**ANNEX 1**

**Advocacy Strategy for the Coalition of Health Professionals Associations in Lesotho (draft)**

**2017 – 2020**

Commissioned

by

Lesotho Boston Health Alliance (LeBoHa)

Prepared and Submitted

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VISION

A country where morbidity and mortality are significantly reduced, thus contribute to attainment of improved health status among the people of Lesotho.

# Acronyms and Abbreviations

**AIDS Acquired Immune Deficiency Syndrome**

**AMLSL Association of Medical Laboratory Scientists of Lesotho**

**ATT Advocacy Technical Team**

**CCJP Catholic Commission for Justice and Peace**

**CHAL Christian Health Association of Lesotho**

**DPE Development for Peace Education**

**GOL Government of Lesotho**

**HIV Human Immunodeficiency Virus Infection**

**HR Human Resources**

**HSA Health Systems Assessment**

**LCN Lesotho Council of Non-Governmental Organisations**

**LDHS Lesotho Demographic Health Survey**

**LeBoHA Lesotho Boston Health Alliance**

**LENASO Lesotho Network of AIDS Services Organisations**

**LENEPWA Lesotho Network of People Living with HIV/AIDS**

**LIRAC Lesotho Inter-religious AIDS Consortium**

**LMA Lesotho Medical Association**

**LMDPC Lesotho Medical Dental and Pharmacy Council**

**LNA Lesotho Nurses Association**

**LNC Lesotho Nursing Council**

**LNFOD Lesotho National Federation of Organisations of the Disabled**

**LPPA Lesotho Planned Parenthood Association**

**MDGs Millennium Development Goals**

**MOH Ministry of Health**

**NAC National Aids Commission**

**NGO Non-Governmental Organisation**

**NMDS National Manpower Development Secretariat**

**NSDP National Strategic Development Plan**

**NUL National University of Lesotho**

**PHC Primary Health Care**

**PSL Pharmaceutical Society of Lesotho**

**PSC Public Service Commission**

**QINUASA Qiloane Nursing Assistants Association**

**RSA Republic of South Africa**

**SDGs Sustainable Development Goals**

**SWOT Strengths, Weaknesses, Opportunities and Threats**

**TRC Transformation Resource Centre**

**TSC Teaching Service Commission**

**WHO World Health Organisation**

**HRDSP Human Resources Development and Strategic Plan**

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# Introduction

Through support and coordination of the Lesotho Boston Health Alliance (LeBoHA),

Health professionals associations in Lesotho came together in 2015 to form a coalition committed to a demand-led health systems strengthening for improved health service delivery for all. The coalition’s work is premised on the conviction that health systems strengthening for improved service delivery for all could only be achieved if professionals and other health workers demand for practice and policy changes through consolidated, systematic and strong advocacy interventions. The coalition members include Lesotho Medical Association (LMA), Lesotho Nurses Association (LNA), Qiloane Nursing Assistants Association (QINUASA), Pharmaceutical Society of Lesotho (PSL**)** and Association of Medical Laboratory Scientist of Lesotho (AMLSL). The members individually have the mandate to enhance capacity of their constituency to deliver quality health service under conducive working conditions while promoting the highest professional and ethical standards. They pursue these through advocacy and lobbying for favourable working conditions, relevant and responsive health policies; skills development for membership through training workshops, Continuous Professional Development ( CPD) initiatives ; research and information sharing on emerging health issues etc.

However, majority of coalition members suffer from weak institutional capacities, hence their effectiveness in influencing policy change is still neither here nor there.

Alongside the associations exist the two professionals’ councils namely; Lesotho Medical Dental and Pharmacy Council (LMDPC) and the Lesotho Nursing Council (LNC). The councils have been established by Acts of parliament as professional regulatory bodies. Among others their mandates include to regulate the activities of clinics and hospitals, the practise of health professionals and keep an updatable digitize database for all medical practitioners, Dentists, Pharmacists, Nurses, Midwives, Allied health professionals and Basotho medical students in the country.

This advocacy strategy sets out the Coalition’s key areas of work for the period 2017–2020. Section 1 of the strategy presents a brief analysis of the Lesotho health situation in terms of health service providers and important basic and recent health statistics. Section 2 describes problems that characterise the health sector in Lesotho which form basis for the vision, mission and goals as well as the theory of change in section 4. Theory of change provides assumptions with regard to conditions that would be necessary to addressing health professional challenges and hence achievement of expected advocacy outcomes. It describes causal relationships among health problems, solutions and the advocacy outcomes. Section 3 deals with the Internal and external forces that would influence the direction of advocacy interventions. These forces are analysed using strengths, weaknesses, opportunities and threats (SWOT) analysis. An attempt is also made to propose mitigation measures to reduce the effects of the weaknesses and threats on the advocacy strategy. Section 5 describes strategic advocacy priorities in the form of outcome areas. The strategic advocacy priorities are directly linked to the health problems identified in section 2. Section 6 identifies institutional capacities and arrangements that would be necessary for the achievement of the advocacy strategy. These are called advocacy enablers. Section 7 is about monitoring and evaluation system. An advocacy implementation plan is proposed as an annexure 1.

