neonates protected at birth against neonatal tetanus (%)	outcome
Child Health	Vitamin A supplementation coverage	Outcome
Delivery	Birth registration coverage	Outcome
Delivery	Births attended by skilled health personnel (%)	Outcome
Delivery	Births by caesarean section (%)	Outcome
Environmental Health	Percentage of health facilities with functional means of Medical Waste Disposal System in line with national guidelines. (functional incinerator as proxy)	Outcome
Environmental Health	Population using improved drinking-water sources (%)	Outcome
Environmental Health	Population using improved sanitation facilities (%)	Outcome
Environmental Health	Population using modern fuels for cooking/heating/lighting	Outcome
Environmental Health	Population using safely managed drinking-water services	Outcome
Environmental Health	Population using safely managed sanitation services	Outcome
Environmental Health	Population using solid fuels	Outcome
Environmental Health	Proportion of water sources with safe drinking water	Outcome
EPI	Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage	Outcome

Programme Area	Description	Result Chain
	among 1-year-olds (%)	
EPI	Hepatitis B (HepB3) immunization coverage among 1-year-olds (%)	Outcome
EPI	Hepatitis B incidence per 100,000 population	Outcome
EPI	Hib (Hib3) immunization coverage among 1-year-olds (%)	Outcome
EPI	Immunization coverage rate by vaccine for each vaccine in the national schedule	Outcome
EPI	Measles (MCV) immunization coverage among 1-year-olds (%)	Outcome
Family Planning	Contraceptive prevalence rate	Outcome
Family Planning	Demand for family planning satisfied with modern methods	Outcome
Family Planning	Prevalence of condom use by adults (aged 15-49 years) during higher-risk sex (%)	Outcome
Family Planning	Proportion of women of reproductive age (aged 15-49 years) who have their need for family planning satisfied with modern methods	outcome
Family Planning	Unmet need for family planning (%)	Outcome
Health Financing	External resources for health as a percentage of total expenditure on health	Outcome
Health Financing	Externally sourced funding (% of current expenditure on health)	Outcome
Health Financing	General government expenditure on health as a percentage of total expenditure on health	Outcome
Health Financing	General government expenditure on health as a percentage of total government expenditure	Outcome
Health Financing	Out-of-pocket expenditure as a percentage of private expenditure on health	Outcome
Health Financing	Per capita government expenditure on health at average exchange rate (US$)	Outcome
Health Financing	Per capita total expenditure on health at average exchange rate (US$)	Outcome
Health Financing	Private expenditure on health as a percentage of total expenditure on health	Outcome
Health Financing	Total capital expenditure on health (% current + capital expenditure on health)	outcome
Health Financing	Total expenditure on health as a percentage of gross domestic product	outcome
Health Financing	Total official flows for medical research and basic heath sectors	Outcome
Health Technology	Density of hospitals (per 100 000 population)	Outcome
Health Technology	Hospital beds (per 10 000 population)	Outcome
Health Technology	New cases of IHR-notifiable diseases and other notifiable diseases	outcome
Health Technology	Percentage of Districts with Updated Emergency Preparedness and	Outcome

Programme Area	Description	Result Chain
	Response Plan	
HIV and AIDS	Antiretroviral therapy (ART) coverage	Outcome
HIV and AIDS	ART retention rate	Outcome
HIV and AIDS	Deaths due to HIV/AIDS (per 100 000 population)	Outcome
HIV and AIDS	HIV incidence rate	Outcome
HIV and AIDS	HIV prevalence rate	Outcome
HIV and AIDS	HIV test results for registered new and relapse TB patients	Outcome
HIV and AIDS	HIV viral load suppression	Outcome
HIV and AIDS	HIV-positive new and relapse TB patients on ART during	Outcome
HIV and AIDS	People living with HIV who have been diagnosed	Outcome
HIV and AIDS	Population aged 15-24 years with comprehensive correct knowledge of HIV/AIDS (%)	Outcome
HIV and AIDS	Prevention of mother-to-child transmission	Outcome
HMIS	Completeness of reporting by facilities	Outcome
HMIS	Completeness of weekly IDSR reports	Outcome
HMIS	Proportion of village health workers who submitted their reports to the health facility on a monthly basis	outcome
HMIS	Timeliness of IDSR weekly reports	outcome
Human Resource	Density of community health workers (per 10 000 population)	Outcome
Human Resource	Density of dentists (per 10 000 population)	Outcome
Human Resource	Density of environment and public health workers (per 10 000 population)	Outcome
Human Resource	Density of nursing and midwifery personnel (per 10 000 population)	Outcome
Human Resource	Density of pharmacists (per 10 000 population)	Outcome
Human Resource	Density of physicians (per 10 000 population)	Outcome
Human Resource	Total number of active Village Health workers	outcome
Management	Percentage of health centres holding at least 80% of planned board/committee meetings	Outcome
Management	Percentage of health centres with functional committees/boards	Outcome
Maternal Health	Antenatal care coverage - at least four visits (%)	Outcome
Maternal Health	Antenatal care coverage - at least one visit (%)	Outcome
maternal health	Exclusive breastfeeding under 6 months (%)	Outcome
Maternal Health	Obstetric and gynaecological admissions owing to abortion	Outcome
Maternal Health	Perioperative mortality rate	Outcome
Maternal Health	Postnatal care visit within two days of childbirth (%)	Outcome
Maternal Health	Postpartum care coverage	Outcome