## 1.1 Health Situational Analysis

### 1.1.1 Health Service Providers

The Ministry of Health (MOH) is the main custodian of the health sector development in Lesotho. It is responsible for setting health policy guidelines and standards, as well as coordination and leadership of all health interventions in the Mountain Kingdom. Health Policy designs are informed by the National Strategic Development Plan (NSDP) 2012/13 – 2016/17. Section 5.4 of chapter 5 of the NSDP aims to *improve health, combat HIV and AIDS and reduce vulnerability*. The Lesotho National Health Policy is the principal framework that guides health development interventions. There is the Health Bill of which the coalition should advocate for its enactment. Lesotho being part of the global village, international trends, standards, declarations, conventions and protocols, such as Millennium Development Goals (MDGs) (now Sustainable Development Goals - SDGs), WHO standards on health workforce etc influence health policy design and strategic interventions. According to the Health Sector Human Resources Needs Assessment report, the health service is delivered in partnership with Government, the private for profit and the private not-for-profit entities through a three structure of primary health care made up of health centres and private facilities. There are 305 primary facilities, 22 secondary level facilities, comprising 22 hospitals with at least one hospital in each district. More than half of the facilities (58%) are owned by the Government, 38% by the Christian Health Association of Lesotho (CHAL), and the remaining owned either privately or operated by NGOs. The majority of staff (75%) therefore is employed by the MOH, whilst 22% are from CHAL, and 3% from private and NGOs.

### 1.1.2 Health Statistics

The development of the advocacy strategy for the coalition of the health professionals associations coincides with the release of the 2015 Millennium Development Goals (MDG) global report and the 2014 Lesotho Demographic Health Survey (LDHS). The MDGs report clearly reveals that Lesotho failed to achieve targets of all health-related MDGs. Lesotho is off-track on achieving Goal 4: reducing Child Mortality, Goal: Improve Maternal Health and Goal 6 Combat HIV/AIDS, Malaria and other diseases. Of the literature reviewed for the development of the advocacy strategy, the LDHS has provided the most recent statistics and comprehensive information describing the health situation in Lesotho.

#### 1.1.2.1 HIV prevalence

The 2014 LDHS reveals that HIV prevalence has increased from 23% in 2004 and 2009 to 25% in 2014 among adults age 15-49. The prevalence rate is 30% among women and 19% among men. Overall, 35% of couples have at least one partner with HIV. In 20% of couples, both partners are HIV positive, while in 15% of couples they are discordant, that is, one partner is HIV positive and the other is HIV negative. Marital status also seems to be an important variable in HIV prevalence that is, 65% of widows are HIV positive, divorced or separated (women 49% and men 43%), married or living with partners (31% women and 30% men). The increase in the HIV prevalence rate in Lesotho is arguably attributed, to a large extent, to closure of the National Aids Commission (NAC) which was responsible for education and coordination of all HIV/AIDS interventions. It is consequently hoped that the recent resuscitation of NAC by the government of Lesotho (GOL) will change the HIV/AIDS situation for the better.

#### 1.1.2.2 Adult mortality

For women and men who have reached age 15, the probability of dying before age 50 is 44% and 48%, respectively. According to WHO Atlas of African Health Statistics 2012, mortality rate among women was 573, while for men it was 676 per 1000 population in 2009, the second biggest mortality rate in Africa after Zimbabwe. Maternal mortality per 100,000 lives was 520 in 1990, escalated to 620 in 2009 and to 1,024 in 2014. Lesotho life expectancy was 48 in 2009, dropping from 60 in 1990. The chronic high mortalities and dropping life expectancy are also attributable to high HIV/AIDS prevalence among Basotho. Another important factor is availability of health facilities. WHO Atlas of African Health Statistics 2012 reveals that among households in which members travel to the nearest health facility by walking, 27% require more than 120 minutes of travel time. However, institutional deliveries in Lesotho have increased from 52% in 2004 to 59% in 2009 and to 77% in 2014. Home deliveries are more common in rural areas and among less educated and poorer women.

# 2. Problems that characterise the Health Profession in Lesotho.

## 2.1 Shortage of Human Resources for Health

### 2.1.1 Inability to absorb health professionals into health employment sector

An apparent problem in the health profession is the supply of health professionals compared to the clients who seek health services. But when looked closely and critically, supply is not the primary problem. With the exception of the medical doctors, there is inability of the health sector to absorb a significant number of health professionals who are roaming outside the health employment sector. Colleges and universities continue to produce hundreds of nurses/midwives, nursing assistants, laboratory scientists and technicians and pharmacists but the real problem is the employment sector’s inability to adequately absorb them despite the acute need for the increased workforce. The bottle neck and the root cause of the low absorption of the graduated health professionals into the employment sector could be traced to the employment policy of the government. There is what is called establishment list which prescribes the number of health workers to be recruited within a certain period of time irrespective of the actual need on the ground. It is apparent that the establishment list policy is not consistent with the magnitude of need on the ground. Notwithstanding, supply of health workers would still remain a concern even if absorption is optimised.

### 2.1.2 Disproportionate distribution of health workers and resources

The problem of shortage is exacerbated by disproportionate distribution of health workers, with most health workers based in the lowlands and urban areas of the country at the expense of the rural and mountain areas. The lowlands and urban areas are better endowed in terms of essential services such as electricity, communication mechanisms, reliable transportation, accommodation, entertainment and enjoyment of social life. The inadequate distribution of the health workers against the rural and mountainous areas has a large and negative impact on people’s health, leading to preventable death and suffering.

According to the Lesotho Health System Assessment 2010, although more than 60 percent of health care is supplied at the Primary Health Care (PHC) level, less than 20 percent of the formal sector labour supply is employed at the PHC level, suggesting a poor distribution of the health workforce. The largest share of the formal sector labour force is employed at the secondary level (46 percent), and 24 percent are employed at the tertiary level. As a result, as of 2004, only 31 percent of filter clinics had the full-time equivalent personnel that they required, and only 41 percent of health centres met minimum staffing standards with respect to nursing personnel. Conversely, the national referral hospital had 108 percent of their full-time equivalent nursing requirements met, and district hospitals had 50 percent of their nursing requirement filled.

Staffing at all levels of the health system is inadequate, causing poor service delivery at community health centres, where PHC is essential. Poor service delivery distorts the referral system whereby patients that should obtain care at lower level facilities refer themselves to a higher level within the health system, rendering organization of services chaotic, impairing access to services and negatively affecting the quality of services offered.

The MOH provides a standard incentive package (M275/month) to employees assigned to the mountainous regions of the country. The amount has insignificant impact. In addition, certain cadres of staff (doctors) receive a sitting allowance when required to work over a specified number of hours. Development partners such as the Clinton Foundation are providing a top-up allowance to nurses working in ART clinics.

### 2.1.3 Brain drain

Brain drain plays a significant role in creating shortages in the health workforce. The fact of the matter is health professionals are a scarce resource throughout the world. Therefore competition over the workforce has become a prominent feature in the health sector. Lesotho is particularly confronted with fierce competition from the neighbouring South Africa, which like other developed countries such as the United Kingdom has more competitive remuneration packages that attract health professionals from poorer and less competitive states. The country has made an effort to train more professionals but attrition is very high and the country has not made an equal effort to promote retention of the trained workforce.

## 2.2 Over-dependence on RSA health system and capital flight

### 2.2.1 Limited medical equipment and health supplies

Limited medical equipment, insufficient and inconsistent drug supply and other health commodities is one of the most glaring challenges in the health profession in Lesotho. Most health facilities lack the basic equipment and drugs necessary for delivering basic health services. In few facilities where the equipment and drugs are available, it is of a very inferior quality. Even the more advanced Queen ‘Mamohato Memorial Hospital has proved to be limited in a number of cases hence heavy referrals onto the South African medical system. Purchase of drugs takes one of the biggest proportion of the budget of the Ministry of Health. There is frequent stock run-outs and the fact that these drugs are not produced internally becomes very expensive for the country.

### 2.2.2 Limited specialised medical practice

A related problem is the limited number of medical doctors and other health professionals with specialisation. There is scarcity of surgeons, psychiatrists, gynaecologists, cardiologists, dermatologists etc. Most doctors, nurses, pharmacists and medical laboratory scientists are general practitioners who are unable to get to the bottom of a lot of chronical and non-communicable disease. In the like manner there is heavy reliance on the South Africa system. The country does not only lose millions of maloti for referrals into the South African facilities, but a lot of lives that could otherwise be saved through specialised practice are being lost every day. The problem owes to lack of decisive policy decisions to produce specialised health professionals and implement retention programmes.

## 2.3 Poor health service delivery

### 2.3.1 Weak accountability and supervision

While there may be clear targets for service delivery on the part of the health workers, accountability mechanisms are very weak. Adherence to standards and number of clients to be served in a day is very minimal. The problem is related to weak or total lack of supportive supervision, a sign for weak management and leadership in the health institutions. Professional errors are always reported in health facilities but perpetrators are seldom held to account. The weak accountability and supervision are to a large extent responsible for poor service delivery in the health facilities and hence failure to meet national and international targets and standards. A related phenomenon, arguably caused by scarcity of medical doctors in the system coupled with weak accountability and supervision is that medical doctors spread themselves too wide, working in public health facilities, as consultants and in private practice. Efficient and effective service delivery gets compromised as they shuttle between the different duty stations, resulting also in late arrivals and limited focus.

### 2.3.2 Deteriorating professional ethics

The health workers in Lesotho have for long time been criticised for relating quite poorly with patients and clients. While there have also been reported errors in the technical aspect of their work, the outcry, particularly in public facilities, is that health workers display bad attitudes, impatience, intolerance and highly compromised work ethic. The cause of these unprofessional behaviours is related to a multiplicity of realities; health facilities are understaffed and therefore staff are overwhelmed by unbearable work overload. Health workers are also strained by bad management and leadership of the health institutions that is so “top-heavy” onto them with little people management skills. They are also demoralised and demotivated by lack of upward movement in their career paths. Quite admittedly the health professionals also come out of universities and colleges ill-prepared to deal with public relations pressures that are a characteristic of the sector.

### 2.3.3 Weak financial absorptive capacity

According to WHO Atlas of African Health Statistics 2012, compared to its peers, Lesotho spends $54 per capita on health, which is higher than the $34 per capita required to provide a minimum package of health interventions. The World Bank (2009) reveals that Lesotho does not suffer from an inadequacy of funds, but rather from chronic underspending of health resources, as well as from a less than optimal allocation of health resources. The most serious implication of consistent underspending of the MOH recurrent budget is that it portrays a picture that there is no need for additional funding for health care services in Lesotho in the short and medium term. There is a shared view that Lesotho is over-resourced in the health sector, with the major problem being that funds do not reach intended beneficiaries in adequate amounts and on time. The key question is to deal with the bottlenecks in health funding in Lesotho; otherwise, any attempt to raise additional revenues for health care services will be met with serious scepticism. The MOH needs to seriously address the root causes of underspending its recurrent budget before attempting to raise additional revenue.

### 2.3.4 Limited participation of health professionals in health policy determination

Interview with the key informants revealed that issues of good governance within the health sector are not held high. In particular, participation of the health professionals who do not only have expertise and first-hand experience but are also the primary implementers of the health policies, strategies and programmes, do not get to inform policy direction. Limited participation of the implementer results into weak ownership of the health frameworks, hence cripples implementation. Limited participation has to do with the generic problem of lack of consultation culture in the policy environment in Lesotho.