Programme Area	Description	Result Chain
Maternal Health	Stillbirth rate	outcome
Maternal Health	Total fertility rate	outcome
Medicines	Availability of essential medicines and commodities	Outcome
Medicines	Availability of STGs and EML in facilities	Outcome
Medicines	Proportion of the population with access to affordable medicines and vaccines on a sustainable basis	outcome
Mental Health	Coverage of services for severe mental health disorders	Outcome
Mental Health	Coverage of treatment interventions (pharmacological, psychosocial and rehabilitation and aftercare services) for substance use disorders	Outcome
Mortality	Mortality rate attributed to household and ambient air pollution	outcome
Mortality	Mortality rate attributed to unsafe water, unsafe sanitation and lack of hygiene (exposure to unsafe Water, Sanitation and Hygiene for All (WASH) services)	outcome
NCDs	Cancer incidence, by type of cancer	Outcome
NCDs	Cervical cancer screening	Outcome
NCDs	Coverage of preventive chemotherapy for selected neglected tropical diseases	Outcome
NCDs	Harmful use of alcohol, defined according to the national context as alcohol per capita consumption (aged 15 years and older) within a calendar year in litres of pure alcohol	Outcome
NCDs	Mortality between 30 and 70 years of age from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases	Outcome
NCDs	Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease	outcome
NCDs	Number of deaths attributed to cancer. Age group 30 - 70	Outcome
NCDs	Number of deaths attributed to cardiovascular disease. Age group 30 - 70	Outcome
NCDs	Number of deaths attributed to chronic respiratory disease. Age group 30 - 70	outcome
NCDs	Number of deaths attributed to diabetes. Age group 30 - 70	outcome
NCDs	Prevalence of current tobacco use among adolescents aged 13-15 years (%)	Outcome
NCDs	Prevalence of raised fasting blood glucose	Outcome
NCDs	Raised blood pressure among adults	outcome
NCDs	Tobacco use among persons aged 18+ years	outcome
NCDs	Total alcohol per capita (age 15+ years) consumption	outcome

Programme Area	Description	Result Chain
NTDs	Suicide mortality rate	outcome
NTDs	Suicide rate	outcome
Nutrition	Anaemia prevalence in children	Outcome
Nutrition	Anaemia prevalence in women of reproductive age	Outcome
Nutrition	Children aged <5 years' overweight (%)	Outcome
Nutrition	Children aged <5 years stunted (%)	Outcome
Nutrition	Children aged <5 years underweight (%)	Outcome
Nutrition	Children aged <5 years wasted (%)	Outcome
Nutrition	Overweight and obesity in adults *(Also: adolescents)*	Outcome
RTI	Death rate due to road traffic injuries	Outcome
RTI	Mortality rate from road traffic injuries	outcome
STIs	Sexually transmitted infections (STIs) incidence rate	outcome
TB	Estimated deaths due to tuberculosis, excluding HIV (per 100 000 population)	Outcome
TB	Estimated prevalence of tuberculosis (per 100 000 population)	Outcome
TB	Notified cases of tuberculosis	outcome
TB	Second-line treatment coverage among multidrug-resistant tuberculosis (MDR-TB) cases	outcome
TB	TB case detection rate	outcome
TB	TB Case Notification	outcome
TB	TB Incidence Rate	outcome
TB	TB mortality rate	outcome
TB	TB patients with results for drug susceptibility testing	outcome
TB	TB prevalence rate	outcome
TB	TB preventive therapy for HIV-positive people newly enrolled in HIV care	outcome
TB	TB treatment success rate	outcome
TB	Treatment success rate for new pulmonary smear-positive tuberculosis cases	Outcome
TB	Tuberculosis case detection rate for new smear-positive cases (%)	Outcome
TB	Tuberculosis deaths per 100,000 population	outcome
Environmental Health	Proportion of local government councils with proper liquid waste management systems	output
Environmental Health	Proportion of local government councils with proper solid waste management systems	output
EPI	Number of girls (9-13) vaccinated for HPV	Output

Programme Area	Description	Result Chain
EPI	Number of reported cases of measles	Output
EPI	Number of reported cases of mumps	Output
EPI	Number of reported cases of neonatal tetanus	Output
EPI	Number of reported cases of pertussis	Output
EPI	Number of reported cases of poliomyelitis	Output
EPI	Number of reported cases of rubella	Output
EPI	Number of reported cases of total tetanus	Output
EPI	Number of reported cases of yellow fever	Output
EPI	Number of suspected meningitis cases reported	Output
Family Planning	Number of Facilities providing FP Services	Output
Family Planning	Number of Facilities reporting FP stock out for more than 7 days (by Commodity)	Output
Family Planning	Number of Facilities reporting FP stock out for more than 7 days (by Commodity) - Condoms	Output
Family Planning	Number of Facilities reporting FP stock out for more than 7 days (by Commodity) - Implants	Output
Family Planning	Number of Facilities reporting FP stock out for more than 7 days (by Commodity) - Injectable	Output
Family Planning	Number of Facilities reporting FP stock out for more than 7 days (by Commodity) - Pills	Output
Health Financing	Number of people covered by health insurance or a public health system per 1,000 population	output
Health Technology	International Health Regulations (IHR) core capacity index	Output
Health Technology	Proportion of facilities with functional medical equipment	output
Health Technology	Proportion of facilities with functional refrigerators	output
HIV and AIDS	Number of HIV positive clients	Output
Human Resource	Number of Graduants	Output
maternal health	Maternal death reviews	Output
Maternal Health	Proportion of births attended by skilled health personnel	output
NTDs	Number of people requiring interventions against neglected tropical diseases	Output

Annex D: References