Problem Tree Analysis

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# 3. Internal and external forces

The main purpose of strategic planning is to bring balance between an organisation’s internal and external forces. The internal and external forces determine the extent to which an organisation succeeds in achieving its mandate. Strengths, weaknesses, opportunities and threats (SWOT) analysis is done from the information generated from the literature review, interview with key informants and the focus group discussion.

|  |  |  |
| --- | --- | --- |
| Strengths | Weaknesses | |
| Because the coalition is at its infancy, it is hosted and incubated by a well-established LeBoHA which has secured donor funding for the organisational development and institutional capacity of the coalition. This arrangement could be strengthened by deploying coalition volunteers while LeBoHA continues to provide mentorship.  There is steering committee for the coalition with terms of reference and a memorandum of understanding, which brings about oneness within members of the coalition.    Members of the associations and the coalition itself are health professionals who have first-hand experience and expertise of the health system. This is an important strength because the health professionals, as primary implementers, own the issues that affect them on daily basis. They are not advocates of the people but are more of self-advocates hence the possibility for impact is maximised. This is more so because the associations seem to have built the necessary levels of enthusiasm and drive to influence policy change in the health sector. | The coalition is not legally registered. This does not only mean they cannot access funding from development partners, but they also do not have a constitution to guide their operations. In the absence of the constitution, the coalition remains susceptible to membership conflict with no point of reference for providing conflict management and resolutions.  Furthermore, the coalition does not have a secretariat with office space and staff to coordinate and manage interventions. The coalition operations, which are mostly organisational development, are currently hosted by the LeBoHA. While it is good for the coalition to be hosted by a well-established LeBoHA, the coalition should start assembling its own staff to slowly wean themselves out for an independent establishment. The starting point could be engagement of qualified volunteers to sit within the LeBoHA secretariat to start advocacy operations and resource mobilisation.  Further while they are all legally registered and have constitutions, most of them do not have secretariat and full time staff. The work is mostly done by executive committee members who are also full time employers of health institutions elsewhere. This arrangement definitely affects the effectiveness of the associations. Advocacy and resource mobilisation thus not well coordinated. In the like manner the coalition members should also employ the volunteer strategy to ensure the executive committees remain at the oversight level while staff handle day-to-day operations. | |
| Opportunities | Threats |
| In the advent of diminishing donor funding due to economic challenges among rich countries, development partners seem to opt to channel funding through coalitions, networks, and federations. So, the health professional associations have better opportunities to secure funding when they work as coalition.  Furthermore, the formation of the coalition comes at a very opportune time just coinciding with the Millennium Development Goals (MDGs) report and the newly adopted Sustainable Development Goals (SDGs) as well as release of the 2014 Lesotho Demographic Health Survey. This coincidence does not only provide plethora of new funding opportunities to respond to results and new global goals particularly pertaining to issues of health, but it also necessitates and makes the coalition much more relevant to contribute and respond through a demand-led advocacy. The situation also provides an opportunity for the coalition to collaborate with other non-health professional associations. | The current political trajectory in Lesotho under coalition governments becomes a big threat to advocacy work. That is, coalition governments by their very nature are very unstable and may collapse before completing their constitutional term. So sudden and frequent change decision makers within government institutions hampers progress and continuity of the advocacy work and minimise changes of achieving expected outcomes. |

# 4. Theory of Change

The advocacy strategy for the coalition is premised on the National Health Policy’s goal *to significantly reduce morbidity and mortality, thus contribute to attainment of improved health status among the people of Lesotho.* To achieve this goal a number of problems that describe the health sector in Lesotho have to be addressed.

Morbidity and mortality could be reduced and hence contribute towards improved status of the people of Lesotho if first, there is sufficient supply, absorption, proportional distribution at different levels and retention of the health workforce through incentivized programmes. Incentivised retention programmes would curb high attrition and brain drain caused by fierce competition from RSA. These would make health service delivery more sustainable and accessible to all and hence reduce morbidity and mortality. The goal of the National Health Policy would further be achieved if there is adequate and sophisticated supply of health medical equipment and specialised medical personnel. Adequate supply of sophisticated equipment and specialisation would contribute towards reduction of morbidity and mortality, while also curbing capital flight experienced through the referrals of patients into a more sophisticated but expensive South Africans health system.

Secondly, good governance should be upheld to create the necessary impetus, morale and motivation to health workers. The assumption is that if the health workers as the implementer of the health policies, strategies and programmes participate at the conceptual stages, they are likely to be relevant and enjoy ownership by the health workers. This would also translate into upholding professional ethics and treating clients and patients with the highest levels of professionalism, hence delivering effective and high quality health services.

Thirdly, Budget execution is perceived to be a reflection of the rate at which services are delivered to the intended beneficiaries. Therefore low budget consumption means the people of Lesotho are being denied their right to health. Financial efficiency and absorptive capacity should be addressed if the morbidity and mortality are to be reduced. Individual performance targets and strong monitoring mechanisms should be established to address the chronic under expenditure in the health sector in Lesotho.

## 4.1 Vision

A country where morbidity and mortality are significantly reduced, thus contribute to attainment of improved health status among the people of Lesotho.

## 4.2 Goal

To advocate for improved access to high-quality and sustainable health services for all through health systems strengthening initiatives.

## 4.3 Objectives

* To advocate for increased supply, absorption and retention of the health workers into the sector through incentivised programmes by 2020.
* To advocate for enhanced health service delivery for all through efficient financial absorptive capacity, good governance and upholding professional ethics.
* To advocate for advanced medical equipment and more specialised medical practitioners to curb mortality and capital flight.

# 5. Strategic Advocacy Areas

The advocacy strategy prioritises the following outcome areas as a response to the problems that characterise the health profession in Lesotho:

* Human Resources for Health strengthened
* Medical Equipment and Specialised Practice improved
* Strengthened Professionalism among the health workers
* Good governance in health sector policy environment enhanced
* Financial resources absorptive capacity in the health sector improved
* Supervision and Accountability strengthened

## 5.1 Human Resources for Health Strengthened

### 5.1.1 Absorption

The paradox between the supply and demand in the health workforce results in disguised shortage. As already identified the problem stems from the recruitment guidelines of the Public Service Commission (PSC) which use the establishment list system. It inhibits the health sector from absorbing health workers into the workforce to fill the chronic shortage. The government should review the current establishment list system. The move should be towards absorbing all health professionals still outside the employment sector to improve the client-health worker ratio. This should be coupled with a long-term health sector reform in which the country delinks recruitment of the health workers from the PSC and form Health Service Commission as in Zambia and Malawi. This should however be treated with caution as the Teaching Service Commission (TSC) which is delinked from the PSC still experiences absorption limitations in spite of the unpalatable student-teacher ratio.

#### 5.1.1.1 Advocacy issues

* Review establishment list to respond to the demands of the health workforce on the ground to improve absorptive capacity.
* Delink management of the human resources from Public Service Commission and establish Health Service Commission

### 5.1.2 Supply

While the immediate challenge is absorption, supply remains a big concern. Even if all health professionals outside the system were to all be absorbed the numbers would still be below the WHO standards. The scarcity of medical doctors in particular needs to be addressed through long-term supply and retention programmes. The efforts to have a medical school should be accelerated and such a school should be attached to the already established and better equipped (with support systems and infrastructure) National University of Lesotho (NUL). Lesotho Health Systems Assessment 2010 has already indicated that 62% of the medical workforce is made of expatriates. This calls for an aggressive and decisive policy decision for the country to produce its own doctors to ensure reliability and sustainability of medical service delivery in Lesotho.

The country’s problem is more than production and supply of doctors; high attrition is quite prominent. The National Manpower Development Secretariat (NMDS) has invested the country’s resources on education of the Basotho people in medicine among others but many of the beneficiaries either do not return to work in the country or they leave the country after a short while. This has rendered NMDS efforts into just an expenditure and not investment. To address the situation the country should develop retention programmes. A bold and decisive policy decision should be made to boost the country’s competitive advantage by providing preferential remuneration packages to retain and attract health professionals, particularly the medical doctors. A preferential treatment for health professionals is necessary if the country has to meet the WHO standards and deal with the plethora of chronic health challenges that confront the nation.

#### Advocacy Issues

* Establish retention policy and/or implement Retention Strategy of 2010.
* Accelerate establishment of Lesotho medical school within the National University of Lesotho by 2017.
* Provide preferential and competitive remuneration packages to health workers to curb attrition and improve retention.

### 5.1.3 Distribution

The distribution of the health workforce within geographical and levels of the sector is another important advocacy strategic area. A policy decision has to be taken to bring about a fairly balanced distribution of the workforce between hard to reach rural and mountain areas and the lowlands and the urban centres. But the balance could only be achieved through introduction of the pull factors into hard-to-reach rural and mountain areas. Such factors should include those incentives such as meaningful (significant) hardship allowance, communication allowance, transportation allowance, accommodation with electricity and internet facilities etc. The M275 is too insignificant to attract workers from the luxuries available in lowlands to the ill-equipped mountain areas. For sustainability purpose, this initiative should primarily be financed from the national coffers as opposed to donor funding that may disappear after some time. The same balance should be introduced across PHC level, secondary level and tertiary level. The need is more at the PHC level but more supply is at both secondary and tertiary levels. As part of the solution, the country should invest in paraprofessionals and community health workers.

* + - 1. Advocacy Issues
* Provide more attractive incentives for workers in hard-to-reach areas to address the imbalance. Other incentives shall include transportation allowance, internet and communication, accommodation with electricity.
* The incentive strategy should be financed from the national coffers.
* Produce and engage more paraprofessionals and community health workers to bridge the gap at the PHC level.

## 5.2 Medical Equipment, drug supply and Specialised Practice Improved

The limitation of the medical equipment, insufficient supply of drugs and scarcity of specialised practitioners do not only cripple service delivery and lead to unnecessary deaths, but they also perpetuate capital flight into the RSA health economy and dependency syndrome. Budgetary adjustments should be made to invest in more sophisticated medical equipment across the majority of the health centres. There should also be an establishment of drug manufacturing factory in the country to improve supply and curb capital flight. In a similar note, the MOH should come up with priority areas for medical specialisation for the country to produce professionals in those. This would again be just an expenditure and futile exercise if it is not coupled with implementation of a sound retention programme. Specialised practitioners should have remuneration packages that would stifle competition from RSA and other Western Countries. The very resources used to export patients to RSA could in the future be utilized for purchase of the required equipment in RSA and for the training of the specialised practitioners.

### Advocacy Issues

* Invest in sophisticated medical equipment to curb capital flight and loss of lives.
* Invest in internal manufacturing of drugs and medical supplies
* Invest in training of medical specialists and develop and implement retention policies that give preferential remuneration packages

## 5.3 Professionalism among the health workers strengthened

While increased supply, absorption and retention programmes are being implemented to ease pressures associated with limited staffing, staff and management should undergo continuous pre and in-service training to strengthen professional ethics and conduct in the advent of increasing demand for health service. The pre-service and in-service programmes should be geared towards building capacity of the health professionals to handle public relations and customer care, people management, leadership and good governance. Functions and functionaries within the health sector should be unpacked to create an ascension ladder for high performing workers. Remuneration packages for health workers should go beyond ordinary standards for motivation, curb attrition and ease the impact of the work overload. In addition LMDA and LNC should be strengthened to ensure adherence to professional ethic and public welfare.

### Advocacy Issues

* Design and implement pre and in-service training programmes geared towards enhancing professional ethics and conduct of health workers.
* Provide preferential remuneration packages to boost morale of the health workers.

## 5.4 Good governance in health sector policy environment enhanced

Involvement of health professionals in the design and development of health policies, strategies and programmes should be a matter of law and must be practised to the letter. The current Health Bill must be reviewed to include a professional’s participation clause that makes it mandatory for all government institutions to seek input and involvement of the health professionals in the development of the health frameworks. The involvement of the health professionals as the primary implementers of the frameworks will not only promote ownership and enthusiasm but would bring about the most relevant and responsive health interventions.

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### 5.4.1 Advocacy Issues

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* Enact Health Bill with professional’s participation clause in all health development frameworks.

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## 5.5 Financial resources absorptive capacity in the health sector improved

As already identified, the immediate problem in the health sector is not financing per se but absorption of allocated financial resources. The health sector receives the second biggest share of the national budget after education and training and enjoys one of the largest donor funding. However, there are ineffectiveness and inefficiencies in delivering planned interventions, hence low financial absorption rate. So underspending should be addressed immediately to provide a clear and true picture of financial gaps in the health sector. To improve the absorptive capacity of the health sector, monitoring, evaluation and reporting systems should be strengthened and streamlined to ensure that interventions, schedules and targets are adhered to. Low absorptive capacity is a clear reflection of the fact that service delivery for beneficiaries has failed. The health workers should operate on the basis of institutional and individual work targets and be accountable for the achievement of the set standards. This would improve service delivery, hence increased budget execution. Budget allocation should also be commensurate with need at different levels. PHC is the level where most of the resources are needed because this is where most services are discharged.

### Advocacy Issues

* Design and implement result-based management to promote effectiveness and efficiency of the budget execution.
* Design and implement routine monitoring and reporting mechanisms to improve accountability.
* Provide an equitable and proportional budget allocation among the levels of the health sector. More resources should be allocated to the PHC where need is big.

# 6. Advocacy Enablers

A certain level of institutional infrastructure should be established to enable the coalition to achieve its advocacy outcomes. These would include some kind of organisational structure for advocacy coordination, capacity development, monitoring and evaluation system and financing.

## 6.1 Organisational Structure

Advocacy work should be a team effort and needs organisational structures for effective coordination and sustainability. At the minimum the following structures should be put in place to coordinate advocacy efforts; advocacy technical team (ATT); coalition secretariat; coalition Board/Executive Committee; and the coalition membership.

### 6.1.1 Advocacy Technical Team

The coalition should establish Advocacy Technical Team (ATT) to coordinate and lead all advocacy interventions; develop advocacy strategies; investigate and conduct minor research on matters related to the sector; raise awareness on advocacy issues; produce policy briefs; and build capacity of members on different aspects of advocacy. The ATT shall be drawn from the coalition association membership and meet quarterly or when necessary.

### 6.1.2 Coalition Secretariat

The coalition shall establish a secretariat whose responsibility among others shall be to provide secretarial, logistical and technical support for the ATT- setting appointments for meetings, arrange transport and meals etc.; follow up advocacy issues in between ATT settings; conduct minor research exercises for the ATT and sometimes provide capacity to ATT members and mobilise resources for advocacy initiatives. All programme staff shall become part of ATT.

### 6.1.3 Coalition Board/Executive Committee

The Coalition Board shall have an oversight role over the work of the secretariat and ATT; review and approve advocacy plans and reports (narrative & financial) from the coalition secretariat.

### 6.1.4 Coalition Member

The membership shall also have oversight responsibility over the Coalition Board. The coalition membership shall approve advocacy proposals, recommendations and reports during Annual General Meeting (AGM) and give advocacy mandate to the Board. Members will also participate in advocacy campaigns.

*Organisational Structure for Advocacy*

## 6.2 Financial Resources

The coalition shall engage in aggressive and innovative resource mobilisation initiatives for effective and sustainable advocacy interventions. The financial resources shall be solicited from development partners, private sector, membership contributions and any other internal fundraising initiatives. The coalition shall develop a resource mobilisation strategy to guide all the resource mobilisation initiatives.

## 6.3 Capacity Development

First of all, the secretariat shall be manned by staff with experience in project management to guide effective advocacy. The coalition shall also engage qualified volunteers to strengthen the capacity of the secretariat. The secretariat in turn shall develop a capacity development plan to promote on-job training initiatives. The secretariat shall engage in regular research and update the membership, the Board and ATT members of the latest national and international standards, health policy areas and good lessons in the advocacy work. This would enhance informed advocacy work.

# Monitoring and evaluation

The coalition should develop a monitoring and evaluation (M&E) system to ensure adherence to scheduled activities, track progress towards achievement of outcomes as well as derive lessons from advocacy interventions for future programming. At the least the coalition should start off with the development of monitoring and evaluation plan for the advocacy strategy. The M&E plan should have features that enable both qualitative and quantitative measurement on outcomes. The outcome indicators and targets should be the primary point of measurement for tracking progress towards achievement of the advocacy outcomes. The proposed minimal structure of the M&E plan should feature outcomes and indicators (as stated in the strategy), baseline, targets, activities, data collection methods, sources of data, means of verification.

# Annex 1: Advocacy Implementation Plan

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Advocacy Goal**: To advocate for improved access to high-quality and sustainable health services for all through health systems strengthening initiatives. | | | | | | | | |
| **Advocacy Objectives:**  1. To advocate for increased supply, absorption and retention of the health workers into the sector through incentivised programmes by 2020.  2. To advocate for enhanced health service delivery for all through efficient financial absorptive capacity, good governance and upholding professional ethics.  3. To advocate for advanced medical equipment and more specialised medical practitioners to curb mortality and capital flight. | | | | | | | | |
| **Outcome** | **Outcome indicators** | **Output** | **Advocacy Issues** | **Advocacy Targets** | **Strategies & activities** | **Allies** | **Cost items** | **Budget (M)** |
| Increased supply & equitability of human resources for health across all levels and regions of Lesotho | % of new health workers employed in PHC & hard-to-rich areas compared to other levels  # of graduated Health professionals absorbed into sector | New Recruitment system in place.  Health Service commission established  New incentive scheme established  Paraprofessionals & community workers engagement programme  Medical school established and attached to NUL  New salary scale for health worker | Review establishment list to respond to the demands of health workforce on the ground to improve absorptive capacity.  Delink management of the human resources for health from Public Service Commission and establish Health Service Commission  Provide more attractive incentives for workers in hard-to-reach areas to address the imbalance. Other incentives shall include transportation allowance, internet and communication, accommodation with electricity. The incentive strategy should be financed from the national coffers.  Produce and engage more paraprofessionals and community health workers to bridge the gap at the PHC level.  Establish retention strategy and/or implement Retention Strategy of 2010.    Accelerate establishment of Lesotho medical school within the national university of Lesotho by 2017.  Provide preferential and competitive remuneration packages to health workers to curb attrition and improve retention. | Public Service Commission, Ministry of Health, Ministry of Public Service, Office of PM | Hold Lobbying meetings with identified targets.  Undertake social mobilisation campaigns through multi-media  Undertake survey to establish number of health professionals produced, absorbed and those who exit | WHO, UNAIDS, LCN (Health & social Development Commission), LeBoHA, LPPA, Pitsong Research Institute, LENEPWA, LENASO, LIRAC | Hall hire, meals, stationery, transport  IEC materials, radio & print airtime, meals, stationery, transport, accommodation  Technical fees, transport, communication, stationery | 50 000  300 000  350 000 |
| Improved Medical Equipment and Specialised Practice | % of Basotho doctors who are qualified in specialised areas  Quality of medical equipment in health facilities |  | Invest in sophisticated medical equipment to curb capital flight and loss of lives.  Invest in training of medical specialists and develop and implement retention policies that give preferential remuneration packages | MOH, MOF, MODP, NMDS | Conduct capacity needs assessment to establish quality and gap in the supply of medical equipment  Conduct capacity assessment to establish the levels of specialisation and gaps in the medical practice  Use the assessment results to lobby and campaign for prioritisation and budget allocation for improved quality of medical equipment and enhanced medical specialisation. | LCN, WHO, LeBoHA, LENASO, LENAPWA, LPPA | Technical fees, transport, communication, stationery, meals, hall hire  Technical fees, transport, communication, stationery, meals, hall hire  Transport, communication, stationery, meals, radio, TV & print media airtime | 350 000  200 000  300 000 |
| Strengthened Professionalism among the health workers | Forms of incentives available for health workers  # of clients/patients satisfied with customer services at health facilities | Training programmes designed and implemented  New salary scale for health worker | Design and implement pre and in-services training programmes geared towards enhancing professional ethics and conduct of health workers.    Provide preferential remuneration packages to boost morale of the health workers.  Design capacity building programme for the LMDA and LNC to ensure adherence to professional ethic and public welfare. | MOH, CHAL, Private facilities, MOF, MODP | Conduct Client satisfaction Survey on services of health workers  Hold lobbying meetings with identified advocacy targets for pre and in-service training programmes  Deliver induction and in-service training on ethics, customer care and professionalism for health professionals | WHO, LeBoHA, LENEPWA, LMDC, LNC | Technical fees, transport, communication, stationery, meals, hall hire  Transport, communication  Facilitation fees, meals, hall hire, accommodation, transport, communication, stationery | 200 000  20 000  400 000 |
| Enhanced good governance in health sector policy environment | # of health frameworks accommodating inputs of health professionals | Health Bill enacted  Input of coalition members in programmes, strategies and policies | Enact Health Bill with professional’s participation clause in all health development frameworks.  Involve health professionals in the design and development of health programmes, strategies and policies and legislation through their organisations. | MOH, CHAL, Parliamentary Portfolio Committee on HIV/AIDS and Social Development, Senate | Review the Health Bill before it is enacted to ensure its relevance to the needs of the health professionals  Lobby and Campaign for enactment of the Health Bill | LCN, TRC ,DPE, LNFOD, WHO, LeBoHA, CCJP, LENASO, LENAPWA, LIRACC | Meals, hall hire, accommodation, transport, meals, communication  Radio, tv, print media airtime, meals, communication, hall hire, transport, stationery | 20 000  100 000 |
| Improved financial resources absorptive capacity in the health sector | % of MOH budget expended end of financial year  Proportion of budget allocation across the 3 levels of the health sector (PHC, secondary & tertiary) | M&E plan developed & implemented  Budget allocated proportionally | Design and implement result-based management to promote effectiveness and efficiency of the budget execution.  Design and implement routine monitoring and reporting mechanisms to improve accountability.  Provide an equitable and proportional budget allocation among the levels of health sector. More resources should be allocated to the PHC where need is big. | MOH, MOF, MODP, Parliamentary Portfolio Committee on economic cluster, Senate | Undertake study on the budget allocations at different levels compared to needs  Lobby and campaign for proportional budget allocations in favour of PHC  Undertake MOH budget monitoring and publish reports through multi media | World Bank, LCN, LENEPWA, LENASO, PACT | Technical fees, hall hire, accommodation, meals, communication, stationery  Radio, tv, print media airtime, meals, communication, hall hire, transport, stationery  Technical fees, transport, communication, stationery, meals, printing, radio, tv and print media airtime | 250 000  100 000  300 000 |

# Annex 2: Advocacy Enablers Implementation Plan

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| --- | --- | --- | --- | --- | --- | --- |
| **Objective:** To strengthen organisational and institutional capacity of the coalition to achieve advocacy outcomes | | | | | | |
| **Output** | **Output Indicators** | **Activities** | **Means of Verification (of activities)** | **Cost items** | **Budget (M)** | **Responsibility** |
| Advocacy organisational structures established | # of advocacy interventions organisations by the structures | Establish advocacy structure with roles and responsibilities  Organise and undertake advocacy activities | Copy of advocacy organisational Structure document  Advocacy activity reports | Hall hire, meals, technical fees, salaries stationery, transport, accommodation  (Budgeted under the strategy) | 500 000  000 | Board & secretariat |
| Financial resources secured | # of fundraising initiatives undertaken  Amount of financial resources secured | Profile and map potential funders and develop proposals  Develop and implement resource mobilisation strategy | Copy of mapping and profiling of potential funders  Resource mobilisation strategy | Communication, stationery, technical fees  Technical fees, meals, hall hire, transport, | 100 000  100 000 | Secretariat (Director) |
| Advocacy outcomes continuously are measured throughout life of the strategy | Frequency of reports produced | Develop and implement M&E plan  Develop and utilize data collection tools | Copy of M&E plan  Copy of data collection tools | Technical fees, hall hire meals, accommodation, transport, stationery  Technical fees, Hall hire, meals, accommodation, transport, stationery | 150 000  50 000 | Secretariat (Director) |

# Annex 3: References

Government of Lesotho, 2012, *National Strategic Development Plan* (NSDP) 2012/13 – 2016/17, Maseru, Lesotho

Health Workforce Advocacy Initiative, *A Toolkit for Health Professionals Advocates*

LeBoHA, 2014, *End of Program Evaluation Report for Strengthening Professional Associations Recruitment and Retention Capacity,* Maseru, Lesotho

LeBoHA, 2016, *Strengthening Professional Associations Recruitment and Retention Capacity (SPARRC) Program: Baseline assessment report*, Maseru, Lesotho

Lesotho Medical Association, 2012, *Draft Strategic Plan 2012/15,* Maseru, Lesotho

Lesotho Medical Dental and Pharmacy Council, 2013, *Draft Strategic Plan*

Lesotho Nurses Association, 2012, *Draft Strategic Plan 2012/15, Maseru, Lesotho*

Ministry of Health and Social Welfare, 2004, *Human Resources Development & Strategic Plan 2005-2025*, Maseru, Lesotho

Ministry of Health, 2010, *Lesotho Health Systems Assessment 2010,* Maseru, Lesotho

Ministry of Health, 2011, *Lesotho National Health Policy 2011*, Maseru, Lesotho

Ministry of Health, 2016, *Lesotho Demographic and Health Survey 2014*, Maseru, Lesotho

National Aids Commission, 2006, *National HIV and AIDS Policy 2006*, Maseru, Lesotho

OSISA,

World Bank. 2009. *Lesotho Health Sector Expenditure Review*. Africa Region.

World Health Organisation 2003. *Human Resources for Health Observatory,* World Health Organization, Regional Office for Africa, Brazzaville, Republic of Congo

World Health Organisation, 2012, *Atlas of African Health Statistics 2012: Health Situational Analysis of the African Region*, Regional Office for Africa, Brazzaville, Republic of Congo

# Annex 4: List of key informants

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| **Name** | **Organisation** | **Designation** |
| Andreas Fusi | Association of Medical Laboratory Scientist of Lesotho | Vice Chairman |
| Bosiele Majara | Ministry of Health/World Bank | Project Coordinator |
| Busa Qhala | Thaba-Bosiu Health centre/Lesotho Nurses Association | Registered Nurse & mid-wife & member |
| David Matsela | Tsepong Clinic & Qiloane Nursing Assistants Association | Senior Nurse & President |
| Gertrude Mothibe | Pharmaceutical Society of Lesotho/University of Lesotho | Pharmacy Lecturer & President |
| Itumeleng Ntloko | Association of Medical Laboratory Scientist of Lesotho | Member |
| Jane Ramokhitli | CHAL | Executive Secretary |
| Keketso sefeane | KESSI Consulting | Former CEO of NAC/CEO KESSI Consulting |
| Khotso Kalake | LBTS/Association of Medical Laboratory Scientist of Lesotho | Senior Lab Technician  & Treasurer |
| Leokaoke Makhetha | National Health Training College | Laboratory Science Senior Tutor |
| Lidya Mokotso | Roma School of Nursing | School Rector |
| Lisema Phafane | Queen Mamohato Memorial hospital & Association of Medical Laboratory Scientist of Lesotho | Senior Lab Technician & Chairperson |
| Mahlape Ramoseme | Ministry of Health | Director of Planning |
| Mamathule Makhotla | Lesotho Council of NGOs | Coordinator for Health and Social Development |
| Mannuku Mokebisa | Lesotho Nurses Association | Retired Nurse & Vice President |
| Mantele Matete | Qiloane Nursing Assistants Association | Nursing Assistant & General Secretary |
| Mokobocho Teboho | Lesotho Boston Health Alliance | Admin Officer |
| Mpopo Tsoele | Pitsong Research Institute | Advisor Decentralisation & decentralised Services/ former Staff of HR alliance for Health Africa |
| Nthabiseng Moalosi | Ministry of Health | HR Manager |
| Ramaili Letsie | St. Joseph Hospital & Lesotho Nursing Council | Senior Nurse & Chairperson |
| Rante Molise | Lesotho Medical Association | Doctor & President |
| Thabang Pulumo | Maloti Hospital, Mapoteng | Chief Executive Officer |
| Thato Konstabole | Lesotho Council of NGOs | Coordinator for Agriculture, Environment and Natural Resources |
| Thato Ramokonate | Lesotho Medical Association | Office Secretary |